DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

May 30, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Review of Medicaid Claims for Adult Mental Health Rehabilitation Services Made by Community Residence Providers in New Jersey (A-02-09-01028)

Attached, for your information, is an advance copy of our final report on Medicaid adult mental health rehabilitation claims submitted by New Jersey. We will issue this report to the New Jersey Department of Human Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through email at James.Edert@oig.hhs.gov. Please refer to report number A-02-09-01028.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION II
JACOB K. JAVITS FEDERAL BUILDING
26 FEDERAL PLAZA, ROOM 3900
NEW YORK, NY 10278

May 31, 2012

Report Number: A-02-09-01028

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

Dear Ms. Velez:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Claims for Adult Mental Health Rehabilitation Services Made by Community Residence Providers in New Jersey*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Kevin W. Smith, Audit Manager, at (518) 437-9390, extension 232, or through email at Kevin.Smith@oig.hhs.gov. Please refer to report number A-02-09-01028 in all correspondence.

Sincerely,

/James P. Edert/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID CLAIMS FOR ADULT MENTAL HEALTH REHABILITATION SERVICES MADE BY COMMUNITY RESIDENCE PROVIDERS IN NEW JERSEY

Daniel R. Levinson
Inspector General

May 2012
A-02-09-01028

Office of Inspector General

http://oig.hhs.gov

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the 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.

In New Jersey (the State), the Department of Human Services (DHS) is the State agency responsible for operating the Medicaid program. Within DHS, the Division of Medical Assistance and Health Services administers the Medicaid program.

Section 1905(a)(13) of the Act authorizes optional rehabilitative services, including any medical or remedial services (provided in a facility, a home, or another setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to the best possible functional level.

The State elected to include coverage of Medicaid adult mental health rehabilitation (AMHR) services provided to mentally ill beneficiaries residing in community residences—group homes, supervised apartments, and family care homes—under a program administered by DHS's Division of Mental Health Services. Examples of AMHR services include assistance with daily living skills, managing medication, individual services coordination, counseling, support services, and crisis intervention.

State regulations governing AMHR services claimed by community residence rehabilitation (CRR) providers are found at title 10, chapters 37A and 77A, of the New Jersey Administrative Code. These regulations state, in part, that:

- An initial nursing assessment must be completed by a registered nurse.
- The assessment must be used in the development of a comprehensive service plan (CSP) signed by the beneficiary.
- The CSP must be reviewed and revised within 90 days of the date of admission and then no less than every 90 days for the first year and every 6 months thereafter.
- A registered nurse must conduct a face-to-face visit with the beneficiary within the required time period.
- The beneficiary must receive AMHR services and be present in the CRR facility.

- AMHR services must be for only treatment-related activities.

- Provider staff must meet education and training requirements.

- Staff must maintain weekly progress notes.

- A comprehensive nursing reassessment must be completed at least annually.

- Providers' reimbursement rates are to be based upon the level of care recommended by a registered nurse.

OBJECTIVE

Our objective was to determine whether the State claimed Federal Medicaid reimbursement for AMHR services provided by CRR providers in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

The State did not claim Federal Medicaid reimbursement for AMHR services delivered by CRR providers in accordance with Federal and State requirements. Of the 100 claims in our random sample, 36 claims complied with Federal and State requirements, but 64 did not.

Of the 64 noncompliant claims, 24 contained more than 1 deficiency:

- For 32 claims, provider staff did not meet education and training requirements.

- For 23 claims, service plan requirements were not met.

- For 15 claims, the provider's staffing levels were not consistent with the required level of care or the providers claimed a higher level of care than was recommended.

- For nine claims, weekly progress notes were not documented.

- For nine claims, a registered nurse did not conduct a face-to-face visit within the required time period.

- For nine claims, services were not documented, supported, or allowable.

- For five claims, nursing assessment requirements were not met.

These deficiencies occurred because: (1) State regulations were not consistent with Medicaid State plan requirements, (2) certain CRR providers did not comply with Federal and State requirements, and (3) the State did not adequately monitor providers for compliance with certain Federal and State requirements.

Based on our sample results, we estimated that the State improperly claimed $30,589,719 in Federal Medicaid reimbursement during our June 12, 2005, through December 26, 2007, audit period.

RECOMMENDATIONS

We recommend that the State:

- refund $30,589,719 to the Federal Government,
- provide CRR providers with guidance to help ensure that they comply with Medicaid State plan requirements, and
- improve its monitoring of providers' claims to ensure compliance with Federal and State requirements.

DEPARTMENT OF HUMAN SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, DHS agreed with some of our findings related to our first recommendation and described the actions it was taking to address our second and third recommendations. With respect to our first recommendation, DHS stated that, in some cases, providers located additional documentation to support sample claims questioned in our draft report. DHS provided this documentation, as well as providers' written explanations for some of the claims, under separate cover. In addition, DHS stated that it believes that our sampling methodology resulted in inaccurate findings.

After reviewing DHS's comments and additional documentation, we revised our findings and modified our statistical estimates accordingly. DHS's comments appear in their entirety as Appendix E.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the 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.

In New Jersey (the State), the Department of Human Services (DHS) is the State agency responsible for operating the Medicaid program. Within DHS, the Division of Medical Assistance and Health Services administers the Medicaid program.

Federal and State Requirements Related to Adult Mental Health Rehabilitation Services

Section 1905(a)(13) of the Act and 42 CFR § 440.130(d) authorize optional rehabilitation services, including any medical or remedial services (provided in a facility, a home, or another setting) recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to the best possible functional level.

Title 10, chapters 37A and 77A, of the New Jersey Administrative Code (NJAC) establish standards for Medicaid reimbursement of community residence services and standards for adult mental health rehabilitation (AMHR) service planning and review by community residence rehabilitation (CRR) providers.[1] These regulations state, in part, that: (1) an initial nursing assessment must be completed by a registered nurse within 14 days of a beneficiary's admission; (2) the assessment must be used in the development of a comprehensive service plan (CSP) signed by the beneficiary; (3) the CSP must be reviewed and revised within 90 days of the date of admission and then no less than every 90 days for the first year and every 6 months thereafter; (4) a registered nurse must conduct a face-to-face visit with the beneficiary within the required time period;[2] (5) the beneficiary must receive AMHR services and be present in the CRR

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[1] Specifically, NJAC 10:37A ("Community Residences for Mentally Ill") establishes standards for the State's community residence program, and NJAC 10:77A ("AMHR Services Provided In/By Community Residence Programs") establishes Medicaid requirements for enrolled beneficiaries. Pursuant to NJAC 10:77A, all community residence program and licensure requirements in NJAC 10:37A must be met.

[2] For a portion of our audit period (June 12, 2005, through June 18, 2007), DHS required a face-to-face interview every 60 days. Effective June 19, 2007, the State amended this requirement to mirror a 90-day requirement for "face-to-face health care monitoring visits" cited in NJAC 10:37A-4.5(c)(9). Specifically, after our audit period, in December 2009, DHS submitted a State plan amendment (No. 09-11) to CMS for approval concerning face-to-face reviews. CMS approved the State plan amendment on April 8, 2011, with an effective date retroactive to June 19, 2007.

facility; (6) AMHR services must be for only treatment-related activities; (7) staff providing services must meet education and training requirements; (8) staff must maintain weekly progress notes; (9) a comprehensive nursing reassessment must be completed at least annually; and (10) providers' reimbursement rates are to be based on the level of care recommended by a registered nurse.

The State elected to include Medicaid coverage of AMHR services provided to beneficiaries in community residences under a program administered by DHS's Division of Mental Health Services (DMHS).

New Jersey's Adult Mental Health Rehabilitation Services Program

DMHS, through its AMHR program, provides Medicaid rehabilitation services to adults with mental illness who reside in community residences, i.e., group homes, supervised apartments, and family care homes.[3] AMHR services for these beneficiaries include assistance with daily living skills, medication management, services coordination, counseling, support services, and crisis intervention.

Program eligibility is determined by a licensed practitioner of the healing arts who, at a minimum, is a State-licensed registered nurse. In community residences, CRR providers develop CSPs, provide AMHR services, and monitor and periodically evaluate beneficiaries' progress. Providers are expected to maintain records documenting AMHR service authorizations, CSPs, progress notes, and staff credentials and training. Medicaid reimbursement is based on specific levels of care (e.g., duration of care) that the CRR provider delivers. Appendix A summarizes the five levels of care authorized for reimbursement.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State claimed Federal Medicaid reimbursement for AMHR services provided by CRR providers in accordance with Federal and State requirements.

Scope

Our review covered 555,475 AMHR services claim lines, totaling $129,249,164 ($64,630,451 Federal share), submitted by 40 CRR providers in the State for the period June 12, 2005, through December 26, 2007. (In this report, we refer to these lines as "claims.")

We did not review the overall internal control structure of DHS, DMHS, or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We conducted fieldwork at the DMHS's offices in Trenton, New Jersey, and at 23 CRR providers throughout the State.

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[3] As part of its licensing process, DMHS certifies the level of care and the number of beds and sites for each CRR services provider.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with DMHS officials to gain an understanding of the program;
- obtained from the State agency's contractor a sampling frame of 555,475 AMHR services claims, totaling $129,249,164 ($64,630,451 Federal share), made by 40 CRR providers for the period June 12, 2005, through December 26, 2007;
- selected a stratified random sample of 100 claims from the sampling frame of 555,475 claims, and for these 100 claims, we:
    - reviewed the corresponding provider's documentation supporting the claim,
    - interviewed provider officials to identify provider policies and procedures for authorizing and reauthorizing AMHR services, and
    - reviewed the professional credentials and training records of the provider staff person(s) who delivered AMHR services; and
- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame.

Appendix B contains the details of our sample design and methodology, and Appendix C contains our sample results and estimates.

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

The State did not claim Federal Medicaid reimbursement for AMHR services delivered by CRR providers in accordance with Federal and State requirements. Of the 100 claims in our random sample, 36 claims complied with Federal and State requirements, but 64 did not. Of the 64 claims, 24 contained more than 1 deficiency.[4] The table below summarizes the deficiencies noted and the number of claims that contained each type of deficiency. Appendix D summarizes the deficiencies, if any, identified for each sampled claim.

[4] Of the 64 claims that did not comply, 48 were fully unallowable and 16 were partially unallowable.

Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Unallowable Claims[5]
Staff education and training requirements not met	32
Comprehensive service plan requirements not met	23
Level-of-care requirements not met	15
Weekly progress notes not documented	9
Face-to-face nursing review requirements not met	9
Services not documented, supported, or allowable	9
Nursing assessment requirements not met	5

These deficiencies occurred because: (1) State regulations were not consistent with Medicaid State plan requirements, (2) certain CRR providers did not comply with Federal and State requirements, and (3) the State did not adequately monitor providers for compliance with certain Federal and State requirements.

Based on our sample results, we estimated that the State improperly claimed $30,589,719 in Federal Medicaid reimbursement during our June 12, 2005, through December 26, 2007, audit period.

STAFF EDUCATION AND TRAINING REQUIREMENTS NOT MET

Pursuant to NJAC 10:77A-2.4(b), each Medicaid provider must develop, update, and administer a comprehensive, competency-based training program for individuals providing adult mental health residential services.[6] CRR providers are required to document that all staff providing AMHR services to residents receive training (NJAC 10:37A-3.1(a)(4)). In addition, pursuant to NJAC 10:77A-2.4(d), individuals who provide AMHR services who have not completed the required training must not deliver the AMHR services alone. Such individuals must be supervised by, and deliver the AMHR services in conjunction with, a trained person who is onsite and provides in-person supervision.

For 32 of the 100 claims in our sample, AMHR services were provided by staff members who did not complete the required training before the sampled service date or whose training was not documented. In addition, we found no evidence that, on the sampled service date, these staff members were supervised onsite and in-person by a trained staff member.

[5] The total exceeds 64 because 24 claims contained more than 1 deficiency.

[6] Competency-based training programs involve measurable skill development and demonstrated, documented evidence of employee skill attainment. Required training curriculum topics include, among other subjects, an overview of AMHR services; emergency preparedness, including, but not limited to, cardiopulmonary resuscitation, first aid, crisis prevention, and infection control; medication; activities of daily living skills; and documenting services.

COMPREHENSIVE SERVICE PLAN REQUIREMENTS NOT MET

Pursuant to NJAC 10:37A-4.5(c)(8), "[t]he CSP should be reviewed and revised as necessary, by the 90th day of admission and then no less frequently than every 90 days for the first year of treatment, and every six months thereafter." In addition, State regulations require that the CSP be signed by both a registered nurse (NJAC 10:37A-5.2(b)(1)) and the beneficiary (NJAC 10:37A-4.5(c)(6)). If the beneficiary is unwilling or unable to sign, the reason must be documented on the CSP.

For 23 of the 100 claims in our sample, CSP requirements were not met.[7] Specifically:

- For 10 claims, a registered nurse did not sign the CSP.
- For eight claims, the CSP was not reviewed and revised within 6 months of the sample claim date. Specifically, the CSP was reviewed and revised between 7 months to 2 years before the sample claim date.
- For six claims, the beneficiary did not sign the CSP and no reason was documented.
- For four claims submitted during the first year of the beneficiary's treatment, the CSP was not reviewed and revised within 90 days of the sample claim.

LEVEL-OF-CARE REQUIREMENTS NOT MET

Rehabilitative services must be recommended by a physician or other licensed practitioner of the healing arts (42 CFR § 440.130(d)). Pursuant to NJAC 10:77A-2.3(b)(1), the initial nursing assessment must include a recommendation for an appropriate level of AMHR service. The comprehensive nursing reassessment must include a justification for the continuation of AMHR services and a recommendation for the appropriate level of care (NJAC 10:77A-2.3(d)). Pursuant to NJAC 10:77A-2.5, Medicaid reimbursement for AMHR services provided in or by a community residence is to be based on the specific level of care delivered by the CRR provider.[8] (See Appendix A.) Further, pursuant to NJAC 10:77A-2.5(g), if a beneficiary is required to remain in a residence while awaiting transfer to a more appropriate facility, the provider must request reimbursement at the lesser of the level of AMHR service approval for the site or the level of care that the resident requires.

For 15 of the 100 claims in our sample, level-of-care requirements were not met. Specifically:

- For 10 claims, the CRR provider's staffing level was not consistent with the level of care for which the provider was reimbursed. For example, for one claim, the provider billed the recommended level of care (Level A+), which required 24-hour staff coverage.

[7] The total exceeds 23 because 4 claims contain more than 1 deficiency.

[8] Attachment 4.19B of the Medicaid State plan details the five levels of care reimbursed by the State Medicaid program and, for each level, the requirements related to the availability of and the number of services provided.

However, the provider could document only that it had provided 15 hours of staff coverage.

- For five claims, the CRR provider claimed reimbursement for a higher level of care than what was recommended by the registered nurse.

WEEKLY PROGRESS NOTES NOT DOCUMENTED

Pursuant to NJAC 10:37A-4.5(c)(10), CRR providers must document the beneficiary's clinical course of treatment and community living skills in the progress notes. The regulation states that progress must be documented by a weekly summary.

For 9 of the 100 claims in our sample, the CRR provider could not document that weekly progress notes reflecting the beneficiary's clinical course of treatment and community living skills were prepared for the sample claim.

FACE-TO-FACE NURSING REVIEW REQUIREMENTS NOT MET

The Medicaid State plan requires that clinical supervision of beneficiaries receiving AMHR services be provided "on an as-needed basis, including, at a minimum, face to face visits every 60 days" (addendum to Attachment 3.1-A of the Medicaid State plan). Further, pursuant to NJAC 10:77A-2.3(c), a registered nurse or higher level professional must conduct a face-to-face review[9] of the beneficiary at least every 60 days. Effective June 19, 2007, DHS amended its Medicaid State plan to require a face-to-face visit every 90 days.

For 9 of the 100 claims in our sample, the CRR provider did not perform or document a face-to-face review within the required time period. Specifically, for three claims provided prior to the effective date of the Medicaid State plan amendment, a face-to-face review was not performed within 60 days of the claim date and for one claim provided after the effective date, a face-to-face review was not performed within 90 days of the claim date. For the remaining five claims, the provider did not document a face-to-face review.

SERVICES NOT DOCUMENTED, SUPPORTED, OR ALLOWABLE

Pursuant to NJAC 10:77A-2.5(b), reimbursement for Medicaid AMHR services provided by or in community residence programs is to be made on a fee-for-service basis for each level of care and is billable in either per diem or quarter-hours units of service. The fee must not include non-treatment- and/or non-rehabilitation-related services, including, but not limited to, room and board and recreational and vocational services. Pursuant to NJAC 10:77A-2.5(c)(1), CRR providers must seek reimbursement on a per diem basis only for the dates that the beneficiary received AMHR services. Pursuant to NJAC 10:77A-2.5(c)(2), providers may seek reimbursement on a per diem basis for AMHR services provided on the date the beneficiary is

[9] During each face-to-face review, the professional is required, at a minimum, to: (1) review the beneficiary's CSP, (2) review observations and progress notes made by the direct-care staff, (3) assess the beneficiary's health, and (4) indicate any changes needed in treatment approaches in the CSP.

admitted to the facility but must not seek reimbursement for AMHR services provided on the date of discharge.

NJAC 10:77A-2.5(d) states that a quarter-hour unit of service is defined as 15 consecutive minutes of service.

For 9 of the 100 claims in our sample, the AMHR service was not documented, supported, or allowable.[10] Specifically:

- For three claims, the provider's service log did not support the number of AMHR services billed.
- For two claims, the provider did not provide documentation for services provided.
- For two claims, the provider did not have a service log to support that AMHR services were actually delivered.
- Two claims contained unallowable AMHR services. Specifically, one claim was for an AMHR service on the date the beneficiary was discharged from the community residence, and one claim was for recreational services.
- One claim was for a quarter-hour unit of service that lasted only 5 minutes.

NURSING ASSESSMENT REQUIREMENTS NOT MET

Pursuant to NJAC 10:77A-2.3(b), the initial nursing assessment must be completed within 14 calendar days of admission, justify the need for continued mental health rehabilitation services, and recommend an appropriate level of service. Pursuant to NJAC 10:77A-2.3(d), comprehensive nursing assessments must be completed at least annually, justify continuation of services, and recommend an appropriate level of care.

For 5 of the 100 claims in our sample, nursing assessment requirements were not met. Specifically, for four claims, there was no annual nursing assessment and for one claim, the initial nursing assessment was not performed within 14 days of admission. For this claim, the initial nursing assessment was performed 31 days after admission.

CAUSES OF THE UNALLOWABLE CLAIMS

State Regulations Not Fully Consistent With Medicaid State Plan Requirements

The Medicaid State plan requires that " … clinical supervision be provided on an as needed basis, including at a minimum, face to face visit every 60 days or more frequently based upon significant change in the individual's condition." Before June 19, 2007, State regulations at NJAC 10:77A-2.3 required a "face-to-face review" of the beneficiary at least every <u>60 days</u> but

[10] The total exceeds nine because one claim has multiple deficiencies.

State regulations at NJAC 10:37A-4.5(c)(9) required a "face-to-face health care monitoring review" every 90 days. On June 18, 2007, the State revised NJAC 10:77A to reflect the 90-day requirement at NJAC 10:37A. After our fieldwork, the State requested that CMS amend the Medicaid State plan to incorporate the 90-day requirement. CMS approved the request in April 2011 with an effective date retroactive to June 19, 2007.

Certain Community Residence Rehabilitation Providers Noncompliant With Federal and State Requirements

Some of the claims were improper because certain CRR providers did not comply with Federal and State requirements. The Addendum to Attachment 3.1-A, page 13(d).9, of the Medicaid State plan requires that beneficiaries receive AMHR services delivered pursuant to a CSP prepared by a treatment team. However, we found that some providers did not have CSPs in place for the period reviewed or they operated under CSPs that were not signed by the treatment team. In addition, State regulations at NJAC 10:77A-2.4 require CRR providers to develop and implement training curriculums that include specific topics (e.g., emergency preparedness). However, we found that certain providers did not include all the required topics in their curriculums or did not document that their employees had attended training.

Community Residence Rehabilitation Providers Inadequately Monitored

We determined that monitoring of CRR providers for compliance with applicable requirements by the State was not adequate. From January 2005 through December 2007, the State conducted 11 monitoring reviews and found deficiencies at 8 providers. These reviews identified deficiencies similar to those found in our audit.

ESTIMATE OF THE UNALLOWABLE AMOUNT

Of the 100 AMHR service claims sampled, 64 were not made in accordance with Federal and State requirements. Based on our sample results, we estimated that the State improperly claimed $30,589,719 in Federal Medicaid reimbursement during our June 12, 2005, through December 26, 2007, audit period. (See Appendix C.)

RECOMMENDATIONS

We recommend that the State:

- refund $30,589,719 to the Federal Government,
- provide CRR providers with guidance to help ensure that they comply with Medicaid State plan requirements, and
- improve its monitoring of providers' claims to ensure compliance with Federal and State requirements.

DEPARTMENT OF HUMAN SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, DHS agreed with some of our findings related to our first recommendation and described the actions it was taking to address our second and third recommendations. With respect to our first recommendation, DHS stated that, in some cases, providers located additional documentation to support sample claims questioned in our draft report. DHS provided this documentation, as well as providers' written explanations for some of the claims, under separate cover.[11] In addition, DHS stated that it believes that our sampling methodology resulted in inaccurate findings.

After reviewing DHS's comments and additional documentation, we revised our findings and modified our statistical estimates accordingly. DHS's comments appear in their entirety as Appendix E.

Office of Inspector General Sampling Methodology

Department of Human Services Comments

DHS questioned our sampling methodology used to determine the estimates for the overpayments associated with unallowable claims for AMHR services and said that it resulted in inaccurate findings and recommendations. DHS stated that the sample we drew does not accurately reflect the relative value of claims in each stratum. DHS stated that it does not believe that the sample sizes were large enough for an accurate estimate of overpayments for unallowable claims for AMHR services.

Office of Inspector General Response

We followed our longstanding statistical sampling policies with regard to both stratification and sample size. The Departmental Appeals Board (Board) has supported the Office of Inspector General's (OIG) use of statistical sampling to calculate the disallowances in accordance with these policies. Specifically, in one case involving OIG's use of statistical sampling, the Board stated that "Since the individual case determinations were voluminous, the auditors used statistical sampling techniques in lieu of examining all records to establish the amount of disallowance, an approach upheld in principle by the courts and this Board before."[12]

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[11] DHS provided two DVDs of additional documentation. The documentation related to 67 sample claims questioned in our draft report that were associated with 18 different providers. In addition to providing documentation, much of which we had already reviewed during our fieldwork, DHS submitted providers' explanations of what it called the "Context and Mitigating Circumstances" for the sample claims.

[12] New Jersey Department of Human Services, DAB No. 2415 (2011); see also California Department of Social Services, DAB No. 816 (1986); Maine Department of Health and Human Services, DAB No. 2292 (2009); New York State Office of Children and Family Services, DAB No. 1984 (2005); California Department of Social Services, DAB No. 524 (1984); Ohio Department of Public Welfare, DAB No. 226 (1981); and precedents cited therein.

Staff Education and Training Requirements Not Met

Department of Human Services Comments

DHS stated that, under separate cover, it provided additional documentation for 18 sample claims questioned in our draft report. For each of the claims, DHS described the documentation provided, most of which consisted of employee training certificates.

Office of Inspector General Response

Based on the State's additional documentation, we fully allowed two claims (2-3 and 2-11), partially allowed two additional claims (1-10 and 2-35), and revised our related finding and statistical estimates accordingly. For 10 other sample claims, the additional documentation did not adequately support that staff education and training requirements had been met. For three other sample claims, DHS did not provide documentation. DHS submitted explanations from providers regarding why the claims were in error, none of which led us to change our determinations. For the remaining sample claim, DHS provided documentation we had already reviewed during our fieldwork.

Comprehensive Service Plan Requirements Not Met

Department of Human Services Comments

DHS stated that, under separate cover, it provided additional documentation for two sample claims questioned in our draft report. For sample claim number 2-6, DHS stated that although no service plan was included in the beneficiary's file by the due date, other documentation demonstrates that the client received services and, therefore, the claim should be allowed. For sample claim number 2-44, DHS stated that the claim was correct; however, the registered nurse signed the CSP more than 1 month after the CSP was reviewed and authorized by the beneficiary and provider staff.

Office of Inspector General Response

DHS did not provide any additional documentation for these two sample claims. However, it provided explanations from the providers, neither of which led us to change our determinations. For sample claim number 2-6, the provider agreed that there was no CSP for the sample service date. For sample claim number 2-44, the provider stated that the claim was correct but that the registered nurse signed the CSP 41 days after it was due to be reviewed.

Level-of-Care Requirements Not Met

Department of Human Services Comments

DHS stated that, under separate cover, it provided additional documentation for five sample claims questioned in our draft report. For two claims, DHS submitted additional timesheets to

support the level-of-care requirement. For the remaining three claims, it provided comments related to causes and mitigating circumstances.

Office of Inspector General Response

Based on the State's additional documentation, we allowed two claims (1-15 and 2-11); however, claim number 2-11 was fully adjusted above, under the "Staff Education and Training Requirements Not Met" finding. Therefore, we revised our statistical estimates for claim number 1-15 only. For the remaining three sample claims, the providers' explanations did not lead us to change our determinations.

Weekly Progress Notes Not Documented

Department of Human Services Comments

DHS stated that, under separate cover, it provided additional documentation for four sample claims questioned in our draft report.

Office of Inspector General Response

DHS provided additional documentation for only one sample claim (2-27), which made it partially allowable, and we revised our related finding and statistical estimates accordingly. For the remaining three sample claims, DHS provided explanations from the providers, none of which led us to change our determinations. For all three sample claims, providers failed to document the progress of the beneficiary toward rehabilitation.

Face-to-Face Nursing Review Requirements Not Met

Department of Human Services Comments

DHS stated that, under separate cover, it provided additional documentation for three sample claims questioned in our draft report. For each of the claims, DHS described the documentation provided and the providers' explanations for the deficiencies we noted.

DHS also stated that it intended to change the Medicaid State plan requirement for face-to-face nursing reviews from 60 days to 90 days. DHS stated that, when we brought the difference in Federal and State requirements to its attention, it immediately submitted a State Plan Amendment (SPA) application to CMS, which CMS approved retroactive to the day after the State changed its regulation (June 19, 2007).[13]

Office of Inspector General Response

We reviewed claims based on the SPA in effect for the sampled service date. Specifically, for claims with service dates before June 19, 2007, a face-to-face nursing review was required every

[13] CMS approved the SPA on April 8, 2011.

60 days. For claims with service dates from June 19, 2007, forward, a face-to-face nursing review was required every 90 days. DHS provided additional documentation for only one sample claim (2-13), which was a computer printout that indicated the period the face-to-face nursing review covered. However, the documentation indicated that the review occurred 31 days after it was due.[14] For the remaining two claims, DHS provided documentation that we had already reviewed during our fieldwork.

Services Not Documented, Supported, or Allowable

Department of Human Services Comments

DHS stated that, under separate cover, it provided additional documentation for three sample claims questioned in our draft report. In addition, for each of the claims, DHS described the documentation provided and the providers' explanations for the deficiencies we noted. For example, for sample claim number 1-42, DHS stated that the provider "billed 6 units from the 99 minute chunk. They did not bill the 5 minute contacts."

Office of Inspector General Response

DHS provided documentation for only one claim, and it was identical to what we had already reviewed during our fieldwork. The explanations from the providers did not lead us to change our determinations. Regarding sample claim number 1-42, the provider's explanation did not mention that the provider claimed services totaling 99 minutes each for 20 additional beneficiaries at the same time and place for "medication management."

Nursing Assessment Requirements Not Met

Department of Human Services Comments

DHS stated that, under separate cover, it provided additional documentation for one sample claim questioned in our draft report.

Office of Inspector General Response

We accepted the new documentation (a signed nursing assessment) and revised this finding accordingly; however, the claim remains unallowable because it contained three additional errors.

[14] The sample service date (March 15, 2006) predated the effective date of the SPA. Therefore, the 60-day requirement was in effect.

APPENDIXES

APPENDIX A: LEVELS OF CARE AUTHORIZED BY THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

<table>
<tr><th>Level of Care</th><th>Definition</th><th>Location</th><th>Rate</th></tr>
<tr><td rowspan="2">Level A+</td><td rowspan="2">Provided to beneficiary residents 24 hours per day, 7 days a week. This includes awake, overnight staff coverage.</td><td>Group Home</td><td>$164 per diem</td></tr>
<tr><td>Supervised Apartment</td><td>$164 per diem</td></tr>
<tr><td rowspan="2">Level A</td><td rowspan="2">Available to beneficiary residents 12 or more hours per day (but less than 24 hours), 7 days per week.</td><td>Group Home</td><td>$131 per diem</td></tr>
<tr><td>Supervised Apartment</td><td>$66 per diem</td></tr>
<tr><td rowspan="2">Level B</td><td rowspan="2">Available to beneficiary residents 4 or more hours per day (but less than 12 hours), 7 days per week.</td><td>Group Home</td><td>$102 per diem</td></tr>
<tr><td>Supervised Apartment</td><td>$3.75 per quarter hour</td></tr>
<tr><td rowspan="2">Level C</td><td rowspan="2">Available to beneficiary residents 1 or more hours per day (but less than 4 hours), 7 days per week.</td><td>Group Home</td><td>$3.75 per quarter hour</td></tr>
<tr><td>Supervised Apartment</td><td>$3.75 per quarter hour</td></tr>
<tr><td>Level D</td><td>Available to beneficiary residents 24 hours per day by a family home care provider.</td><td>Family Home</td><td>$40 per diem</td></tr>
</table>

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was adult mental health rehabilitation (AMHR) service claim lines (claims) provided by community residence rehabilitation (CRR) providers that were submitted for Federal Medicaid reimbursement by New Jersey (the State). The claims were for AMHR services provided from December 26, 2004, through December 19, 2007, with payment dates from June 12, 2005, through December 26, 2007 (our audit period).

SAMPLING FRAME

The sampling frame was a computer file containing 555,475 claims for AMHR services delivered by CRR providers in the State during our audit period. The total Medicaid reimbursement for the 555,475 claims was $129,249,164 ($64,630,451 Federal share). The claims were extracted from the State's Medicaid payment files provided to us by staff of the State's Medicaid Management Information System fiscal agent.

SAMPLE UNIT

The sample unit was an individual Federal Medicaid claim from the sampling frame.

SAMPLE DESIGN

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

Stratum 1: less than $200 (Federal share)—505,307 claims
Stratum 2: equal to or greater than $200 (Federal share)—50,168 claims

SAMPLE SIZE

We selected a sample of 100 claims, with 50 items per stratum.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Audit Services' statistical software, RAT-STATS. We used the random number generator for our sample.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the claims in each stratum. After generating 50 random numbers for each stratum, we selected the corresponding frame items. We then created a list of 100 sample items.

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate our estimates. We used the lower limit of a 90-percent confidence level to estimate the overpayment associated with the unallowable claims.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Stratum Number	Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Unallowable Claims	Value of Unallowable Claims (Federal Share)
1	505,307	$26,797,141	50	$3,332	27	$1,637
2	50,168	$37,833,310	50	$37,611	37	$22,980
Total	**555,475**	**$64,630,451**	**100**	**$40,943**	**64**	**$24,617**

Estimated Unallowable Costs
(Limits Calculated for a 90-Percent Confidence Level)

Point estimate	$39,604,114
Lower limit	$30,589,719
Upper limit	$48,618,509

APPENDIX D: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED CLAIM

Legend	
Deficiency 1	**Staff education and training requirements not met**
Deficiency 2	**Comprehensive service plan requirements not met**
Deficiency 3	**Level-of-care requirements not met**
Deficiency 4	**Weekly progress notes not documented**
Deficiency 5	**Face-to-face nursing review requirements not met**
Deficiency 6	**Services not documented, supported, or allowable**
Deficiency 7	**Nursing assessments requirement not met**

Claim No.	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	Total
1-01	X		X					2
1-02								0
1-03								0
1-04								0
1-05		X		X				2
1-06								0
1-07	X		X					2
1-08*	X							1
1-09								0
1-10*			X					1
1-11	X	X					X	3
1-12		X						1
1-13								0
1-14								0
1-15								0
1-16								0
1-17	X							1
1-18			X					1
1-19	X							1
1-20		X						1
1-21		X						1
1-22								0
1-23								0
1-24	X							1
1-25		X		X				2
1-26	X							1
1-27			X					1
1-28	X							1

Claim No.	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	Total
1-29								0
1-30		X						1
1-31							X	1
1-32	X					X		2
1-33		X						1
1-34	X	X	X					3
1-35	X							1
1-36								0
1-37				X				1
1-38								0
1-39								0
1-40								0
1-41				X				1
1-42						X		1
1-43								0
1-44								0
1-45								0
1-46								0
1-47								0
1-48								0
1-49								0
1-50	X		X					2
2-01*	X							1
2-02								0
2-03								0
2-04*	X							1
2-05*			X					1
2-06		X						1
2-07						X		1
2-08					X			1
2-09*			X				X	2
2-10*	X							1
2-11								0
2-12		X				X		2
2-13*			X		X			2
2-14								0
2-15								0
2-16				X				1
2-17	X	X		X	X			4

Claim No.	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	Total
2-18								0
2-19	X						X	2
2-20*	X							1
2-21	X		X	X				3
2-22								0
2-23								0
2-24	X	X				X	X	4
2-25*	X							1
2-26						X		1
2-27*	X							1
2-28	X			X				2
2-29*	X							1
2-30								0
2-31	X	X		X	X			4
2-32		X			X			2
2-33		X						1
2-34								0
2-35*	X							1
2-36		X			X			2
2-37								0
2-38	X	X	X			X		4
2-39*					X			1
2-40								0
2-41		X						1
2-42*					X			1
2-43	X	X				X		3
2-44		X	X					2
2-45		X						1
2-46	X		X					2
2-47								0
2-48		X						1
2-49	X		X		X	X		4
2-50*	X							1
Totals	**32**	**23**	**15**	**9**	**9**	**9**	**5**	**64**

* Claims that were partially disallowed.

APPENDIX E: DEPARTMENT OF HUMAN SERVICES COMMENTS

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PO BOX 712
TRENTON, NJ 08625-0712

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

VALERIE HARR
Director

October 25, 2011

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

Report Number: A-02-09-01028

Dear Mr. Edert:

Please accept this response to your letter dated August 9, 2011 concerning the Department of Health and Human Services, Office of the Inspector General's (OIG) draft report entitled *"Review of Medicaid Claims for Adult Mental Health Rehabilitation Services Made by Community Residence Providers in New Jersey"* Your letter provides an opportunity to comment on this draft report #A-02-09-01028.

Audit Objective

The objective of this examination was to determine whether the State claimed Federal Medicaid reimbursement for Adult Mental Health Rehabilitative (AMHR) services provided by Community Residential Rehabilitative (CRR) providers in accordance with Federal and State requirements for the audit period of June 12, 2005 through December 26, 2007. AMHR services are provided to mentally ill beneficiaries residing in community residences under a program administered by the New Jersey Department of Human Services' (DHS) Division of Mental Health Services (DMHS).

Audit Conclusions

The draft audit report concludes that the State did not claim Federal Medicaid reimbursement for AMHR services provided by CRR providers in compliance with Federal and State requirements. While 33 of the 100 claims in the random sample fully complied with Federal and State requirements, the remaining 67 claims did not meet one or more of the applicable requirements.

The draft report states that the deficiencies occurred because: (1) State regulations were not consistent with Medicaid State plan requirements, (2) certain CRR providers did not comply with Federal and State requirements, and (3) the State did not adequately monitor CRR providers for compliance with certain Federal and State requirements. Based upon the sample results, the

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auditor estimated that New Jersey was improperly reimbursed $33,876,428 in Federal Medicaid reimbursement during the June 12, 2005 through December 26, 2007 audit period.

We appreciate the opportunity to provide this response to the draft OIG audit report. Following are the auditors' recommendations and the Division of Medical Assistance & Health Services (DMAHS) responses:

Recommendation 1:

The OIG recommends that New Jersey refund $33,876,428 to the Federal Government:

The State concurs with some but not all of the findings concerning claims for Medicaid reimbursement for AMHR services provided by CRR providers. We have addressed each category of deficiencies below and in some cases additional documentation to support Sample Claims was located and forwarded directly to the auditor.

Furthermore, based on the analysis outlined below, which was performed with the assistance of a statistician, we believe that the sampling methodology used by the auditor resulted in inaccurate findings and recommendations.

Analysis of OIG Sampling Methodology

The auditor's analysis does not accurately reflect the characteristics of the defined strata as shown by the table below. The purpose of defining a sampling frame is to take the proportionality of the subgroups in the sample and population into account in deriving the population estimates. As shown in the Table below, this was not done for this analysis. The total value of claims in Stratum 1 was 41% of the total. In the sample, however, the value of claims for Stratum 1 was only 8% *of the total value. The sample that was drawn does not accurately reflect the relative value of claims in each stratum.*

Table: OIG sample results and estimates with population and sample percentages

Stratum Number	*Claims in Frame*	*Value of Frame (Federal Share)*	*%*	*Sample Size*	*Value of Sample (Federal Share)*	*%*	*Unallowable Claims*	*Value of Unallowable Claims (Federal Share)*
1	*505,307*	*$26,797,141*	*41%*	*50*	*$3,332*	*8%*	*28*	*$1,794*
2	*50,168*	*$37,833,310*	*59%*	*50*	*$37,611*	*92%*	*39*	*$24,948*
Total	*555,475*	*$64,630,451*	*100 %*	*100*	*$40,943*	*100 %*	*67*	*$26,742*

The August 9, 2011 draft report is silent as to the justification for selecting a sample size of only 50 claims from a stratum with a total of 505,307 claims and a sample size of only 50 claims from a stratum with a total of 50,168 claims for a total of only 100 claims from a total of 555,475 claims. We do not believe these samples are large enough for an accurate estimate of overpayment for unallowable AMHR Medicaid claims in New Jersey. There is a great deal of variance in types of claims filed and the amount of those claims. When it is known that population characteristics vary greatly, it is usual for researchers studying that characteristic to select fairly large samples in order to obtain valid estimates of the population characteristic.

Given the broad range of types of and amounts of claims, it does not appear that results found for this very small sample of claims generalize across the entire population of AMHR Medicaid claims in New Jersey during the period under investigation.

The sampling frame chosen for this investigation was simply not adequate to provide a valid estimate of the amount of overpayment associated with unallowable claims for AMHR Medicaid services in New Jersey. The sampling frame chosen fails to account for many key variables such as type of service and type of disability served likely to be correlated with both the value of claims and types of deficiencies in claims. In addition, given the known variance across types of claims and the amount of claims across the state, the sample sizes chosen were too small to justify generalization of the results to the entire population of claims in the state.

STAFF EDUCATION AND TRAINING REQUIREMENTS NOT MET

Finding: 0

Pursuant to NJAC 10:77A-2.4(b), each Medicaid provider must develop, update, and administer a comprehensive, competency-based training program for individuals providing adult mental health residential services. CRR providers are required to document that all staff providing AMHR services to residents receive training (NJAC 10:37A-3.1(a)(4)). In addition, pursuant to NJAC 10:77A-2.4(d), individuals who provide AMHR services who have not completed the required training must not deliver the AMHR services alone. Such individuals must be supervised by, and deliver the AMHR services in conjunction with, a trained person who is onsite and provides in-person supervision. For 36 of the 100 claims in the sample, AHMR services were provided by staff members who did not complete the required training before the sampled service date or whose training was not documented. In addition, there was no evidence that these staff members were supervised onsite and in-person by a trained staff member.

Response:

Additional documentation was provided under separate cover for the following claims:

Claim #	Provider	Date of Service	Issue	Documentation
2-11	Cape May Counseling	10/1-29/2006	12 days of service with employees who did not have CPR or first aid (RA, PD, JG, BM)	Copies of CPR and First Aid certificates are provided for all employees in question
2-29	Care Plus of NJ	7/17-31/2005	MA-No first aid, provider stated they did not have any training for this employee prior to 2007; this employee worked alone on 7/30/05	Copies of three training certificates are provided. Dates issued: 4/18/90, 9/06/03 and 9/22/05
2-46	Career Opportunity Development	3/1-15/2005	No training documentation: AM, SC, ED; No personnel files for CB, DK, EE, BL (all terminated)	Copies of certificates are provided.

Claim #	Provider	Date of Service	Issue	Documentation
2-46	Career Opportunity Development		Provider stated they do not keep training records after an employee terminates their employment.	Agency located files for terminated employees, copies of certificates are provided
2-35	Comprehensive Behavioral	10/22-28/2007	SO-no CPR worked 5 hrs alone on 10/28; MS no first aid worked 8 hrs alone on 10/26	A copy of a certificate for SO is provided. No First aid documentation for MS could be located.
2-3	Comprehensive Behavioral Health	4/23-29/2007	LG- AMHR, CPR and First aid done after service date, HW CPR and first aid done after service date	Copy of certificates for LG is provided. Unable to provide the documentation for HW.
2-9	Delaware House	3/1-31/2006	RK did not have support for CPR/first aid until after service date (2009)	Documentation provided
2-19	Preferred Behavioral Health	4/9-15/2006	EB - No First aid, JL No CPR/First aid, MM CPR/First aid after service, SB CPR/First aid after service, PT No First aid, DT No training documented	Documentation provided
1-08	SERV	3/23/2006	Training was not maintained for the Home Care provider (BD)	Certifications were located and copies are provided by agency
1-07	SJ Behavioral Health	5/16/2005	No qualifications for RB	Agency provided telephone pre-employment reference check, application for employment and resume that reports his qualifications. Employee meets all qualifications requirements (10:37A-5.3).
1-10	SJ Behavioral Health	11/29/2007	PS did not have CPR/First aid training	Copies of certifications are provided.
1-11	SJ Behavioral Health	9/5/2006	No CPR for AS, No First aid for JD, No training documented for EF	Agency provided copies of certificates for 2 out of 3 employees in question. AS training is not available

1-17	SJ Behavioral Health	4/16/2005	Could not locate any training provided from 2005 (provider only had 2007 training)	Agency provided a copy of Training Agenda for 10/24/05 to 10/28/05 with attached sign in sheets.
1-07	SJ Behavioral Health		No training CG and RB	Copies of certifications are provided by agency
1-34	SJ Behavioral Health	7/19/2006	STM-missing AMHR training; KJ-missing first aid and AMHR training	Copies of certifications are provided by agency
1-35	SJ Behavioral Health	7/6/2005	ST missing CPR,first aid,AMHR training; CG-missing AMHR training	AMHR training was provided to ST and CG. No documentation available for CPR and first aid training for ST.
1-19	St. Mary Hospital	8/29/2006	Provider did not have training for first aid until Jan 2007 (employees MD and FF)	Staff had BLS training for Healthcare Providers which is more advanced than CPR/First Aid Trng.
1-28	St. Mary Hospital	7/12/2006	Provider was unaware of First aid training request (employees MC and FF)	Staff had BLS training for Healthcare Providers which is more advanced than CPR/First Aid Training.
2-43	Triple C Housing	7/1-31/2005	No CPR-AC, TM, JS	1 out of 3 CPR certificates in question are provided.

2-43	Triple C Housing		See 2-43 above	No qualifications, CPR, first aid, AMHR training for AS	Employee meets residential counselor's requirements and qualifications. Copy of resume and application for employment are provided by agency. No CPR, First Aid, AMHR training documents are available

2-4	Triple C Housing	11/1-30/2007	$2,349.14	Three staff members worked alone on 27 days of services and did not have CPR/first aid training (EF, DO, LG)	On days in question there was one or more staff members working who had CPR Certification. No certification was provided for employees in question.

The State concurs with the remainder of this finding.

COMPREHENSIVE SERVICE PLAN REQUIREMENTS NOT MET

Finding:

Pursuant to NJAC 10:37A-4.5(c)(8), "[t]he CSP should be reviewed and revised as necessary, by the 90th day of admission and then no less frequently than every 90 days for the first year of treatment, and every six months thereafter." In addition, State regulations require that the CSP be signed by both a registered nurse (NJAC 10:37A-5.2(b)(1)) and the beneficiary (NJAC 10:37A-4.5(c)(6)). If the beneficiary is unwilling or unable to sign, the reason must be documented on the CSP. For 23 of the 100 claims in the sample CSP requirements were not met.

Response:

Additional documentation was provided under separate cover for the following claims:

Claim #	Provider	Date of Service	Issue	Documentation
2-6	Care Plus Inc.	11/4-15/2007	During the first year the service plan was reviewed on 6/4/07 and 12/14/07. They either misplaced or never reviewed service plan in Sept.	No service plan was included in the file for Sept., but documentation provided demonstrates that the client received services consistently and progress was noted.
2-44	Community Hope Inc	6/12-18/2005	RN did not review and sign the 6/2005 CSP until 7/2005 which is after the service date under review	The claim is correct, however CSP was reviewed and authorized by consumer and staff on 6/8/05 and signed by nurse on 7/11/05

The State concurs with the remainder of this finding.

The CSP is an indispensable component of proper treatment. Although the providers should have documented clients' refusal to sign, it should be noted that when dealing with seriously mentally ill individuals, compliance with such tasks as signing as evidence of participation in CSP developed can be problematic.

LEVEL-OF-CARE REQUIREMENTS NOT MET

Finding:

Rehabilitative services must be recommended by a physician or other licensed practitioner of the healing arts (42 CFR § 440.130(d)). Pursuant to NJAC 10:77A-2.3(b)(1), the initial nursing assessment must include a recommendation for an appropriate level of AMHR service. The comprehensive nursing reassessment must include a justification for the continuation of AMHR services and a recommendation for the appropriate level of care (NJAC 10:77A-2.3(d)).

Pursuant to NJAC 10:77A-2.5, Medicaid reimbursement for AMHR services provided in or by a community residence is based on the site-specific level of care delivered by the CRR provider. Further, pursuant to NJAC 10:77A-2.5(g), if a beneficiary is required to remain in a residence while awaiting transfer to a more appropriate facility, the provider must request reimbursement at the lesser of the level of AMHR service approval for the site or the level of care that the resident requires. For 17 or the 100 claims in the sample, the level-of-care requirements were not met.

Response:

Additional documentation was provided under separate cover for the following claims:

Claim #	Provider	Date of Service	Issue	Documentation
2-11	Cape May Counseling		For 10 days, the logs show there was no staff available from 8am-4pm (3rd, 4th, 5th, 6th , 13th, 18th, 19th, 20th, 26th, 27th)	Time sheets of the staff for the dates and shift in question are provided
1-15	Easter Seals (Wanamassa)	10/16/2007	A+ level but only provided 15 hours of coverage	Provided documentation for 23 hours of coverage. Another time sheet for the 24 hour coverage is being provided.
2-49	New Bridge Svcs	5/25-31/2005	Documentation for 6 of the 7 days could not support Level A+ coverage was met (24 hrs)	The staffing pattern did meet level of care for A+ however staff on duty did not have required CPR & First Aid training
1-18	SERV	10/16/2005	Nursing Assessment recommended Level C but billed A+ (moved pt because bug infestation)	Justification is provided.
2-13	SERV		Provider could not document staffing for Level A+ on 4 of the 31 days (1st, 11th, 15th, 30th)	A detailed explanation of the agencies night shift coverage is provided.

The State concurs with the remainder of the finding.

WEEKLY PROGRESS NOTES NOT DOCUMENTED

Finding:

Pursuant to NJAC 10:37A-4.5(c)(10), CRR providers must document the beneficiary's clinical course of treatment and community living skills in the progress notes. The regulation states that progress must be documented by a weekly summary. For 10 of the 100 claims in the sample, the CRR provider could not document that weekly progress notes were prepared for the sample claim date.

Response:

Additional documentation was provided under separate cover for the following claims:

Claim #	Provider	Date of Service	Issue	Documentation
1-25	SERV	4/27/2005	Provider could not locate weekly progress notes for period of review	Progress notes are missing, but agency provided Consumer Care report for 4/27/05 proving that client was present and received services
1-37	SERV	4/6/2005	Provider left note in file that weekly progress note for the period reviewed could not be located	Agency provided Consumer Care report for 4/6/05 proving that client was present and received services.
1-41	SERV	4/1/2006	Provider left note in file that weekly progress note for the period reviewed could not be located	Agency provided Consumer Care report for 4/01/06 proving that client was present and received services.
2-27	Easter Seals Society CCA of NJ	11/19-26/2006	There were no weekly progress notes in file; agency referred to the billing log as demonstrating the type of rehab services provided for the week under review	Documentation is provided, but copy is not readable. Agency is attempting to provide a better copy.

The State concurs with the remainder of the finding.

FACE-TO-FACE NURSING REVIEW REQUIREMENTS NOT MET

Finding:

The Medicaid State plan requires that clinical supervision of beneficiaries receiving AMHR services be provided "on an as-needed basis, including, at a minimum, face to face visits every 60 days" (addendum to Attachment 3.1-A of the Medicaid State plan). Further, pursuant to NJAC 10:77A-2.3(c), a registered nurse or higher level professional must conduct a face-to-face review of the beneficiary at least every 60 days. Effective June 19, 2007, DHS amended its Medicaid State plan to require a face-to-face visit every 90 days.

For 9 of the 100 claims in the sample, the CRR provider did not perform or document a face-to-face review within the required time period. Specifically, for three claims provided prior to the

effective date of the Medicaid State plan amendment, a face-to-face review was not performed within 60 days of the claim date and, for one claim provided after the effective date, a face-to-face review was not performed within 90 days of the claim date. For the remaining five claims, the CRR provider did not document a face-to-face review.

Response:

Additional documentation was provided under separate cover for the following claims:

Claim #	Provider	Date of Service	Issue	Documentation
2-13	SERV	10/1-31/2005	On Oct 1st the face- to-face was 64 days since previous review. On Oct 29 they performed a review that was 91 days late.	The auditors' dates in question are not accurate. Nursing assessment report indicates nursing review on 10/24/2005. Prior review was on 7/29/05. Both reviews were within 90 day limit.
2-36	Easter Seal (Wanamassa)	10/15-21/2006	Missing face-to-face review paperwork in file. Was one done 5/30/06 and 11/23/06? Discussed with provider who said it was either misplaced or never prepared	Copy of 90-day supervisory follow-up is provided.
2-42	Delaware House	2/1-28/2007	Face-to-face does not cover period from 2/1-5/07	Weekly notes covering period in question are provided. If a person is not present for the 24 hour period this is indicated and no billing is generated.

The State concurs with the remainder of the finding.

Clearly the State's intent was to change the requirement from an original time period of 60 days to a slightly longer period of 90 days. As noted above, as soon as the auditors brought the discrepancy between the regulations and the SPA to our attention we immediately initiated a SPA to increase the period from 60 to 90 days. As evidenced by the SPA the State's request was approved retroactive to June 19, 2007 which was the day after the underlying regulations were changed to minimize the opportunity for future non-compliance on this issue.

SERVICES NOT DOCUMENTED, SUPPORTED, OR ALLOWABLE

Finding:

Pursuant to NJAC 10:77A-2.5(b), reimbursement for Medicaid AMHR services provided by or in community residence programs is made on a fee-for-service basis for each level of care and is billable in either per-diem or quarter-hours units of service. The fee must not include nontreatment and/or nonrehabilitation-related services, including, but not limited to, room and board, recreational, and vocational services. Pursuant to NJAC 10:77A-2.5(c)(1), CRR providers must seek reimbursement on a per diem basis only for the dates that the beneficiary received AMHR services. Pursuant to NJAC 10:77A-2.5(c)(2), CRR providers may seek reimbursement on a per diem basis for AMHR services provided on the date the beneficiary is admitted to the

facility but must not seek reimbursement for AMHR services provided on the beneficiary's date of discharge. During each face-to-face review, the professional is required, at a minimum, to: (1) review the beneficiary's CSP, (2) review observations and progress notes made by the direct-care staff, (3) assess the beneficiary's health, and (4) indicate any changes needed in treatment approaches in the CSP.

For quarter-hour units, NJAC 10:77A-2.5(d) states that a quarter-hour unit of service is defined as 15 consecutive minutes of service. For 9 of the 100 claims in the sample, the AMHR service was not documented, supported, or allowable.

Response:

Additional documentation was provided under separate cover for the following claims:

Claim #	Provider	Date of Service	Issue	Documentation
1-32	SERV	4/13/2007	Only service provided was transportation to recreation activity	Agency provided Consumer Care report for 4/13/07 and stated that client was eligible for Level A services billing.
1-42	SERV	11/13/2006	The services rendered were not 15 minutes in duration and should not have been billed (Level B SA)	Agency billed 6 units from the 99 minute chunk. They did not bill the 5 minute contacts
2-43	Triple C Housing	7/1-31/2005	Missing shift log for 7/20,30	Agency provided 2 copies of residence activity logs for night shift both dated 7/31/05. Looks like staff wrote down incorrect date. Documentation for 7/20 is not provided.

The State concurs with the remainder of the finding.

NURSING ASSESSMENT REQUIREMENTS NOT MET

Finding:

Pursuant to NJAC 10:77A-2.3(b), the initial nursing assessment must be completed within 14 calendar days of admission, justify the need for continued mental health rehabilitation services, and include a recommendation for an appropriate level of service. Pursuant to NJAC 10:77A-2.3(d), comprehensive nursing assessments must be completed at least annually, include justification for continuation of services, and contain a recommendation for an appropriate level of care. For 6 of the 100 claims in the sample, nursing assessment requirements were not met.

Response:

Additional documentation was provided under separate cover for the following claim:

Claim #	Provider	Date of Service	Issue	Documentation
2-21	Easter Seals (Somerville)	9/3-9/2006	Annual nursing assessment was not found in file	Documentation was found however it did not have RN signature and no Case Manager signature

The State concurs with the remainder of this finding.

Recommendations 2 and 3:

The OIG recommends that the State provide CRR providers with guidance to help ensure they comply with Medicaid State plan requirements and improve its monitoring of CRR providers' claims to ensure compliance with Federal and State requirements.

The State takes the findings raised in this draft report very seriously. While the State believes that its' monitoring of CRR providers is adequate, the State agrees that monitoring can be improved. As a result of this audit, DMHS is providing technical assistance to CRR providers and also is working to eliminate any areas of ambiguity between varying regulations, rules, and SPAs. Additionally, DMHS is reviewing its auditing procedures, licensure reviews, program reviews and Medicaid reviews to ensure compliance with all Federal and State requirements. The State views documentation of services provided for the length of time and composition of allowable activity required by the regulations as absolutely essential to properly support reimbursement. The State will assure that the comprehensive reviews continue to address documentation requirements and specifically review documentation requirements as part of the technical assistance that will be provided.

In instances where DMHS identified non-compliance by CRR providers during its monitoring reviews, DMHS practice has been to require providers to prepare and implement a corrective action plan. State staff are charged with following up on corrective actions related to material deficiencies. Additionally in cases of material deficiencies particularly life safety deficiencies, DMHS has taken action such as instituting moratoriums on accepting new consumers, suspended or issued conditional licenses and included contract contingencies to assure prompt action toward remediation. The State would suggest that the fact that 8 monitoring visits did identify issues similar to those identified in the audit does demonstrate that DMHS was conducting monitoring and was seeking to remediate deficiencies through corrective action plans.

We would like to thank you for the professional manner and cooperative spirit in which this audit was conducted and look forward to your evaluation of the material from the providers that we sent separately under cover. If you have any questions or require additional information, please contact me or Richard Hurd at 609-588-2550.

Sincerely,

Valerie Harr
Director

VH:H
c: Jennifer Velez
Richard Hurd