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Department of Human Services
Division of Mental Health and Addiction Services
Ancora Psychiatric Hospital

July 1, 2010 to August 31, 2013

Stephen M. Eells
State Auditor

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Enclosed is our report on the audit of the Department of Human Services, Division of Mental Health and Addiction Services, Ancora Psychiatric Hospital for the period of July 1, 2010 to August 31, 2013. If you would like a personal briefing, please call me at (609) 847-3470.

Stephen M. Eells
State Auditor
September 3, 2014

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Scope

We have completed an audit of the Department of Human Services, Division of Mental Health and Addiction Services, Ancora Psychiatric Hospital for the period July 1, 2010 to August 31, 2013. Our audit included financial activities accounted for in the state's General Fund and the hospital's non-appropriated accounts. We also evaluated select general controls related to the hospital's Time and Leave Reporting System encompassing security management, logical access, and change management.

The hospital provides services for voluntarily and legally committed mentally ill persons from Atlantic, Camden, Cape May, Cumberland, Gloucester, Ocean, and Salem counties. As of August 31, 2013, the hospital had 463 patients. The hospital's average annual revenues and expenditures were $25 million and $106 million, respectively, during the audit period. The major components of revenue are cost recoveries from Medicare, Medicaid, and the counties. We reviewed transactions recorded at the hospital level for county billings, however, an evaluation of the county per diem rate setting calculation was excluded from our audit scope. In addition, activity within the hospital's regional laundry service was excluded from our review.

Objectives

The objectives of our audit were to determine whether financial transactions were related to the hospital's programs, were reasonable, and were recorded properly in the accounting systems. In addition, we determined the adequacy of select general controls over the hospital's Time and Leave Reporting System including policies and procedures to manage and maintain the system, user authentication to provide system security, and recovery methods to enable system continuity.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, 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. 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 objectives.

In preparation for our testing, we studied legislation, the administrative code, circular letters promulgated by the Department of the Treasury, and policies of the Department of Human Services and the hospital. Provisions we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our sample tests of financial transactions. We also read the budget messages, reviewed financial trends, and interviewed agency personnel to obtain an understanding of the programs and the internal controls.

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

Conclusions

We found that financial transactions included in our testing were related to the hospital's programs and were recorded properly in the accounting system. We also found the financial transactions were reasonable except for certain internal control weaknesses and inefficiencies related to revenue recoveries, payroll, and purchasing which merit management's attention. Selected general controls over the hospital's Time and Leave Reporting System were adequate, although we did note that the system lacked certain features that would ensure compliance with the hospital's policies and procedures.

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Medicare Revenue

Improvement over the Medicare Part A and Medicare Part B claims process would increase revenues.

Medicare is a federal health insurance program that is comprised of two major components, Part A and Part B. Medicare Part A is hospital insurance that covers inpatient hospital care including room and board. Patients who are treated for psychiatric conditions in specialty facilities, such as Ancora, are covered for 90 days of care per illness plus a 60-day lifetime reserve with a maximum of 190 lifetime days. Medicare Part B is medical insurance that shares the cost of health care with beneficiaries through the use of an annual deductible and coinsurance. It covers medically-necessary and other preventive services. The hospital can bill Medicare for covered services when a patient with Medicare Part B coverage is seen by a doctor. Part B also covers certain inpatient hospital ancillary services when coverage is no longer provided under Medicare Part A because benefits have been exhausted. The Department of Human Services, Office of Finance, has the responsibility to submit Medicare claims for reimbursement and to follow-up on denied or rejected claims.

Medicare Part A Inpatient Hospital Insurance

During fiscal years 2011 and 2012, the department was reimbursed $7.6 million and, on average, billed Medicare Part A $693 per day. Our review of Medicare Part A billings noted the following issues.

- Hospital admission data contained 1,142 patient records for fiscal year 2011 of which 634 indicated no Medicare Part A coverage. However, our review disclosed that 10 of those patients had the coverage already in effect and another 20 patients had applied and had been approved for Social Security benefits. Those benefits, including Medicare Part A and Part B coverage, became effective either during the admission or following discharge, but prior to subsequent re-admission. As a result, updated patient eligibility information was not entered into the billing system utilized by the department. We found 1,010 Part A covered days that were not billed. The hospital has since updated some patients' admission information and billed for 586 Part A covered days. The remaining admissions are currently under review. Our review of fiscal year 2012 noted 593 Part A covered days that were not billed. If all the identified Part A covered days were recovered by the hospital, revenue recoveries would have increased by $1.1 million.

- The hospital's admission data for fiscal years 2011 and 2012 showed 1,120 admissions with Medicare Part A coverage. When compared with the department's Medicare Part A billing records, 323 of these admissions had no billing histories. A sample of 82 admissions disclosed that the department did not collect 613 Part A covered days from ten admissions. Five admissions had incomplete patient eligibility data accounting for 336 Part A covered days and the department has since billed 247 days. In addition, five other Medicare Part A claims were rejected due to incorrect information. As a result of our audit, the department

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corrected and resubmitted claims for 277 covered days. Our review also disclosed that Part A claims for one patient had not been submitted since admission in 1996. Because Medicare Part A benefits were not exhausted, potentially eligible Part B ancillary services could not be billed. Based on the Medicare Part A daily billing average of $693, potential recoveries identified in our sample totaled $424,000.

In addition, our sample included 16 admissions with private health insurance providers. The hospital did not bill private insurance for four of these admissions representing 1,483 hospital days.

Medicare Part B – Physician Billings

The hospital's Medicare Part B billing clerks regularly review each patient's medical file where doctor visits and procedures performed are recorded. Billable visits are recorded and coded on the Medicare Part B billing log sheet and entered into the department's billing system. Claims are then submitted for reimbursement by the department. Our review of Medicare Part B physician billings disclosed the following issues.

- A sample of patients with a history of Medicare Part B covered medical visits during their admission disclosed that an additional 40 percent of billable physician charges were not claimed. This may have resulted in lost revenues of $400,000 over fiscal years 2011 and 2012.

- The hospital had, on average, admitted 233 patients monthly with Medicare Part B coverage. However, our audit found an average of only 208 patients with Part B claim submissions included in their admission histories. We estimate that an additional $135,000 could have been collected if all Part B claims were submitted during fiscal years 2011 and 2012.

- Part B physician billings averaged $530,000 during fiscal years 2011 and 2012. However, not all doctors were properly documenting patient visits according to the hospital's Medicare Part B billing clerks. An additional $150,000 may have been collected if the physicians recorded patient visits in detail.

- The department processed an average of 7,700 claims totaling $555,176 annually during fiscal years 2011 and 2012. An average of 1,565 claims totaling $107,742 were denied including 219 claims because some staff physicians were not properly registered in the hospital's Medicare billing group. One physician employed since January 2010 had no billings until July 2011.

The department introduced a new Medicare Part B billing system in January 2013 which should alleviate some of the above issues.

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Medicare Part B – Ancillary Services

Medicare Part B claims for ancillary services can not be submitted unless Part A billings against a patient are exhausted, completed, or dispositions on prior billings have been received. The billing rates for fiscal years 2011 and 2012 were $39.92 and $42.51 per day, respectively, and the hospital was reimbursed $2 million. The following issues were disclosed during our review.

The hospital records showed 1,029 admissions with Medicare Part B coverage in fiscal years 2011 and 2012. There were no billing histories for 454 admissions. We reviewed 20 such admissions and noted that 5,425 eligible days for seven admissions were not billed. These eligible days included days prior to fiscal year 2011 through December 31, 2012. We estimate, the department did not bill $1.2 million for admissions with Medicare Part B Ancillary Services coverage.

The department's fiscal year 2011 and 2012 Medicare Part A billing records disclosed 510 patients having zero days paid. If Part A inpatient days for these patients were exhausted, the department should have billed Part B to recover costs. We selected a sample of 231 patients and matched these claims to the department's Part B Ancillary Services billing records. Fifty-eight patients had no ancillary services billings and another 64 patients' billings were incomplete. We further analyzed 10 patients with no ancillary services billings and found that 2,919 eligible days were not billed. We also analyzed 11 patients with incomplete billings and noted that 568 days were not billed. The department has since billed all 3,487 days brought to their attention. These days billed included days prior to fiscal year 2011. We estimate the department could have billed Medicare Part B for an additional $400,000 in fiscal years 2011 and 2012. Although Medicare Part B recoveries lower the costs included in the county per diem rate calculation, the additional recoveries from both Medicare Part B Physician and Ancillary Services would have had an insignificant effect on the county rate.

Recommendation

We recommend the Department of Human Services and/or the hospital:

- Improve the monitoring of patients whose social security benefits are applied for during their admission and update the system once the benefits are approved.
- Review admissions with Part A and Part B coverage that have no billing histories to ensure all claims are properly submitted.
- Bill private insurance providers where applicable.
- Provide additional training for billing professionals to ensure all Medicare Part B billable visits are properly transferred from the patient records to the billing sheets including instructions for physicians to write patient consultation in detail.

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- Ensure all physicians are properly registered in the hospital's Medicare billing group.

- Monitor and review Medicare Part A claims with no payments to determine if benefits have been exhausted and services could then be billed.

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Interim Assistance

Interim Assistance should be closely monitored to enhance monetary recoveries from patients.

Interim Assistance (IA) is a payment procedure developed by the State of New Jersey and the Federal Social Security Administration. The IA program allows patients who are eligible and have applied for Federal Supplemental Security Income (SSI) to receive an advance of state funds to cover care and maintenance costs at a program sponsor (community home) upon their release from a state psychiatric hospital.

Between fiscal years 2008 and 2013 the hospital disbursed $3.8 million and recovered only $2.1 million. IA is intended to act as a revolving fund, serving the needs of the greatest number of patients while regularly recovering advanced funds through the capture of retroactive SSI benefit payments. Our review disclosed that the hospital did not monitor patients' SSI applications once submitted. IA costs are reviewed only when patients' retroactive SSI benefit payments are received by the hospital. Retroactive payments were occasionally sent to patients or their representative payees. The hospital's recovery efforts were insufficient. The hospital maintains a manual patient ledger which shows current disbursements and receipts. However, our review disclosed no summary records of amounts outstanding from previous fiscal years. Patients or their representative payees with outstanding balances were not referred to the attorney of the Department of Human Services, Division of Mental Health Services for legal actions as required by the N.J.A.C. 10:38-7.8. Our sample included all IA program recipients during the month of August 2012. As of June 2013 outstanding balances from misdirected retroactive payments totalled $130,000.

In addition, the hospital's lack of oversight on patient movement while under the care of the program sponsors resulted in overpayments to these sponsors. Requests for refunds were not made, even though the hospital was aware of the overpayments. Our sample disclosed $3,800 in overpayments to sponsors for IA recipients in August 2012.

Recommendation

We recommend that the hospital strengthen monitoring of patients' SSI applications, increase efforts to recover advanced funds from patients or their representative payees by properly maintaining records of outstanding balances with referrals to DHS attorneys in compliance with N.J.A.C. 10:38-7.8, and seek refunds of overpayments from sponsor providers.

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Overtime

The hospital needs to monitor overtime hours and enforce overtime policies.

Direct Care Scheduling and Control

The hospital paid $9.5 million in overtime during fiscal year 2012 of which $8.2 million were attributed to employees with direct patient-care duties. This represents an increase of $2.2 million when compared to fiscal year 2011. Our review disclosed the following.

- The hospital has an overtime policy for the well-being of both patients and employees. The policy prohibits employees from working more than 16 consecutive hours in a given day, working double shifts on two consecutive days, or working in excess of 40 overtime hours in a two-week pay period. The policy was implemented to maintain a safe working environment for employees and to ensure quality care for patients. Our review disclosed that an average of 54 employees worked more than 40 hours of overtime each pay period in fiscal year 2012. Our review also found instances where employees worked more than 80 hours of overtime during a two-week pay period in addition to their normal work week, worked more than 16 consecutive hours in a day, and worked double shifts on two consecutive days.

- Overtime compensation for employees with other direct care titles, such as Human Services Assistant, Human Services Technician and Licensed Practical Nurses totalled $4.7 million in fiscal year 2012. We reviewed the scheduling of those titles for the month of June 2012. Our review disclosed that, on average, the hospital had a shortage of 26 employees in these titles scheduled from Friday to Monday and the hospital incurred an average of 533 overtime hours per day for that time frame. In addition, we found that, despite an average of 18 employees more than staffing needs indicated, from Tuesday to Thursday the hospital incurred 279 overtime hours per day.

- We analyzed nurse scheduling for two pay periods and noted that the hospital was required to provide 101 charge nurses to work the three daily shifts. However, 114 charge nurses worked during these two pay periods, an overage of 13. Eight nurses received overtime compensation.

Our review also noted that Supervisors of Nursing Services (SNS) approved regular and overtime timesheets, including their own. This is not in compliance with hospital policy and weakens the internal controls over time reporting. All timesheets are to be approved by an Assistant Director of Nursing Services.

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Casual Overtime

Hospital employees with direct care titles recorded 19,000 hours in casual (less than 3 hours) unscheduled overtime in fiscal year 2012 amounting to $821,000. This is the result of employees arriving prior to the start of a shift, working through break time, or remaining beyond the end of a shift. These unscheduled hours were not pre-approved and justifications were not detailed on time records. Casual overtime may result from habitual behavior rather than necessity. The following are examples that were found during our review.

- Supervisors of Nursing Services incurred 3,581 casual overtime hours during fiscal year 2012. One SNS employee claimed extended shift overtime for 171 of 176 shifts, while another recorded 114 half-hour or less break overtime claims and an additional 147 extended shift claims.

- Charge nurse positions also incurred 6,828 casual overtime hours totaling $353,820 including one charge nurse with 144 half-hour or less pre-shift claims out of 227 shifts.

Recommendation

We recommend the hospital:

- Strictly enforce its existing overtime policy to maintain a safe working environment for its staff and to provide quality care to its patients.

- Review the scheduling process for employees with direct care titles with the objective to reduce overtime by the balancing of staffing levels throughout the week and avoiding extraneous overtime compensation when staffing levels exceed the minimum requirements.

- Enforce its timesheet authorization policy to ensure hours worked, especially overtime hours, are properly authorized.

- Strengthen controls over casual overtime. The hospital should advise the payroll unit to not pay casual overtime unless reasonable explanations are provided on timesheets with proper authorization.

Assistant Directors of Nursing Services

Excess hours worked by an Assistant Director of Nursing Services should not result in cash compensation.

The Nursing Care Coordinator office (NCC) was established for the purpose of improving the quality of patient care. Operated 24 hours per day, the NCC is staffed through the use of 14

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Assistant Director of Nursing Services (ADONS) positions with salaries averaging $90,938 in fiscal year 2012. All ADONS are in a non-limited (N4) title. Per N.J.A.C. 4A:6-2.3(b)-2, employees in this title work at least a 40-hour workweek with occasional requirements for a longer workweek to complete projects or assignments. These employees are not eligible for cash overtime compensation. However, our audit found that whenever ADONS worked in excess of 40 hours in a workweek, the hospital paid these employees $45 per hour through the use of a Department of Human Services-approved Special Services title. In fiscal year 2012 these additional payments totaled $147,000. Excess hours were generally the result of ADONS covering shifts as a result of leave and did not represent extraordinary work activities.

Recommendation

We recommend the hospital consider the use of non-cash compensation for Assistant Directors of Nursing Services.

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Purchasing

Controls over purchasing need to be strengthened.

The hospital did not comply with the Department of the Treasury Circular Letter 11-10-DPP when procuring goods and services. The hospital employs a buyer who processes all purchases except medical equipment. However, the buyer was not fully utilized. Unit supervisors would make purchases without going through the buyer. We noted the following exceptions.

- We reviewed 65 transactions and found 20 purchase orders and related documents were not approved by the business office, including 13 purchase orders that were prepared after the goods or services were delivered or rendered.

- Nine of the 21 sampled purchases which required quotes did not have proper quotes on file.

In addition, our review found control weaknesses in the areas of language interpretation services, and the purchasing and distribution of patient clothing.

Language Interpretation Services

The hospital paid a vendor for language interpretation services $706,396 during fiscal year 2011. In addition to the regular hourly rate, the vendor charged a traveling fee based on miles traveled for one language and an hourly travel rate for all other languages. We could not verify if mileage or hours traveled to the hospital were accurate because itemized bills received did not list addresses of these translators. The vendor was awarded a contract in fiscal year 2014 with an all inclusive rate for each language. These rates were higher when compared to the vendor's prior billing method, regular hourly rate plus travel reimbursements. We further noted that these

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hourly rates were $13-$68 per hour higher when compared to the contract interpreter's rates utilized by the state's Administrative Office of the Courts (AOC). In addition, the AOC has a limit on the daily allowance plus reimbursement for miles traveled in excess of 60 miles roundtrip.

Patient Clothing

The hospital's clothing expenditure averaged $305,617 or $636 per patient during fiscal years 2010 through 2012, which was 50 percent more than the next highest psychiatric hospital. The hospital maintains a clothing unit with four employees responsible for maintaining requisition sheets and receiving reports, completing clothing tagging forms for issued clothing, and updating the inventory system. Our review disclosed the following weaknesses in this section.

The hospital has an inventory system that tracks the receipt and issuance of clothing. Physical counts are performed during the year. However, discrepancies noted during the count were not investigated or adjusted on the inventory system. As of December 2012, the discrepancy between the system's totals and physical inventory was $309,788. In addition, a portion of the clothing unit storage area is not secured which increases the risk of items being lost through theft.

The hospital averaged 149 clothing purchase orders annually from fiscal years 2010 through 2012. Our review disclosed the following inefficiencies related to these purchases.

- Price comparisons are not performed on items of similar quality among state contract vendors to receive the lowest price. We analyzed seven purchase orders totaling $34,207 and noted that up to $13,000 savings may have been realized if price comparisons were performed.

- Non-contract clothing items are purchased through state vendors by utilizing contract line prices associated with other items. This circumvents the Department of the Treasury, Division of Purchase and Property Circular Letter 11-10-DPP bidding requirements.

- Incorrect items delivered by vendors are accepted by clothing unit employees. This could result in inferior or worthless product purchases.

- The inventory system is incorrectly updated for price and quantity. This could lead to an incorrect par level reorder point resulting in unnecessary or emergency purchases.

Recommendation

We recommend the hospital takes necessary actions to comply with Circular Letter 11-10-DPP including proper approval of purchase orders and compliance with procurement guidelines for all purchases and payments. In addition, the following corrective actions are recommended.

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- Request the Department of Treasury's Purchase Bureau procure language interpretation services to align costs with those of the New Jersey Administrative Office of the Court for comparable services.

- Strengthen controls over the purchasing and distribution of patient clothing, including the reconciliation of physical counts with system totals and investigation of variances, securing all clothing areas, comparing contract vendors to obtain the best price, returning, if appropriate, vendor substituted items, and accurately updating the inventory records.

Payroll

Timekeeping system lacks needed features and controls.

The hospital utilizes an internally developed timekeeping system to maintain leave time and record hours worked. However, the system lacks certain features which would ensure its compliance with the hospital's policies and procedures. During our review, we noted that the system allowed employees to carry over excess leave balances that are not allowed by the state or department policies. In addition, the system is unable to automatically calculate annual vacation allotment based on an employee's years of service. The allotment needs to be manually calculated and entered into the system which resulted in 128 vacation hours not being properly credited to three of the employees we sampled.

We also found that the system could allow timekeepers to make changes to prior pay periods' leave time. This could result in leave balances being altered without supervisory approval.

Recommendation

We recommend that the hospital modify its current payroll timekeeping system to include edits to properly calculate employee annual allotment and carry over balances. Additional modifications should include a prior pay period lock out feature after an appropriate time interval has lapsed, to prevent changes without supervisory approval.

Petty Cash

Controls over petty cash disbursements need to be strengthened to prevent misuse of funds.

Petty cash funds are established to provide a method of payment to be used for goods and services that require immediate purchase per Department of the Treasury Circular Letter 05-03-OMB. The hospital's annual petty cash disbursements averaged $13,143 for fiscal years 2011 through 2013. Our review noted that the hospital did not follow the circular letter in disbursing funds.

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The hospital disbursed funds for food service purchases and employee reimbursements such as parking, tolls, and meals. Per Treasury Circular Letter 12-14-OMB, an employee shall be reimbursed for expenses incurred during the regular business travel upon the completion of a travel voucher documenting these expenses.

In addition, a food service employee received reimbursement for items purchased for patients with special dietary needs. These items were purchased from various stores at different locations, including out-of-state, usually during the employee's normal work hours. However, a review of the receipts submitted disclosed the items could be procured by the hospital's buyer.

Recommendation

We recommend the hospital strengthen its controls over petty cash disbursements. The hospital should discontinue the practice of reimbursing employee business related travel expenses, including meal expenses incurred while on regular business hours. In addition, food service related purchases should be procured by the hospital's buyer in accordance with state purchasing guidelines.

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Ancorage

Controls over the Ancorage operation need to be strengthened.

The hospital has an on-grounds restaurant/general store (Ancorage) which serves patients, employees, and visitors. Our review of the Ancorage operations disclosed internal control weaknesses. Although Ancorage sales do not involve cash, the risk of errors and irregularities still exist. A sound internal control system provides for adequate segregation of duties between purchasing, receiving, and inventorying. Our review disclosed one individual placed orders, received goods, counted inventory, determined merchandise pricing, and closed out the register.

Recommendation

We recommend the hospital strengthen internal controls by adequately segregating duties.

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Firehouse

The hospital should evaluate its use of the consultant.

Ancora has a firehouse on the hospital grounds which was established when the facility was opened in 1955 and provides around-the-clock coverage. The firehouse has six employees including one fire chief. Each 24-hour shift is covered by one employee. Annual costs including

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fringe benefits averaged $657,000 from fiscal years 2010 through 2013. The firehouse monitors fire alarms, determines the severity of each incident, and notifies the county if support is needed. Our review of the firehouse activity log showed that their daily activities included carrying out fire evacuation drills, inspecting for fire hazards, assisting remediation of toilet flooding, rescuing patients trapped in elevators, and preparing and filing various fire and safety related reports. A contracted vendor performs monitoring, inspection, and testing of the fire protection system.

The hospital contracted with two consultants. The purpose of the contract is to provide coverage when full time firehouse employees are absent, thereby avoiding overtime costs. We reviewed one consultant's billing hours for 2012, and found that the consultant recorded 487 hours, of which only 76 hours were when there was no other firehouse personnel on duty. In addition, the six APH firehouse employees still had 1100 hours of overtime, earning $47,000 in 2012.

In March 2008, the hospital retained a retired individual from the firehouse to serve as part of a six-member management support team to monitor patient safety. This individual has averaged 438 hours or $12,967 annually from fiscal years 2009 through 2013, with 58 percent of the hours charged allocated to the firehouse. We further noted that four members of the support team were terminated since fiscal year 2010 and another has not been in active pay status since April 2011. We found no evidence of what service was provided by this remaining consultant and no support for charging expenditures against the accounts of the firehouse.

Recommendation

We recommend that the hospital evaluate the effectiveness of the contracted consultants in reducing overtime and the continued use of the retired employee consultant.

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Observations

Laundry

An analysis of the hospital's laundry room log disclosed that the weight of patient clothing received from each of the hospital's five halls varied as illustrated below.

	Main	Birch	Cedar	Larch	Holly
Lbs of Laundry Sept-Dec 2012	3791	4270	3447	1834	3703
Avg Hall Population Sept-Dec 2012	125	90	55	85	134
Avg lbs of Laundry per Patient	30	48	63	22	28

The hall with the smallest average patient population sent 2 ½ times the laundry compared to the hall with the largest population. An opinion expressed by laundry operations personnel claimed that hall personnel are doing a less than adequate job of ensuring patient clothing is sent for laundering and the numbers above would support that opinion.

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Each of the hospital's five halls maintained additional clothing items for the convenience of patients. However, the distribution of clothing items is not recorded. These orders represented 14 percent of the total clothes distributed. Based on the fact that this facility's per patient clothing costs exceed those of the other state psychiatric hospitals, we recommend hospital management investigate potential causes of these anomalies.

Overtime Growth

Previously in this report we identified specific issues related to overtime including excessive hours of work and casual overtime. In addition, we observed overall overtime payments have increased from $7.3 million in fiscal year 2011 to $10.5 million during fiscal year 2013. The following schedule lists the top 10 positions with overtime earnings and the growth of overtime expenses between FY11 and FY13.

Position Title	Overtime Increase FY11 vs FY13	Overtime Gross FY11	Overtime Gross FY13	Average Positions Fy11	Average Positions FY13
HUMAN SERVICES ASSISTANT	77.02%	$1,816,671.87	$3,215,879.67	398	371
CHARGE NURSE 12 MONTHS	64.24%	1,720,416.70	2,825,599.23	130	133
SUPERVISOR OF NURSING SERVICES	8.28%	769,856.71	833,613.95	27	30
SR HUMAN SERVICES TECHNICIAN	64.41%	472,151.83	776,273.97	51	50
PRACTICAL NURSE	24.23%	623,763.33	774,919.15	74	57
HUMAN SERVICES TECHNICIAN	2.54%	498,770.74	511,431.12	54	36
SENIOR FOOD SERVICE HANDLER	73.29%	140,286.17	243,099.18	45	57
RESIDENTIAL LIVING SPECIALIST	128.29%	93,693.42	213,892.03	22	21
SR BUILDING MAINTENANCE WORKER	0.53%	94,574.13	95,075.83	84	81
ASSISTANT INSTITUTION FIRE CHIEF	146.72%	26,582.25	65,582.80	5	4

An earlier finding cited scheduling as a cause for the rise of overtime for Human Services Assistant and Technician positions. That could also be a cause of the 64 percent increase in overtime earned by Charge Nurses.

Firehouse

As a final observation, our survey of the hospital's firehouse personnel indicated that the state of the current equipment of the firehouse is deteriorating. The main fire truck requires frequent repairs, with replacement costs starting around $200,000. There are four other firehouses within six miles of Ancora and we found that one of the state's other two psychiatric hospitals has closed its firehouse while retaining only the fire chief.

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State of New Jersey
DEPARTMENT OF HUMAN SERVICES
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CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

August 28, 2014

Stephen M. Eells, State Auditor
Office of the State Auditor
Office of Legislative Services
125 South Warren Street
PO Box 067
Trenton, NJ 08625-0067

Dear Mr. Eells:

I am writing in response to your July 17, 2014 correspondence related to the audit of the Department of Human Services, Division of Mental Health and Addiction Services, Ancora Psychiatric Hospital (APH).

Below you will find responses to the findings listed in the draft audit report for the period July 1, 2010 through August 31, 2013.

Medicare Revenue

Medicare Part A

The Office of Finance has developed a series of reports that will improve the monitoring of patients who become eligible for Medicare during and subsequent to hospital admission. These reports identify patients in the hospital census without Medicare eligibility status. The patients identifying data is then checked against several data warehouses – NJMMIS, Molina, and Social Security - in order to determine Medicare Part A eligibility. The Office of Finance has reviewed all patients with open episodes and has billed for all eligible services to maximize Medicare Part A revenue.

Ancora Psychiatric Hospital (APH) has implemented an internal review process to improve the monitoring of patients' financial information. The six month review will capture eligibility status changes during a patient's admission and subsequent stay.

Medicare Part B – Physician Billing

The Ancora employees referred to in the audit report as "billing clerks" should be changed to "medical coders". These coders are trained in Medicare Part B procedures related to fee-for-service reimbursement. They are also trained in Current Procedure Terminology (CPT) and ICD-9 diagnosis terminology.

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(a) Finding – 40% of billable physician charges were not claimed.

The reason was partially due to process issues and staff turnover that have been addressed by the hospital's Health Information Management (HIM) Director.

(b) Finding – 208 patients with Part B Claims submitted with admission histories.

An average of only 208 patients per month with Part B claim submissions was due to how Ancora identifies a patient as being Medicare Part B eligible. The report utilized by the medical coders was not generated from the Oracle database. The Office of Finance MBS uses the Part B insurance record from the Oracle database to determine eligibility. Ancora's database is now linked to Oracle; reports are generated on a weekly basis to identify Medicare Part B patients.

(c) Finding – Unfiled Medicare Part B claims, improper documentation of doctors' patient visits and staff physicians not properly registered in the hospital's Medicare billing group. Further review showed that missed billing opportunities were also due to missing data from the medical documentation necessary to complete a claim.

Ancora has addressed this issue internally by providing ongoing training on all Part B billable visits to ensure that all data is properly transferred from the patient records to the claim for submission. The hospital will make sure that all physicians are registered with Medicare to obtain their UPIN numbers.

Medicare Part B Ancillary
Medicare Part B ancillary claims have also been reviewed to ensure that there are no gaps in billing histories. A programming glitch that prematurely closed and discharged Part A patients before Part B ancillary claims were billed, has also been corrected.

Interim Assistance
The hospital will work with the Social Services Department to ensure that the Interim Assistance Program (IAP) beneficiary continues to be eligible for IAP by monitoring patient movement and eligibility for SSI benefits through routine checks on the status of the application. Ancora will ensure that the correct GR code is listed on the eIAR system to receive reimbursement from Social Security for patients discharged on the IAP. Ancora will ensure that proper recording of outstanding balances are maintained and overpayments are recovered.

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Overtime
The hospital Overtime Review Team meets with the Nursing Department and the Scheduling Department representatives three days a week to review staff deployment and overtime utilization. Overtime has decreased by $438,000 between fiscal years 2013 and 2014 since the issuance of the draft audit report.

Assistant Director of Nursing Services
Assistant Directors of Nursing Services (ADNS) do not receive excess overtime compensation through the use of a DHS-approved Special Services title. The practice of compensating ADNS at the rate of $45 an hour is only for coverage in the NCC office, which operates as the facility's charge office after hours.

Purchasing
All purchases will be processed by the Buyer who will ensure that Circular 11-10-DPP guidelines are followed. The quotes will be filed with the purchase orders and all related documents. The Business Manager or designee will approve all purchases. A new inventory system has been purchased and inventory records are now updated in an effort to strengthen controls over purchases and distribution.

The current contract for interpreter services has an all-inclusive rate of $85 per hour for all languages. Ancora Spanish-speaking employees provide assistance with the Spanish-speaking patients in need of an interpreter. As a result, the cost for language interpreter services at Ancora has been reduced.

Payroll
The Division has long recognized that an automated timekeeping system must be implemented to address widespread concerns of payroll operations. The Department has embarked upon a project to automate the timekeeping functions in our hospitals via a Request for Proposal (RFP). The State has received vendor responses to the RFP and is currently in the evaluation stage for the proposals submitted. It is projected that there will be several efficiencies realized by replacing the current antiquated manual processes with an automated timekeeping/scheduling solution.

Petty Cash
The utilization of the P-card has reduced the need for petty cash. All State vehicles have an E-Z-Pass transponder for tolls instead of issuing petty cash. Employees are required to submit monthly travel vouchers for reimbursement for parking and meals. Additionally, patients will have bagged lunches for community field trips when appropriate.

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Ancorage
Segregation of duties for purchasing and receiving inventory was accomplished when the operation became a vocational rehabilitation program in October 2013.

Firehouse
APH has retained the services of a retired Fire Chief as a consultant to provide assistance with fire code compliance and accreditation in the area of fire safety.

Sincerely,

Jennifer Velez
Commissioner

JV:07