

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW JERSEY CLAIMED MEDICAID
ADULT MENTAL HEALTH PARTIAL CARE
SERVICES THAT WERE NOT IN
COMPLIANCE WITH FEDERAL AND
STATE REQUIREMENTS**

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Office of Inspector General

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EXECUTIVE SUMMARY

New Jersey claimed at least \$95 million in Federal Medicaid reimbursement over 4 years for adult mental health partial care services that were unallowable.

WHY WE DID THIS REVIEW

During a prior review of New Jersey's claims for Medicaid services to adults with mental illness who reside in community residences, we identified a significant number of services improperly submitted for Federal Medicaid reimbursement. On the basis of these results, we decided to review clinic services provided to these Medicaid beneficiaries on an outpatient basis.

The objective of this review was to determine whether the New Jersey Department of Human Services (State agency) claimed Federal Medicaid reimbursement for adult mental health partial care services (partial care) that complied with Federal and State requirements.

BACKGROUND

In New Jersey, the State agency administers the Medicaid program. The State agency offers partial care services to Medicaid beneficiaries with serious mental illnesses. The purpose of the partial care services program is to provide individualized outpatient clinic services (e.g., group and individual therapy, prevocational services, and medication management) to beneficiaries in order to reduce unnecessary hospitalization.

The Centers for Medicare & Medicaid Services (CMS) *State Medicaid Manual* (the Manual) establishes requirements for various types of outpatient psychiatric treatment programs, including clinic services. The Manual establishes specific documentation guidelines for intake assessments, individualized plan-of-care development, and services provided. State regulations require providers to: (1) provide mental health services by, or under the direction of, a psychiatrist affiliated with the facility where those services are provided; (2) perform an intake assessment; (3) develop and periodically review a written individualized plan of care for each beneficiary; (4) maintain written documentation to support each medical or remedial therapy service, activity, or session; and (5) write progress notes at least once a week.

HOW WE CONDUCTED THIS REVIEW

From January 1, 2009, through December 31, 2012, the State agency claimed Federal Medicaid reimbursement totaling approximately \$272 million (\$136 million Federal share) for 3,876,416 claims for partial care services. We reviewed a simple random sample of 100 of these claims.

WHAT WE FOUND

Most of the State agency's claims for Federal Medicaid reimbursement for partial care services did not comply with Federal and State requirements. Of the 100 claims in our random sample, 8 claims complied with Federal and State requirements, but 92 claims did not. Of the 92 noncompliant claims, 19 contained more than 1 deficiency:

- For 84 claims, services were not documented or supported.
- For 20 claims, services were not provided by, or under the direction of, a psychiatrist affiliated with the facility where the services were provided.
- For six claims, individualized plan-of-care requirements were not met.
- For four claims, weekly progress notes were not documented.
- For one claim, the partial care provider did not provide an applicable intake assessment.

The deficiencies occurred because the State agency did not adequately monitor the partial care services program to ensure that providers complied with these requirements. Providers stated that two State agency components—the Division of Medical Assistance & Health Services and the Office of Program Integrity and Accountability—conducted onsite reviews of their facilities that were inconsistent. For example, providers stated that the State agency components had different standards for documenting services. Further, we found that the Division of Medical Assistance & Health Services’ reviews did not include tests for compliance with certain requirements (e.g., physician affiliation agreements, prior authorization of services, and services included in the beneficiary’s plan of care) and were sometimes inconsistent. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$94,830,718 in Federal Medicaid reimbursement for partial care services that did not meet Federal and State requirements.

WHAT WE RECOMMEND

We recommended that the State agency:

- refund \$94,830,718 to the Federal Government,
- issue guidance to the partial care provider community on Federal and State requirements for claiming Medicaid reimbursement for partial care services, and
- improve its monitoring of partial care providers to ensure compliance with Federal and State requirements.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency disagreed with our first recommendation and generally agreed with our remaining recommendations.

According to the State agency, our review imposed unreasonable documentation standards on providers. Further, the State agency contended that noncompliance with State law is not appropriate grounds for a financial disallowance. Specifically, the State agency argued that Office of Management and Budget Circular A-87 does not apply to payments to private

Medicaid providers, no longer requires compliance with State law, and does not apply when State law does not authorize a recoupment. The State agency also asserted that we should not recommend a disallowance based on missing documentation of claims submitted more than 3 years before the start of our review.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. Federal and State requirements are clear regarding what are appropriate grounds for a financial disallowance and how long providers in New Jersey are required to maintain documentation related to Medicaid claims.

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INTRODUCTION

WHY WE DID THIS REVIEW

During a prior review of New Jersey's claims for Medicaid services to adults with mental illness who reside in community residences, we identified a significant number of services improperly submitted for Federal Medicaid reimbursement.¹ On the basis of these results, we decided to review clinic services provided to these Medicaid beneficiaries on an outpatient basis.

OBJECTIVE

The objective of this review was to determine whether the New Jersey Department of Human Services (State agency) claimed Federal Medicaid reimbursement for adult mental health partial care services (partial care) that complied with Federal and State requirements.

BACKGROUND

Medicaid Program

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

New Jersey's Medicaid Partial Care Services Program

In New Jersey, the State agency administers the Medicaid program. The State agency offers partial care to Medicaid beneficiaries with serious mental illnesses. The partial care services program provides individualized outpatient clinic services (e.g., group and individual therapy, prevocational services, and medication management) to beneficiaries to reduce unnecessary hospitalization. To be eligible for Medicaid reimbursement for partial care services, beneficiaries must receive 2 to 5 hours of partial care services per day. Services are billed on an hourly (i.e., per unit) basis.

Federal and State Requirements Related to Partial Care Services

Section 1905(a)(9) of the Social Security Act (the Act) authorizes clinic services furnished by or under the direction of a physician. The CMS *State Medicaid Manual* (the Manual) establishes requirements for various types of outpatient psychiatric treatment programs, including clinic

¹ *Review of Medicaid Claims for Adult Mental Health Rehabilitation Services Made by Community Residence Providers in New Jersey* (A-02-09-01028), issued May 31, 2012.

services. The Manual establishes specific documentation guidelines for intake assessments, individualized plan-of-care development, and services provided.²

Principles and standards for determining allowable costs incurred by State and local governments under Federal awards are established by 2 CFR part 225 (Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*). To be allowable, costs must be authorized or not prohibited by State or local laws and regulations (2 CFR part 225, App. A, C.1.c).

New Jersey law (N.J. Rev. Stat. § 30:4D-12) requires partial care providers to maintain individual records necessary to fully disclose the nature and extent of each service provided and any other information that the State agency may require. State regulations require providers to: (1) provide mental health services by, or under the direction of, a psychiatrist affiliated with the facility where those services are provided; (2) perform an intake assessment; (3) develop and periodically review a written individualized plan of care for each beneficiary (at least every 90 days during the first year and every 6 months thereafter); (4) maintain written documentation to support each medical or remedial therapy service, activity, or session; and (5) write progress notes at least once a week (New Jersey Administrative Code (NJAC) 10:66-2.7). Finally, effective July 1, 2009, the Medicaid State plan requires the prior authorization of partial care services for the services to be eligible for Medicaid reimbursement.

For details on Federal and State requirements related to partial care services, see Appendix A.

HOW WE CONDUCTED THIS REVIEW

From January 1, 2009, through December 31, 2012, the State agency claimed Federal Medicaid reimbursement totaling approximately \$272 million (\$136 million Federal share) for 3,876,416 claims for partial care services.³ Of these claims, we reviewed a simple random sample of 100 claims. Specifically, we reviewed documentation to determine whether partial care services were provided in accordance with Federal and State requirements.

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

Appendix B contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

² In the Manual, section 4221(A), CMS explains the need for specific documentation guidelines for outpatient psychiatric services. According to CMS, there have been “instances of billing for services without sufficient documentation to establish that the services were clearly related to the patient’s psychiatric condition. With the ongoing effort to encourage furnishing psychiatric treatment in the least restrictive setting possible, there is an increasing need for coverage guidelines specifically directed at outpatient programs.”

³ This number excludes 460,823 claims associated with children less than 18 years of age and claims with service dates before July 1, 2008. In addition, we removed 47,013 claims submitted by 2 providers under investigation.

FINDINGS

Most of the State agency's claims for Federal Medicaid reimbursement for partial care services did not comply with Federal and State requirements. Of the 100 claims in our random sample, 8 claims complied with Federal and State requirements, but 92 claims did not. Of the 92 noncompliant claims, 19 contained more than 1 deficiency. Table 1 summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

Table 1: Summary of Deficiencies in Sampled Claims

Deficiency	Number of Unallowable Claims ^a
Services not documented or supported	84
No physician affiliation agreement	20
Plan-of-care requirements not met	6
Weekly progress note not documented	4
Intake assessment requirement not met	1

^a The total exceeds 92 because 19 claims contained more than 1 deficiency.

The deficiencies occurred because the State agency did not adequately monitor the partial care services program to ensure that providers complied with these requirements. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$94,830,718 in Federal Medicaid reimbursement for partial care services that did not meet Federal and State requirements.⁴

SERVICES NOT DOCUMENTED OR SUPPORTED

A beneficiary's plan of care must include a written description of the beneficiary's treatment objectives, including the treatment regimen and specific medical or remedial services, therapies, and activities used to meet the objectives. The plan of care must also include a projected schedule for service delivery that includes the frequency and duration of each type of planned therapeutic session or encounter.⁵ For services provided that are not specifically included in the beneficiary's plan of care, the provider must have documentation to explain how the services being billed relate to the treatment regimen and objectives contained in the beneficiary's plan of care.⁶

⁴ To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total at least 95 percent of the time.

⁵ The Manual § 4221(C)(1); N.J. Rev. Stat. §§ 30:4D-12(d) and (e); NJAC 10:66-2.7(k).

⁶ The Manual § 4221(D).

Partial care providers must maintain records that fully disclose the type and extent of services provided as well as the medical necessity for the services.⁷ Individual services must be documented daily⁸ and total 2 to 5 hours per day, excluding meals and breaks.⁹ To satisfy these requirements, providers must document, at a minimum, the following elements: (1) specific service type, (2) date and time the service was provided, (3) service duration, (4) practitioner's signature, (5) setting in which the service was provided, and (6) notation of any significant deviation from the treatment described in the plan of care.¹⁰

New Jersey regulations state that prevocational services may be reimbursed and define prevocational services as interventions, strategies, and activities that help beneficiaries acquire general work behaviors, attitudes, and skills.¹¹ To qualify as a prevocational service: (1) the plan of care must state that the therapeutic work activity is a form of intervention intended to address the individual deficits identified in the beneficiary's assessment, and (2) the work activity is facilitated by a qualified mental health services worker. Vocational services, however, are not reimbursable within the context of a partial care program.¹²

For 84 of the 100 claims in our sample, services were not documented or supported.¹³ Specifically:

- For 61 claims, services provided were not included in the specific therapies and activities identified in the beneficiary's plan of care.^{14, 15} The claims and related documentation did not include detailed explanations of how these services related to the treatment regimen and objectives of the beneficiary's plan of care.

⁷ NJAC 10:66-1.6(a).

⁸ NJAC 10:66-2.7(l)(3).

⁹ NJAC 10:66-2.7(d). Services are billed on an hourly (i.e., per unit) basis.

¹⁰ The Manual § 4221(D); N.J. Rev. Stat §§ 30:4D-12(d) and (e); NJAC 10:66-2.7(l)(1).

¹¹ NJAC 10:66-2.7(f).

¹² NJAC 10:66-2.7(g). Vocational services are defined as "interventions, strategies and activities that assist individuals to acquire skills to enter a specific occupation and take on the role of colleague (that is, a member of a profession) and/or assist the individual to directly enter the workforce and take on the role of an employee, working as a member of an occupational group for pay with a specific employer."

¹³ The total exceeds 84 because 63 claims contained more than 1 error.

¹⁴ Services related to these 61 claims were also not included in the associated beneficiary's projected schedule of services that identified the frequency and duration of each type of service.

¹⁵ Watching certain movies and playing certain games were examples of activities that were billed that were not included in the beneficiary's plan of care or did not have an explanation of how the activities related to the treatment regimen or objective in the plan of care. For example, during one site visit, we observed beneficiaries watching the movie "Silence of the Lambs." The provider had no documentation to support how that activity related to the beneficiaries' plans of care.

- For 22 claims, documentation did not support the full duration of services billed.¹⁶
- For 18 claims, required elements (e.g., service type, setting, practitioner’s signature) were not documented.
- For 11 claims, the provider did not provide documentation that services were provided on the date of service billed.
- For five claims, the prevocational documentation requirements were not met or a vocational activity was provided.

NO PHYSICIAN AFFILIATION AGREEMENT

If a beneficiary is being treated in an independent clinic, the Act requires the beneficiary’s care to be under the direction of a physician, and New Jersey regulations require that the physician be directly affiliated with the clinic.¹⁷ In New Jersey, for a physician to be considered affiliated with a clinic, there must be a physician–clinic contractual agreement or some other type of formal, written agreement on file at the clinic, and the agreement must stipulate that the physician is obligated to supervise the care provided to beneficiaries at the clinic.¹⁸

For 20 of the 100 claims in our sample, the partial care provider did not provide us a contractual agreement or some other type of formal written agreement between the clinic and the supervising physician.

PLAN-OF-CARE REQUIREMENTS NOT MET

A written, individualized plan of care must be developed for each beneficiary receiving continued care and be designed to improve the beneficiary’s condition to the point where continued treatment in the program is no longer necessary.¹⁹ Periodic review of the plan of care must take place on a regular basis: at least every 90 days during the first year and every 6 months thereafter.^{20, 21}

For 6 of the 100 claims in our sample, plan-of-care requirements were not met. Specifically, for four claims, the partial care provider did not provide a plan of care that was prepared before our

¹⁶ For these claims, we adjusted our disallowance to allow for the documented duration of services.

¹⁷ The Act § 1905(a)(9); NJAC 10:66-1.3(e), -2.7(c).

¹⁸ NJAC 10:66-1.3(g), -2.7(c).

¹⁹ The Manual § 4221(C); NJAC 10:66-2.7(k).

²⁰ The Manual § 4221(E); NJAC 10:66-2.7(m).

²¹ Periodic reviews determine (1) the beneficiary’s progress toward the treatment objectives, (2) the appropriateness of the services being furnished, and (3) the need for the beneficiary’s continued participation in the program.

sampled service date.²² For two other claims, the partial care provider did not provide a plan of care that had been reviewed for the 6-month period encompassing our sampled service date.²³

WEEKLY PROGRESS NOTE NOT DOCUMENTED

Providers are required to prepare and maintain a weekly progress note in the beneficiary's medical file that documents the beneficiary's clinical progress, complications, and treatment.²⁴

For 4 of the 100 claims in our sample, the partial care provider did not give us a weekly progress note covering our sampled service date. Specifically, for two of the four claims, no progress note was provided. For each of the remaining two claims, a note was provided; however, the note indicated that the beneficiary's counselor was absent during the week and contained no information that documented the beneficiary's clinical progress, complications, or treatment.

INTAKE ASSESSMENT REQUIREMENT NOT MET

Providers are required to perform an intake assessment of each beneficiary in the partial care services program within 14 days of the beneficiary's first encounter or by his or her third clinic visit, whichever is later, for the beneficiary to be considered for continued treatment.²⁵

For 1 of the 100 claims in our sample, the partial care provider did not give us an applicable intake assessment because, according to provider officials, the document had been destroyed.

INADEQUATE STATE AGENCY MONITORING

The deficiencies occurred because the State agency did not adequately monitor the partial care program to ensure that providers complied with these requirements. Providers stated that two State agency components—the Division of Medical Assistance & Health Services (DMAHS)²⁶ and the Office of Program Integrity and Accountability²⁷—conducted onsite reviews of their facilities that were inconsistent. For example, providers stated that the State agency components had different standards for documenting services. Further, we found that DMAHS reviews did

²² Three of the four claims required plan-of-care reviews every 6 months. For all three, the provider had no plan of care in the beneficiary's case file prepared before our sampled service date. Providers for two of those three documented that a plan of care review was prepared 8 to 12 months after the sampled service month, and the provider for the third claim did not provide documentation of any such review. For the fourth claim, services began in October 2009, our sampled service date was in December 2009, but the plan of care was not prepared until March 2010.

²³ Reviews of these plans of care were performed more than 1 year after the previous review was done.

²⁴ The Manual § 4221(D); NJAC 10:66-2.7(1)(2)(3).

²⁵ The Manual § 4221(B); NJAC 10:66-2.7(j).

²⁶ DMAHS administers the State agency's Medicaid program.

²⁷ Within the Office of Program Integrity and Accountability, the Office of Licensing regulates programs serving persons with mental illness, developmental disabilities, and traumatic brain injuries.

not include tests for compliance with certain requirements (e.g., physician affiliation agreements, prior authorization of services, and services included in the beneficiary's plan of care) and were sometimes inconsistent. Although DMAHS reviewers used a common worksheet to conduct their reviews, they did not uniformly identify instances of noncompliance with New Jersey requirements because they interpreted these requirements differently.

RECOMMENDATIONS

We recommended that the State agency:

- refund \$94,830,718 to the Federal Government,
- issue guidance to the partial care provider community on Federal and State requirements for claiming Medicaid reimbursement for partial care services, and
- improve its monitoring of partial care providers to ensure compliance with Federal and State requirements.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our first recommendation and generally agreed with our remaining recommendations.

According to the State agency, our review imposed unreasonable documentation standards on providers. Further, the State agency contended that noncompliance with State law is not an appropriate grounds for a financial disallowance. Specifically, the State agency argued that OMB Circular A-87 does not apply to payments to private Medicaid providers, no longer requires compliance with State law, and does not apply when State law does not authorize a recoupment. The State agency also asserted that we should not recommend a disallowance based on missing documentation of claims submitted more than 3 years before the start of our review.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. The State agency's comments are included in their entirety as Appendix E.

UNREASONABLE DOCUMENTATION STANDARDS

State Agency Comments

According to the State agency, OIG is holding providers to unreasonable documentation standards. The State agency asserted that a beneficiary's plan of care is not intended to list every partial care service that the beneficiary might need. The State agency stated that providers should have flexibility to provide appropriate services based on their professional judgement and that section 4221(d) of the Manual should allow for the provision of services not listed in a

beneficiary's plan of care as long as there is documentation explaining why those services are necessary.

Office of Inspector General Response

We agree that section 4221(d) of the Manual establishes minimum documentation requirements. However, we note that the documentation requirements include the standard that “[f]or services that are not specifically included in the recipient’s treatment regimen, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient’s [plan of care] should be submitted with bills.”²⁸

We did not assess the sufficiency of explanations included in the claims or other records. Rather, for 61 claims, there was *no documentation* that provided any explanation of how the associated services related to the beneficiary’s treatment regimen and plan of care. Further, CMS disallowances based on similar findings of noncompliance with documentation standards of section 4221 of the Manual have been upheld by the Departmental Appeals Board (DAB).²⁹

NONCOMPLIANCE WITH STATE LAW IS NOT GROUNDS FOR DISALLOWANCE

State Agency Comments

The State agency stated that private Medicaid providers are not subject to the principles of OMB Circular A-87 because they are not Federal subgrantees. According to the State agency, OMB eliminated the provision of OMB Circular A-87 regarding compliance with State laws. The State agency speculated that OMB did not intend to require grantees to comply with State laws in revised guidance known as the Uniform Guidance (UG).

Office of Inspector General Response

The DAB has long upheld CMS disallowances under the Medicaid program based on providers’ noncompliance with applicable State regulations based on the provisions of OMB Circular A-87.³⁰ Further, we note that OMB did not eliminate the provision regarding compliance with State laws. Rather, the provision was moved to another section of the Code of Federal Regulations.

²⁸ These requirements are in place to address CMS’s concerns regarding inappropriate billing for outpatient psychiatric treatment programs. Specifically, CMS was concerned about “instances of billing for services without sufficient documentation to establish that the services were clearly related to the patient’s psychiatric condition” (CMS, State Medicaid Manual § 4221(a)).

²⁹ New York Department of Social Services, DAB No. 1235 (1991).

³⁰ Most recently, the DAB upheld CMS’s disallowance of certain claims based on OMB Circular A-87 and the plain language of New York’s regulations. Those State regulations had specific documentation requirements that must be met by providers of continuing day treatment services for claims to be reimbursable. See New York State Department of Health, DAB No. 2637 (2015); citing New York Department of Social Services, DAB No. 1112 (1989) and New York State Department of Social Services, DAB No. 1235 (1991).

Under 2 CFR § 200.403, for costs to be allowable, they must “be necessary and reasonable for the performance of the Federal award,” and for a cost to be reasonable, consideration must be given to, among other things, “Federal, state, local, tribal, and other laws and regulations.”³¹ OMB verified that it intended compliance with applicable Federal and State laws to remain as part of the UG. This issue was specifically addressed in guidance for the UG in the form of a frequently asked question: “Section 200.403 does not specify a requirement for compliance with Federal, state, local, tribal, and other laws and regulations. Is this requirement otherwise addressed in the Uniform Guidance?” The response was, “Yes. Compliance with applicable laws and regulations is included at Sections 200.303 Internal Controls and 200.404 Reasonable costs.”³² Thus, compliance with State laws has been required under OMB Circular A-87 and continues to be required under the UG.

CLAIMS SUBMITTED MORE THAN 3 YEARS BEFORE AUDIT PERIOD

State Agency Comments

The State agency stated that Federal regulations (42 CFR § 433.32) require States to maintain documentation for 3 years from the date of submission of a final expenditure report or until a pending audit finding has been resolved. Therefore, according to the State agency, our recommended disallowance should be revised to allow claims submitted before this period.

Office of Inspector General Response

We agree that Federal regulations require States to maintain documentation for 3 years. However, as the State agency recognized in footnote 3 of its comments, New Jersey requires all Medicaid-enrolled providers to retain all of their records for 5 years, in accordance with N.J. Stat. Ann. § 30:4D-12(d).³³ The service dates associated with our sample claims were within the State’s 5-year document-retention period.

³¹ OMB consolidated various cost principles applicable to different types of entities into the UG, which is located at 2 CFR part 200. HHS codified the guidance in its regulations at 45 CFR part 75, establishing uniform administrative requirements, cost principles, and audit requirements for HHS awarding agencies and their grantees. Further, the UG has a general effective date of December 26, 2014, and does not apply to the time period covered by this audit (45 CFR § 75.110(a)).

³² Frequently Asked Questions, *For the OMB’s Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* at 2 CFR 200, available at <https://cfo.gov/wp-content/uploads/2015/09/9.9.15-Frequently-Asked-Questions.pdf>. Accessed on September 9, 2016.

³³ Codified at Title 10 § 49-9.8(b) of the New Jersey Administrative Code.

APPENDIX A: FEDERAL AND STATE REQUIREMENTS RELATED TO ADULT PARTIAL CARE SERVICES

Section 1905(a)(9) of the Act authorizes clinic services furnished by or under the direction of a physician.

Section 1902(a)(27) of the Act and Federal regulations (42 CFR § 431.107) establish requirements for keeping medical records as are necessary to disclose the extent of services the provider furnishes to the beneficiary.

The Manual § 2500.2 requires that supporting documentation include the date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service; nature, extent, or units of service; and place of service.

The Manual § 4221 establishes requirements for various types of organized outpatient programs of psychiatric treatment including clinic services. The Manual states that the following guidelines help ensure appropriate use of outpatient psychiatric programs:

- The provider should perform an intake assessment for each beneficiary being considered for entry into an outpatient psychiatric treatment program.
- The provider should develop an individualized plan of care that describes the treatment regimen and the projected schedule for service delivery, including the frequency and duration of each type of planned session or encounter.
- The provider should periodically review the plan of care to determine the progress toward the treatment objectives.
- The provider should prepare written documentation which supports each medical or remedial therapy, service, activity, or session that is billed. At a minimum, the documentation should include: (1) the specific service; (2) the date and actual time the service is provided; (3) who provided the service; (4) the setting in which the service was provided; (5) the amount of time it took to deliver service; (6) the relationship of the service to the treatment regimen described in the plan of care; and (7) updates describing the patient's progress. For services not specified in the beneficiary's treatment regimen, the provider should prepare a detailed explanation of how the services being billed relate to the treatment regimen and objectives in the beneficiary's plan of care.

Federal regulation 2 CFR part 225 (OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*) establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. App. A, C.1.c. provides that to be allowable costs must be authorized or not prohibited by State or local laws or regulations.

New Jersey law (N.J. Rev. Stat. § 30:4D-12) requires providers to maintain individual records necessary to fully disclose the nature and extent of each service provided and any other information that the State agency may require by regulations.

NJAC 10:66-2.7(a) and (j) state that the provider must perform an intake assessment within 14 days of the first encounter or by the third clinic visit (whichever is later for each client being considered for continued treatment). This evaluation must be written and include the client's mental condition, determine whether treatment in the program is appropriate, include certification (signed statement) by the evaluation team that the program is appropriate to meet the treatment needs of client, and be made part of the medical records. The evaluation process should include a physician and an individual experienced in diagnosis and treatment of mental illness, although an appropriately qualified individual may satisfy both criteria.

NJAC 10:66-2.7(k) and NJAC 10:66-1.6 state that the provider must develop a written, individualized plan of care for each client who receives continued treatment. The plan of care shall be included in the client's records and must include: (1) a written description of the treatment objectives, including both the treatment regimen and the specific medical or remedial services, therapies, and activities that should be used to meet the objectives; (2) a projected schedule for service delivery that includes the frequency and duration of each type of planned therapeutic session or encounter; (3) a projected schedule for completing reevaluations of the client's condition and updating the plan of care; and (4) the type of personnel that will be furnishing the services.

NJAC 10:66-2.7(m) states that the provider must periodically review the client's plan of care at least every 90 days during the first year and every 6 months thereafter. Periodic reviews shall be documented in detail in the client's records. This review shall determine the progress toward the treatment objectives, the appropriateness of the services being furnished, and the need for continued participation in the program.

NJAC 10:66-2.7(a) and (d) states that partial care services are 2 to 5 hours per day of active programming, excluding meals, breaks, and transportation.

N.J. Rev. Stat. §§ 30:4D-12(d) and (e), NJAC 10:66-1.6, and NJAC 10:66-2.7(l) state that the provider must document individual services daily. The provider must develop and maintain legibly written documentation to support each medical or remedial therapy service, activity, or session that is billed. At a minimum, this documentation must consist of: (1) the specific services provided; (2) the date and time services are provided; (3) the duration of services provided (e.g., 1 hour, half hour); (4) the signature of the practitioner or provider rendering services; (5) the setting in which services are provided; and (6) a notation of any significant deviation from the treatment described in the plan of care.

NJAC 10:66-1.6, and NJAC 10:66-2.7(l)(3) state that the provider must write progress notes in the client's record at least weekly. The notes must be legible and be written, signed, and dated. Overall progress for the week should be reflected in the weekly progress note.

NJAC 10:66-1.2 (definition of "prevocational services") and NJAC 10:66-2.7(a), (e), and (f)

state that prevocational services may be reimbursed. Prevocational services include interventions, strategies, and activities that assist an individual to acquire general work behavior, attitudes, and skills needed to take on the role of a worker. Examples of services or interventions not considered prevocational include training in technical or occupational skills; college preparation; student education, including preparation of school-assigned classwork or homework; and individual job development.

NJAC10:66-1.2 (definition of “vocational services”) and NJAC 10:66-2.7(g) state that vocational services are not reimbursed. Vocational services include interventions, strategies, and activities that assist an individual to acquire skills to enter a specific occupation and take on the role of colleague or assist an individual to directly enter the workforce and take on role of an employee.

NJAC10:66-1.3 states that the provider and a psychiatrist must have a formal, written agreement on file at the facility by which the psychiatrist is obligated to supervise the care.

The Medicaid State plan (Addendum to Attachment 3.1-A, pg. 9) requires prior authorization for partial care services, effective July 1, 2009.

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 3,876,416 adult partial care claim lines, totaling \$272,172,538 (\$136,220,942 Federal share), submitted by 112 partial care agencies in New Jersey from January 1, 2009, through December 31, 2012. (In this report, we refer to these lines as claims.) Our review did not cover claims associated with children less than 18 years of age, claims with service dates before July 1, 2008, and claims submitted by two providers under investigation.

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System (MMIS) file for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims data in the MMIS to New Jersey's claim for reimbursement on the Quarterly Medicaid Statement of Expenditures (Form CMS-64).

During our audit, we did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at the State agency's offices in Trenton, New Jersey, and at partial care agencies throughout New Jersey.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with the State agency officials to gain an understanding of the State's partial care services program;
- obtained an electronic file containing 4,384,252 Medicaid partial care services claims submitted by 114 providers in New Jersey during our audit period from the State agency's MMIS;
- reconciled the adult partial care services claimed for Federal reimbursement by the State agency on Forms CMS-64 for our audit period with the data obtained from the MMIS file to establish reasonable assurance of authenticity and accuracy;
- excluded 460,823 claims associated with children under age 18 and claims with service dates before July 1, 2008, and removed 47,013 claims submitted by 2 providers under investigation;
- identified a sampling frame of 3,876,416 claims, totaling \$272,172,538 (\$136,220,942 Federal share);

- selected a simple random sample of 100 claims from our sampling frame and for each of the 100 claims:
 - obtained and reviewed beneficiary clinical records to determine if claims complied with Federal and State requirements and
 - reviewed the credentials of the mental health services worker who provided the service to the beneficiary;
- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 3,876,416 claims; and
- discussed our results with State agency officials.

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

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population was adult partial care services claims submitted by providers in New Jersey during our January 1, 2009, through December 31, 2012, audit period that the State agency claimed for Federal Medicaid reimbursement.

SAMPLING FRAME

The sampling frame was an Access file containing 3,876,416 detailed claims for partial care services submitted by 112 providers in New Jersey during our audit period. We excluded 460,823 claims associated with children less than 18 years of age and claims with service dates before July 1, 2008. In addition, we removed 47,013 claims submitted by 2 providers under investigation. The total Medicaid reimbursement for the 3,876,416 claims was \$272,172,538 (\$136,220,942 Federal share). The Medicaid claims were extracted by our advanced audit techniques staff from the State agency's Medicaid payment files provided to us by staff of the State agency's MMIS fiscal agent.

SAMPLE UNIT

The sample unit was an individual Federal Medicaid claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General, Office of Audit Services (OAS) statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to appraise the sample results. We estimated the overpayment associated with the unallowable claims at the lower limit of the two-sided 90-percent confidence interval.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Details and Results

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Claims	Value of Unallowable Claims (Federal Share)
3,876,416	\$136,220,942	100	\$3,478	92	\$2,660

Table 3: Estimated Unallowable Costs
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$103,129,334
Lower limit	\$94,830,718
Upper limit	\$111,427,950

APPENDIX E: STATE AGENCY COMMENTS



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

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ELIZABETH CONNOLLY
Acting Commissioner

August 4, 2016

Brenda M. Tierney
Acting Regional Inspector General
for Audit Services
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

RE: *Draft Audit Report No. A-02-13-01029*

Dear Ms. Tierney:

Thank you for the opportunity to comment on the Office of Inspector General's ("OIG") draft audit report, *New Jersey Claimed Medicaid Adult Mental Health Partial Care Services That Were Not in Compliance with Federal and State Regulations*.

As explained below, the New Jersey Department of Human Services ("DHS") disagrees with the OIG's recommendation that the State should refund \$94,830,718 to the federal government.

1. The OIG's \$94.8 Million Disallowance Recommendation is Unwarranted.

The OIG's significant recoupment recommendation is based on five findings from its review of 100 of the more than 3.8 million partial care claims for services rendered during the four-year audit period, calendar years 2009 through 2012. In this limited sample, the OIG found that: (1) eighty-four claims were for services "not documented or supported"; (2) twenty claims were for services "not provided by, or under the direction of, a psychiatrist affiliated with the facility where the services were provided"; (3) six claims were for services with noncompliant plans of care; (4) four claims lacked weekly progress notes; (5) one claim was not supported by a valid intake assessment.

These findings do not support a \$94.8 million disallowance.

a. The Draft Audit Report Imposes Unreasonable Standards on Entities Providing Dynamic and Comprehensive Services to Individuals with Serious Mental Illness.

The State's partial care program provides services and monitoring for adults with serious mental illness. The purpose of the program is to facilitate community integration and to avoid hospitalization and relapse. Services include pre-vocational services and mental health rehabilitation.

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Consistent with the State Medicaid Manual (“SMM”), each individual receiving partial care services has a plan of care that outlines his or her treatment regime and projected schedule for receiving services. SMM § 4221(c). However, as a clinical matter, treatment for individuals with serious mental illness must be dynamic and fluid. The plan of care is not intended to list every partial care service that a patient might need; on any given day, clinicians working directly with patients must have the flexibility to provide the most appropriate services for each patient, based on their professional judgment, even if that means providing services not expressly listed in the plan of care. For that reason, the SMM allows providers of outpatient mental health clinic services to provide services not listed in the plan of care, as long as there is some documentation explaining why those services are “necessary in order to achieve the treatment objectives.” SMM § 4221(d).

In the draft audit report, the OIG has taken a hyper-technical approach to analyzing compliance with state and federal regulations. The OIG has not alleged that the State was overbilled, or that inappropriate services were provided to patients, or that services were provided to ineligible individuals. Instead, the overwhelming majority of the OIG’s findings concern allegations that providers failed to include sufficient detail in their paperwork (*i.e.*, in the plans of care and the documentation explaining the provision of services not listed in the plans of care). The OIG is holding providers to unreasonable standards of compliance with respect to these documentation requirements. Even if these sampled claims were noncompliant, at worst it was minor noncompliance with technical documentation requirements, for which a federal recoupment is *not* appropriate.

Imposing unreasonable standards of document maintenance will likely force providers to take their focus away from their most important function: providing services to patients with serious mental illness. It will also discourage providers from pursuing clinically appropriate departures from patients’ plans of care: If providers need to worry about forfeiting their entire Medicaid reimbursement any time their documented explanation for departing from the plan of care has a technical flaw, they will be significantly less likely to do so.

In order to assure compliance with federal documentation rules, the State audits partial care providers more frequently than it audits other providers participating in the Medicaid program. Specifically, it audits every partial care provider once a quarter. In the course of these audits, the State has *not* found the widespread noncompliance with documentation requirements that the OIG now alleges.

b. Noncompliance with State Law is Not an Appropriate Grounds for a Disallowance.

Much of the noncompliance alleged by the OIG relates to *state*, not federal, requirements. Federal law does not provide a basis upon which CMS can recoup for noncompliance with these types of state law requirements.

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In support of its position, the OIG cites Office of Management and Budget (“OMB”) Circular A-87, which states: “To be allowable under Federal awards, costs must. . . [b]e authorized or not prohibited under State or local laws or regulations.” 2 C.F.R. Pt. 225, App’x A, C.I.c (2013).

OMB Circular A-87 was designed to govern the administrative costs incurred by state and local government grantees. *See* 2 C.F.R. § 225.5 (explaining that Part 2 “establishes principles and standards for determining costs for Federal awards carried out through grants, cost reimbursement contracts, and other agreements with State and local governments and federally-recognized Indian tribal governments”).¹ OMB A-87 was never intended to apply to private Medicaid providers, who are not federal grantees or sub-grantees. As such, it does not authorize the federal government to take a disallowance based on a private provider’s noncompliance with OMB A-87’s terms.

Further, the provision of OMB A-87 relied on by the OIG was eliminated by the OMB in its most recent re-codification of its cost principles. *See* 78 Fed. Reg. 78,590 (Dec. 26, 2013). The OMB has apparently concluded that the federal government does not have an interest in enforcing compliance with state laws. This decision makes sense in light of the problematic policy implications of federal enforcement of state law. For example, penalizing a State for failing to comply with or enforce its own rules discourages States from establishing robust regulatory regimes to help ensure that high-quality health care is safely delivered to Medicaid beneficiaries. Given that the OMB itself has decided to repeal the relevant provision of the circular, it would be inappropriate for the OIG to recommend a disallowance based on noncompliance with that provision.

Even if OMB A-87 applies here, it does not authorize a disallowance based on the state law provisions on which the OIG relies. Under the plain language of OMB A-87, the federal government’s ability to recoup based on state law turns on whether the state law authorizes recoupment for noncompliance. In this case, the OIG relies on four different New Jersey statutory and regulatory provisions: N.J. Stat. Ann. § 30:4D-12 (record retention); N.J. Admin. Code § 10:66-1.3 (clinic shall have a formal, written agreement with the clinic); and N.J. Admin. Code § 10:66-1.6 (record retention); and N.J. Admin. Code § 10:66-2.7 (mental health services). State law does *not* require recoupment for noncompliance with these provisions. Therefore, the “costs” at issue – that is, the payment to the providers for services that allegedly did not comply with these provisions – are “not prohibited” under state law and recoupment based on A-87 is unwarranted and inappropriate.²

¹ *See also* 2 C.F.R. § 225.20 (“This part establishes principles and standards to provide a uniform approach for determining costs and to promote effective program delivery, efficiency, and better relationships between governmental units and the Federal Government. The principles are for determining allowable costs only.”); Pt. 225, App’x A, A.1 (“[OMB A-87] establishes principles for determining the allowable costs incurred by State, local, and federally-recognized Indian tribal governments (governmental units) under grants, cost reimbursement contracts, and other agreements with the Federal Government.”).

² *Cf. N.Y. State Dep’t of Soc. Serv.*, DAB No. 1235 (1991) (explaining that a disallowance was warranted because the State did not explain “circumstances or conditions pursuant to which the

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c. OIG Should Not Recommend Recoupment Based on Missing Documentation of Claims Submitted More than Three Years Before the Start of the Audit Period.

Many of the OIG's findings of noncompliance are based on missing documentation. The OIG cites federal documentation requirements at Section 1902(a)(27) and 42 C.F.R. § 431.107 as requiring the partial care providers to have retained this missing documentation. However, the missing documentation pertains to claims from 2009-2012, between two and six year prior to the start of the OIG's audit, and neither Section 1902(a)(27) or 42 C.F.R. § 431.107 requires providers to retain documentation for years after the claim at issue has been submitted.³ Federal regulations at 42 C.F.R. § 433.32 require States to maintain documentation "to assure that claims for Federal funds are in accordance with applicable Federal requirements," but only "for 3 years from date of submission of a final expenditure report" or until a pending audit finding has been resolved.

OIG notified DHS about this audit by letter dated May 20, 2013. Thus, partial care providers did not have any federal obligation to maintain any documentation of claims submitted prior to May 20, 2010, and the recoupment recommendation should be decreased to the extent it is based on missing documentation of claims submitted prior to that date.

2. The State will Continue to Provide Guidance to Partial Care Providers, and Will Continue to Work to Improve its Monitoring of Providers, to Ensure Compliance with State and Federal Law.

As explained above, the State already has in place a robust auditing program for partial care providers. In addition to partial care programs being reviewed quarterly with attention to the participation and active programming, the initial evaluation, the plan of care development, daily and group documentation, weekly documentation and periodic reviews required by regulation, staff also sit in on active groups and monitor the activity. DMAHS staff monitor for how clients are encouraged to participate as well as the quality of the programming. This information is shared with the program director at the end of the visit and is generally included in the yearly summary. DMAHS also meets with a large provider group representing partial care programs on a quarterly basis to address concerns including changes in regulations or areas of concern raised during audits.

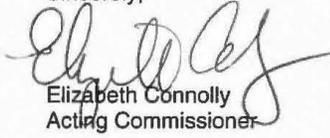
[State] would have excused an overpayment sanction"); *N.Y. State Dep't of Soc. Serv.*, DAB No. 1112 (1989) (concluding that payments were not authorized under state law under OMB A-87 because the state regulation at issue (1) did not grant New York discretion to pay for noncompliant services and (2) had served as the basis for the New York's own provider-specific disallowances).

³ New Jersey state law requires that providers retain documentation for five years but, as explained above, a federal disallowance based on state law is inappropriate.

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Thank you again for the opportunity to comment on this draft audit report. If you have any questions about this letter, please do not hesitate to contact me or Richard Hurd at 609-588-2550.

Sincerely,



Elizabeth Connolly
Acting Commissioner

EC:02

c. Elizabeth Connolly
Chris Bailey
Richard Hurd
Valerie Harr
Meghan Davey
Gerry Suozzo
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