April 16, 2010

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Joseph E. Vengrin/
Deputy Inspector General for Audit Services

SUBJECT: Review of New Jersey's Medicaid School-Based Health Claims Submitted by Maximus, Inc. (A-02-07-01051)

Attached is an advance copy of our final report on New Jersey's Medicaid school-based health claims submitted by Maximus, Inc. 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 George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at George.Reeb@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-02-07-01051.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

April 23, 2010

Report Number: A-02-07-01051

Ms. 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 & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of New Jersey's Medicaid School-Based Health Claims Submitted by Maximus, Inc*. 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 Richard Schlitt, Audit Manager, at (212) 264-4817 or through email at Richard.Schlitt@oig.hhs.gov. Please refer to report number A-02-07-01051 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 & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF NEW JERSEY'S MEDICAID SCHOOL-BASED HEALTH CLAIMS SUBMITTED BY MAXIMUS, INC.

Daniel R. Levinson
Inspector General

April 2010
A-02-07-01051

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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 certain 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 Department of Human Services is responsible for operating the Medicaid program.

Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. No. 100-360) amended section 1903(c) of the Act to permit Medicaid payment for medical services provided to children under the Individuals with Disabilities Education Act through a child's individualized education plan. Pursuant to Federal and State requirements, such services require a referral or prescription from a properly credentialed physician or licensed practitioner. These services must be provided by an individual who meets Federal qualification requirements and be fully documented. In addition, pursuant to New Jersey's State Medicaid plan requirements, these services must be documented in a treatment plan.

For the period July 27, 2003, through October 4, 2006, New Jersey received more than $32.2 million in Federal Medicaid reimbursement for school-based health claims submitted by its billing agent, Maximus, Inc. (Maximus).

OBJECTIVE

Our objective was to determine whether New Jersey's Medicaid school-based health claims submitted by its billing agent, Maximus, complied with Federal and State requirements.

SUMMARY OF FINDINGS

New Jersey's claims for reimbursement of Medicaid school-based health services submitted by Maximus did not fully comply with Federal and State requirements. Of the 100 school-based health claims in our sample, 49 complied with Federal and State requirements. However, the remaining 51 did not.

Of the 51 noncompliant claims, 19 claims contained more than one deficiency:

- Thirty-two claims contained services that were not provided or supported.

- Twenty-four claims lacked a referral or prescription.

- Fourteen claims did not meet Federal provider qualification requirements.

- Eight claims contained services not documented in the child's plan.

These deficiencies occurred because: (1) New Jersey provided improper guidance concerning Federal Medicaid requirements to school-based health providers, (2) school-based health providers did not comply with guidance related to Federal requirements, and (3) New Jersey did not adequately monitor school-based health claims for compliance with Federal and State requirements.

Based on our sample results, we estimate that New Jersey was improperly reimbursed $8,079,312 in Federal Medicaid funds during our July 27, 2003, through October 4, 2006, audit period.

RECOMMENDATIONS

We recommend that New Jersey:

- refund $8,079,312 to the Federal Government,

- provide proper and timely guidance on Federal Medicaid criteria to its school-based health providers, and

- improve its monitoring of school-based health providers' claims to ensure compliance with Federal and State requirements.

NEW JERSEY COMMENTS

In its comments on our draft report, New Jersey disagreed with our recommended refund. In addition, New Jersey questioned our sampling methodology and disagreed with what we accepted as valid referrals. However, New Jersey also described corrective actions that it planned to take in response to the remaining recommendations. New Jersey also provided additional documentation for 5 of the 53 claims questioned in our draft report.

OFFICE OF INSPECTOR GENERAL RESPONSE

Our statistical sampling methodology used to determine the estimated overpayment was valid. After reviewing the additional documentation provided by New Jersey, we determined that some services for the five claims complied with Federal and State requirements and revised our findings and recommended refund accordingly.

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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 certain 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.

Medicaid Coverage of School-Based Health Services

Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. No. 100-360) amended section 1903(c) of the Act to permit Medicaid payment for medical services provided to children under the Individuals with Disabilities Education Act (IDEA) (originally enacted as P.L. No. 91-230 in 1970) through a child's individualized education plan.

Federal and State rules require that school-based health services be (1) referred or prescribed by a physician or another appropriate professional, (2) provided by an individual who meets Federal qualification requirements, (3) fully documented, (4) actually furnished in order to be billed, and (5) documented in the child's plan.

In August 1997, CMS issued a guide entitled *Medicaid and School Health: A Technical Assistance Guide* (technical guide). According to the technical guide, school-based health services included in a child's plan may be covered if all relevant statutory and regulatory requirements are met. In addition, the technical guide provides that a State may cover services included in a child's plan as long as: (1) the services are listed in section 1905(a) of the Act and are medically necessary; (2) all Federal and State regulations are followed, including those specifying provider qualifications; and (3) the services are included in the State plan or available under the Early and Periodic Screening, Diagnostic and Treatment Medicaid benefit. Covered services may include, but are not limited to, physical therapy, occupational therapy, speech pathology/therapy services, psychological counseling, nursing, and transportation services.

New Jersey's Medicaid Program

In New Jersey, the Department of Human Services is responsible for operating the Medicaid program. Within the New Jersey Department of Human Services, the Division of Medical Assistance and Health Services administers the Medicaid program. The administrative responsibility for operating New Jersey's school-based health services program, known as the Special Education Medicaid Initiative (SEMI), is shared among three State departments: Human Services, Education, and Treasury. The State also contracted with a billing agent, Maximus, Inc.

(Maximus), to help administer its Medicaid school-based health services program. The responsibilities of each are as follows:

1. The Department of Human Services oversees school-based health provider enrollment, provides technical assistance to school-based health providers, and processes providers' claims through New Jersey's Medicaid Management Information System fiscal intermediary.

2. The Department of Education (DOE) certifies school-based health providers and provides policy guidance.

3. The Department of Treasury serves as the contract manager for the SEMI billing agent.

4. The billing agent was responsible for processing billing agreements and pupil registration information from school-based health providers, providing technical assistance (including monitoring) on school-based health program issues, and conducting Medicaid eligibility verification for registered pupils. Maximus was the contracted billing agent for New Jersey during our audit period.[1]

The primary State guidance for administering and operating the school-based health program is the *SEMI Provider Handbook* (State handbook). New Jersey and the billing agent developed the handbook using both education and Medicaid requirements. The State handbook is issued to all school-based health providers and contains detailed instructions on their responsibilities under the school-based health program.

Pursuant to New Jersey's Medicaid State plan, the school-based health program comprises rehabilitative services,[2] evaluation services,[3] and transportation services.[4] School-based health providers submitted monthly "turnaround documents" to Maximus that showed the daily school-based services provided during the month to each student. Maximus then prepared claims based

[1] Maximus oversaw the SEMI program from November 1998 to January 2005 under a contingency-fee-based arrangement. New Jersey received Federal Medicaid reimbursement for claims submitted by Maximus through October 2006. Although Maximus was not paid directly with Federal Medicaid funds, it was paid a percentage of the Federal Medicaid reimbursements made for New Jersey's SEMI program. We selected this program for review as part of a nationwide contingency-fee review.

[2] Often referred to as related school health services, rehabilitative services include occupational, physical, and speech-language therapies; audiology services; psychological counseling and psychotherapy; and nursing.

[3] Evaluation services identify the need for specific services and prescribe the range and frequency of services that the student requires. Evaluation services may include reevaluation or review of the current services specified in the child's plan.

[4] Transportation services are allowable when provided on the same day as a related service and when transportation is included in the child's plan. Pursuant to a May 21, 1999, letter from the Director of CMS's Center for Medicaid and State Operations to all State Medicaid directors, only specialized transportation can be billed to Medicaid. According to CMS, "specialized transportation" means that a child requires transportation in a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus.

on the documents received. A school-based claim consisted of a bill for related school-based health services, evaluation services, or transportation services.

The Federal Government's share of costs for school-based health claims is known as the Federal medical assistance percentage (FMAP). From July 27, 2003, through June 30, 2004, the FMAP was 52.95 percent in New Jersey; from July 1, 2004, through October 4, 2006, the FMAP was 50 percent. For the period July 27, 2003, through October 4, 2006, the State received more than $32.2 million of Federal Medicaid reimbursement for 86,533 claims.

Prior Office of Inspector General Audit Reports

On May 19, 2006, the Office of Inspector General issued a report (A-02-03-01003) on the State's SEMI program for the period July 1, 1998, through June 30, 2001. The objective of the audit was to determine whether Federal Medicaid payments for school-based health services claimed by school-based health providers in New Jersey were in compliance with Federal and State requirements. Among other recommendations, the report recommended that New Jersey refund $51,262,909 to the Federal Government and work with CMS to resolve $1,046,786 in set-aside claims.[5]

On February 8, 2008, the Office of Inspector General issued a report (A-02-04-01017) on the rates used by New Jersey for claiming Federal Medicaid reimbursement for the SEMI and Medicaid Administrative Claiming programs. The objective of the audit was to determine whether the rates used by New Jersey were reasonable and complied with Federal requirements and the Medicaid State plan. The report recommended that New Jersey work with CMS to determine overpayment amounts for the period July 1, 1998, through June 30, 2001, and ensure that rates used to claim Federal Medicaid reimbursement for school-based health services are properly developed and documented.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether New Jersey's Medicaid school-based health claims submitted by its billing agent, Maximus, complied with Federal and State requirements.

Scope

Our review covered 86,533 claims totaling $62,563,888 ($32,223,604 Federal share) for the period July 27, 2003, through October 4, 2006. During our audit, we did not review the overall internal control structure of Maximus, New Jersey, or the Medicaid program. Rather, we limited our internal control review to those controls that were significant to the objective of our audit.

We conducted fieldwork at the Department of Human Service's offices in Mercerville and Trenton, New Jersey, as well as at 49 selected schools throughout the State.

[5] CMS sustained the recommendations with minor adjustments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidelines;
- held discussions with New Jersey and billing agent officials to gain an understanding of New Jersey's school-based health services program;
- obtained an understanding of computer edits and administrative controls regarding claiming Medicaid reimbursement for school-based health services;
- obtained a computer-generated file identifying all Medicaid school-based health claims submitted by New Jersey for the period July 27, 2003, through June 27, 2007;
- separated the file into two segments based on billing agent: claims submitted by Maximus and claims submitted by Public Consulting Group, Inc. (PCG),[6] and the Maximus sampling frame consisted of 86,533 student-months (all services provided to an individual student for a month during our audit period) with a total Medicaid paid amount of $62,563,888 ($32,223,604 Federal share);
- used stratified random sampling techniques to select a sample of 100 claims from the sampling frame of 86,533 claims;[7]
- visited the school associated with each sample claim to review documentation supporting the claim;[8]
- determined if the service provider or speech pathologist associated with the sample claim was certified by the American Speech-Language-Hearing Association (ASHA) and/or licensed by the New Jersey Division of Consumer Affairs, the State licensing agency; and
- estimated the dollar impact of the improper Federal reimbursement claimed in the total population of 86,533 school-based claims.

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

[6] We will be conducting a separate review (A-02-07-01052) of claims submitted by New Jersey for the period April 6, 2005, through June 27, 2007, when PCG was the State's school-based health services billing agent.

[7] The 100 sample claims included 163 services: 46 claims for speech services, 37 for evaluation services, 26 for occupational therapy services, 19 for physical therapy services, 15 for transportation services, 12 for nursing services, and 8 for psychological counseling services.

[8] If documentation was not readily available, we accepted faxed copies at later dates.

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 objective.

FINDINGS AND RECOMMENDATIONS

New Jersey's claims for reimbursement of Medicaid school-based health services submitted by Maximus did not fully comply with Federal and State requirements. Of the 100 school-based health claims in our sample, 49 complied with Federal and State requirements. However, the remaining 51 did not. Table 1 summarizes the deficiencies noted and the number of claims that contained each type of deficiency. Appendix C contains a summary of deficiencies, if any, identified for each sampled claim.

Table 1: Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Deficient Claims[9]
Services not provided or not supported	32
Referral or prescription requirements not met	24
Federal provider requirements not met	14
Services not documented in child's plan	8

These deficiencies occurred because: (1) the State provided improper or untimely guidance concerning Federal Medicaid requirements to school-based health providers, (2) school-based health providers did not comply with State guidance related to Federal requirements, and (3) the State did not adequately monitor school-based health claims from providers for compliance with Federal and State requirements.

Based on our sample results, we estimate that New Jersey was improperly reimbursed $8,079,312 in Federal Medicaid funds during our July 27, 2003, through October 4, 2006, audit period.

SERVICES NOT PROVIDED OR NOT SUPPORTED

Pursuant to section 1902(a)(27) of the Act, States claiming Federal Medicaid funding must document services provided. This requirement is reiterated in CMS's technical guide and the State handbook, which both state that school-based health providers must maintain records documenting that a related service or evaluation service was provided. The technical guide states that relevant documentation includes the date and location of the service, the identity of the provider, and the length of time required for the service.

[9] The total exceeds 51 because 19 claims contained more than 1 deficiency.

In addition, pursuant to 42 CFR § 455.1(a)(2), States are required to have a method for verifying whether services reimbursed by Medicaid were actually furnished. Further, pursuant to 42 CFR § 455.18, New Jersey's Medicaid provider agreements require providers to certify that the information on their Medicaid claims is true, accurate, and complete.[10] Providers and billing agents also certify that they agree to keep records necessary to fully disclose the extent of services provided, as required by section 1902(a)(27) of the Act.

For 32 of the 100 claims in our sample, school-based health providers received Medicaid payments for services that were not provided or not supported.[11] Specifically:

- For 18 claims, documentation indicated that the related service(s) billed were not provided. Specifically:
    - For 10 claims, documentation for the associated student did not support the number of services billed.
    - For six claims, the associated student's attendance record indicated that the student was absent from school on at least 1 day that the school-based health provider claimed services.
    - For two claims, the school-based health provider submitted duplicate claims for the same service.
- For 10 claims containing specialized transportation services, school-based health providers did not have documentation to support the number of transportation services billed.
- For six claims, school-based health providers could not provide any documentation to support the related service.

REFERRAL OR PRESCRIPTION REQUIREMENTS NOT MET

Pursuant to 42 CFR § 440.110 (a)(b)(c), a referral or prescription from a physician or another licensed practitioner of the healing arts is required for physical therapy; occupational therapy; and services for individuals with speech, hearing, and language disorders provided by or under the direction of a qualified practitioner to be eligible for Medicaid reimbursement. For nursing services, the New Jersey Board of Nursing Statute 45:11-23 allows nurses to execute medical regimens as prescribed by a licensed (or otherwise legally authorized) physician or dentist.

[10] The regulation requires State Medicaid claim forms to include a certification by providers that the information on the claims is true, accurate, and complete or States may print similar wording above the claimant's endorsement on checks payable to providers. In New Jersey, both the Provider Electronic Billing Agreement for Providers With Billing Agents and the Medicaid Health Insurance Portability and Accountability Act Electronic Data Interchange Agreement include such certifications.

[11] The total exceeds 32 because 2 claims contain more than 1 deficiency.

For 24 of the 100 claims in our sample, the school-based health provider could not provide referrals or prescriptions to support the related service. Specifically, 21 speech therapy services, 6 occupational therapy services, and 1 physical therapy service did not meet Federal referral and prescription requirements; 3 nursing services did not meet State prescription requirements.[12]

FEDERAL PROVIDER REQUIREMENTS NOT MET

Federal regulations (42 CFR § 440.110) set forth provider credential requirements for physical, occupational, and speech therapy services. For 14 of the 100 claims in our sample, the speech therapy or occupational therapy practitioner associated with the claim did not meet these regulations.

Speech Therapy Provider Requirements Not Met

Pursuant to 42 CFR § 440.110(c)(2), for a speech therapy claim to be eligible for Medicaid reimbursement, it must be provided by or under the direction of a speech pathologist who: (1) is certified by ASHA or (2) has completed the equivalent educational requirements and work experience necessary to be eligible for ASHA's certificate of clinical competence or (3) has completed the academic program and is in the process of acquiring the necessary work experience to qualify for the certificate.

In a December 28, 1993, letter, CMS asked New Jersey officials to provide assurance that speech therapy providers would meet the qualifications detailed in 42 CFR § 440.110(c)(2). In an August 1, 1995, letter, New Jersey assured CMS that it would bill Medicaid for only those services provided by or under the direction of qualified speech-language practitioners.

However, for 13 of the 100 claims in our sample, the practitioner who provided the speech therapy service was not ASHA-certified or did not have the equivalent educational requirements and work experience necessary to be eligible for ASHA certification.

ASHA requires all applicants for certification in speech language pathology to possess a master's or doctoral degree granted by a regionally accredited institution of higher education and have completed a minimum of 75 semester credit hours in a course of study addressing the knowledge and skills pertinent to the field of speech-language pathology. Additionally, applicants must complete a 350-hour clinical practicum under the supervision of an individual who holds a certificate of clinical competence and a 36-week, full-time fellowship.

None of the practitioners associated with the 13 claims in our sample met these requirements. The practitioners that provided the services were authorized by the New Jersey DOE to serve in public schools as either a speech correctionist or a speech language specialist. The DOE does not require specific coursework towards a master's degree, a 350-hour clinical practicum, or a clinical fellowship.

[12] The total exceeds 24 because multiple related school-based health services were provided and billed on the same monthly claim.

Finally, for the 13 sample claims in question, the school-based providers did not furnish any documentation showing that the services provided met the "under the direction of" requirements. Pursuant to 42 CFR § 440.110(c) and Medicaid State Operations Letter 95-12, issued on February 9, 1995, "under the direction of a speech pathologist" means that the speech pathologist is individually involved with the patient under his or her direction and accepts ultimate responsibility for the actions of the personnel that he or she agrees to direct.

Occupational Therapy Provider Requirements Not Met

Pursuant to 42 CFR § 440.110(b)(2), for an occupational therapy claim to be eligible for Medicaid reimbursement, the occupational therapist providing the service must be registered by the American Occupational Therapy Association (AOTA) or be a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by AOTA. For 1 of the 100 claims in our sample, the individual who provided the occupational therapy service did not meet these provider requirements. The school-based health services were provided by an occupational therapist assistant and the provider did not provide any documentation showing that the services were "under the direction of" a licensed occupational therapist.

SERVICES NOT DOCUMENTED IN CHILD'S PLAN

Section 1903(c) of the Act permits Medicaid payment for medical services provided to children under IDEA if the services are included in a child's plan. Pursuant to Part B of IDEA, school districts must prepare a child's plan for each child that specifies all special education and related services that the child needs. New Jersey's State Medicaid plan provides that a child's plan must state which related services are to be provided. For 8 of the 100 claims in our sample, the related school-based health or transportation service was not documented in the child's plan. Specifically, for five claims, the associated school could not produce the child's plan, and for three claims, the child's plan did not document the services billed.[13]

CAUSES OF THE IMPROPER CLAIMS

Although the frequency at which New Jersey improperly claimed school-based health services for Medicaid reimbursement decreased from our prior audit (A-02-03-01003), our review found deficiencies similar to those previously reported.[14] We found three main causes of the unallowable claims.

[13] School officials indicated that the child's plan associated with each of the five sampled claims may have followed the child to another school. The school officials contacted schools where each child's plan may have been sent but were unable to produce the child's plan associated with each of these claims.

[14] The number of claims in error decreased from 109 out of 150 sampled claims to 51 out of 100 sampled claims.

New Jersey Issued Improper Guidance Regarding Provider Requirements

Some of the improper claims occurred because New Jersey issued guidance to school-based health providers that did not adequately explain Federal provider requirements. For example, New Jersey's guidance did not indicate that, per Federal regulations, speech and occupational therapy services require referrals.

Providers Did Not Comply With Federal Requirements

Some of the improper claims occurred because school-based health providers did not comply with Federal requirements. The State handbook specifies that school-based health providers must maintain records per Federal requirements that document a related service or an evaluation service was provided on a specific date. However, some providers did not maintain this documentation. As a result, we were unable to verify that services billed were actually provided.

New Jersey Did Not Adequately Monitor School-Based Health Claims

Based on our review, we determined that monitoring by Maximus was not effective and that New Jersey did not adequately monitor school-based health claims to ensure compliance with program requirements by providers and Maximus. From January 2003 through the end of its contract with New Jersey, Maximus conducted 40 monitoring visits. We reviewed documentation from these monitoring visits and detected deficiencies similar to those that we found in our audit.

RECOMMENDATIONS

We recommend that New Jersey:

- refund $8,079,312 to the Federal Government,
- provide proper and timely guidance on Federal Medicaid criteria to its school-based health providers, and
- improve its monitoring of school-based health providers' claims to ensure compliance with Federal and State requirements.

NEW JERSEY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, New Jersey disagreed with our recommended refund. In addition, New Jersey questioned our sampling methodology and disagreed with what we accepted as valid referrals. However, New Jersey also described corrective actions that it planned to take in response to the remaining recommendations.

New Jersey also provided additional documentation for five claims we questioned in our draft report. After reviewing this documentation, we determined that some services for the five claims complied with Federal and State requirements and revised our findings and recommended refund

accordingly. We have summarized New Jersey's comments, along with our response, below, and we have included those comments in their entirety as Appendix D.

Sampling Methodology

New Jersey Comments

New Jersey questioned our sampling methodology used to determine the estimate for the overpayment associated with unallowable claims for school-based health services and said that it resulted in inaccurate findings and recommendations. New Jersey stated that our sample size did not appear large enough for an accurate estimate of overpayments. New Jersey also said that our sample should have been stratified based on the type of service and the beneficiary's medical condition (i.e., type of disability).

Office of Inspector General Response

We followed our longstanding statistical sampling policies with regard to both sample size and stratification. The Departmental Appeals Board (Board) has supported the Office of Inspector General's (OIG) use of statistical sampling to calculate disallowances in accordance with these policies. Specifically, in one case involving the 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 the disallowance, an approach upheld in principle by courts and this Board before."[15]

Referrals

New Jersey Comments

New Jersey stated that it did "not concur with the auditor's interpretation of acceptable referral documentation" for two sample claims (S1-4 and S1-10) and provided documentation related to the claims. New Jersey said that there is no "definitive guidance" as to how long a referral is valid to support services. In addition, New Jersey stated that, for three sample claims (S1-28, S2-15, and S2-29), the individual who referred the speech therapy services was certified by ASHA but was not licensed by the State's licensing body. New Jersey stated that, because ASHA-certified individuals can provide speech therapy services, referrals for speech therapy services by ASHA-certified individuals should be allowed.

Office of Inspector General Response

We agree that there is no guidance regarding how long a referral is valid to separate services. Therefore, we accepted claims that we questioned in our draft report related to this issue and have revised our findings, recommended refund, and Appendix C accordingly. However, we

[15] California Department of Social Services, DAB No. 816 (1986); see also Maine Dept. 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.

disagree with New Jersey's statement that an unlicensed individual can refer services. Pursuant to 42 CFR § 440.110 (a)(b)(c), a referral or prescription from a physician or another licensed practitioner of the healing arts is required for physical therapy; occupational therapy; and services for individuals with speech, hearing, and language disorders.

Additional Documentation

New Jersey Comments

New Jersey provided additional documentation for 3 of the 53 claims (S1-27, S2-32, and S2-45) questioned in our draft report.

Office of Inspector General Response

We reviewed the documentation that New Jersey provided for the three claims and accepted some services based on the documentation. Specifically, we accepted some services that we previously questioned because of referral issues; however, we continue to question services related to these claims that still did not meet referral, provider, or documentation requirements. We have revised our findings, recommended refund, and Appendix C accordingly.

Attendance

New Jersey Comments

New Jersey stated that, for one sample claim (S2-39), there was service documentation in place although attendance data for the corresponding student did not match. New Jersey indicated that there are multiple reasons that attendance may be in error and that "valid service documentation data" should be accepted as proof of service delivery.

Office of Inspector General Response

Students must be in attendance on a given day to receive school-based health services on that day. To determine if a student was in attendance on the date of a sampled service, we reviewed the school register to determine if school was in session and the student was marked present. We then compared the school's attendance record to the SEMI service record. For sample claim S2-39, the school register indicated that the student was absent from school. Therefore, we did not accept the billed SEMI service for this claim.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was Medicaid claims for school-based services provided by school-based health providers in New Jersey that were submitted for Federal Medicaid reimbursement by Maximus, Inc. (Maximus). The claims were for service dates from July 1, 1998, through January 31, 2005, with payment dates from July 27, 2003, through October 4, 2006 (our audit period).

SAMPLING FRAME

The sampling frame was a computer file containing 86,533 student-months representing all claims for school-based services provided by school-based health providers in New Jersey with payment dates from July 27, 2003, through October 4, 2006. The total Medicaid paid amount for the 86,533 student-months was $62,563,888 ($32,223,604 Federal share). State officials extracted the database from the paid claims files maintained at the Medicaid Management Information System fiscal agent.

SAMPLE UNIT

The sample unit was an individual student-month. Each sampling unit represents all services provided to an individual student for a month during our audit period that were billed for Federal Medicaid reimbursement by Maximus.

SAMPLE DESIGN

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

- Stratum 1—less than $1,400.00: 70,445 student-months

- Stratum 2—equal to or greater than $1,400.00: 16,088 student-months

SAMPLE SIZE

We selected a sample of 100 student-month claims with 50 items from each stratum.

SOURCE OF THE RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services' statistical software, RAT-STATS, to generate the random numbers.

METHOD OF SELECTING SAMPLE ITEMS

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

ESTIMATION METHODOLOGY

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

APPENDIX B: 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	70,445	$16,332,459	50	$11,202	26	$4,577
2	16,088	$15,891,145	50	$50,881	25	$12,966
Total	**86,533**	**$32,223,604**	**100**	**$62,083**	**51**	**$17,542**[1]

Estimated Overpayment Associated with the Unallowable Claims
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$10,619,719
Lower Limit	$8,079,312
Upper Limit	$13,160,126

[1] The dollar amounts do not add due to rounding.

APPENDIX C: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED CLAIM

Legend

1	Referral or prescription requirements not met
2	Federal provider requirements not met
3	Services not provided or not supported
4	Services not documented in child's plan

Office of Inspector General Review Determinations on the 100 Sampled Claims

Claim No.	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S1-1					0
S1-2	X				1
S1-3	X				1
S1-4					0
S1-5	X				1
S1-6	X			X	2
S1-7					0
S1-8				X	1
S1-9					0
S1-10					0
S1-11					0
S1-12					0
S1-13					0
S1-14					0
S1-15			X		1
S1-16	X		X		2
S1-17	X	X			2
S1-18					0
S1-19					0
S1-20					0
S1-21					0
S1-22	X		X		2
S1-23				X	1
S1-24		X			1
S1-25	X				1
S1-26	X	X	X		3
S1-27	X	X			2
S1-28	X				1
S1-29	X		X		2
S1-30					0
S1-31	X		X		2
S1-32					0
S1-33			X		1

Claim No.	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S1-34					0
S1-35			X		1
S1-36					0
S1-37					0
S1-38					0
S1-39		X	X		2
S1-40	X			X	2
S1-41					0
S1-42	X	X		X	3
S1-43					0
S1-44					0
S1-45			X		1
S1-46	X			X	2
S1-47					0
S1-48					0
S1-49		X	X	X	3
S1-50			X		1
S2-1					0
S2-2					0
S2-3					0
S2-4			X		1
S2-5					0
S2-6			X		1
S2-7			X		1
S2-8			X		1
S2-9				X	1
S2-10			X		1
S2-11					0
S2-12					0
S2-13					0
S2-14		X			1
S2-15	X				1
S2-16					0
S2-17					0
S2-18	X	X	X		3
S2-19	X	X	X		3
S2-20					0
S2-21					0
S2-22					0
S2-23					0
S2-24					0
S2-25					0

Claim No.	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S2-26					0
S2-27					0
S2-28					0
S2-29	X				1
S2-30					0
S2-31					0
S2-32			X		1
S2-33					0
S2-34			X		1
S2-35			X		1
S2-36			X		1
S2-37			X		1
S2-38			X		1
S2-39	X	X	X		3
S2-40	X	X	X		3
S2-41			X		1
S2-42					0
S2-43			X		1
S2-44					0
S2-45	X	X			2
S2-46	X	X	X		3
S2-47					0
S2-48					0
S2-49			X		1
S2-50			X		1
Category Totals	24	14	32	8	78

51 claims in error

APPENDIX D: NEW JERSEY COMMENTS

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PO Box 712
TRENTON NJ 08625-0712
TELEPHONE 1-800-356-1561

JON S. CORZINE
Governor

JENNIFER VELEZ
Commissioner

JOHN R. GUHL
Director

August 27, 2009

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 K. Javits Federal Building – Room 3900
New York, NY 10278

Report Number A-02-07-01051

Dear Mr. Edert:

This is in response to your letter dated May 14, 2009 concerning the Department of Health and Human Services, Office of the Inspector General's (OIG) draft report entitled "Review of New Jersey's Medicaid School-Based Health Claims Submitted By Maximus, Inc." Your letter provides the opportunity to comment on this draft report.

The objective of this review was to determine whether New Jersey's Medicaid school-based health claims submitted by its billing agent, Maximus, complied with Federal and State requirements. The review period was July 27, 2003 through October 4, 2006.

The draft audit report concluded that New Jersey's claims for reimbursement of Medicaid school-based health services submitted by Maximus did not fully comply with Federal and State requirements. While 47 of the 100 school-based health claims in the sample fully complied with all Federal and State requirements, the remaining 53 did not meet one or more of the applicable requirements. The report indicates that the non-compliance issues were manifested in four types of deficiencies: services were not provided or not supported; referral or prescription requirements were not met; federal provider requirements were not met; and services were not documented in child's plan. The report states that the deficiencies occurred because: the State provided improper or untimely guidance concerning Federal Medicaid requirements to school-based health providers; school-based health providers did not comply with State guidance related to Federal requirements; and the State did not adequately monitor school-based health claims from providers for compliance with Federal and State requirements. Based on the sample results, the auditor estimated that New Jersey was improperly reimbursed $8,849,949 in Federal Medicaid funds during the July 27, 2003, through October 4, 2006, audit period.

Following are the auditors' recommendations and the Division of Medical Assistance and Health Services (DHMAS) responses:

I. RECOMMENDATION:

New Jersey should refund $8,849,949 to the Federal Government

RESPONSE:

The State does not concur with this recommendation. Based on the analysis outlined below performed with the assistance of a statistician, it appears the sampling methodology used by the auditor provided inaccurate findings and recommendations.

Analysis of OIG Sampling Methodology

To select a probability sample of a population in order to accurately estimate some characteristic of the total population, it is necessary to define the population.[1] This definition of a population for a particular study is called the *sampling frame*. Individual elements and units within the sampling frame are selected for a study using various kinds of sampling procedures.

The selection of random samples is the preferred method for studies in which population characteristics are estimated based on sample because random sampling leads to extremely accurate estimates when the sampling procedures are appropriate for what we know (or can assume) about the characteristics of the total population. Random samples can be selected by simple random sampling or by stratified random sampling. Simple random sampling leads to accurate results if we know or can assume that the population is relatively homogenous with respect to the questions of interest. For instance, a sample of student-months representing the rate of non-compliance of all Medicaid school-based health claims submitted for one type of service for individuals within one type of disability category selected by simple random sampling may be extremely accurate for estimating the overall rate of non-compliance.

If known or assumed, however, that the population is heterogeneous with respect to the questions of interest so that the findings are likely to differ substantially within subgroups of the population, the validity of the estimates of population characteristics is greatly improved by stratified random sampling. Stratified random sampling ensures that the proportion of individual units within each subgroup of the sample matches the proportion of individual units within each subgroup of the total population and thus the combined estimates derived from subgroups within the sample represent the characteristics of the total population accurately.

Medicaid claims for school-based services in New Jersey include a broad array of different types of services. The services for which school-based health claims are submitted include:

1. Rehabilitative services--occupational, physical, and speech-language therapies; psychological counseling and psychotherapy; and nursing;
2. Evaluation services identifying the need for specific services and prescribing the range and frequency of services that the student requires which may include reevaluation or review of the current services specified in the child's plan; and
3. Specialized transportation services in a vehicle adapted to serve the needs of the disabled, including specially adapted school buses, when provided on the same day as a related service and when transportation is included in the child's plan.

Each subgroup of services is quite likely to differ substantially in ways that may impact overall estimates of noncompliant claims for the entire population of school-based health claims. In addition to the cost of services, the proportion of claims submitted varies by type of service. The proportion of claims submitted as well as the extent to which multiple claims are submitted for services provided across all three major types of services differs substantially by disability group as well with some lower-incidence disability groups accounting for a relatively high proportion of claims. Since it is likely that types of noncompliance--services not provided or supported, services lacking a referral or prescription, services meeting Federal provider qualification requirements, and services not documented in the child's plan-- are also correlated with the type of services provided, any estimation procedure based on a sampling frame that does not

[1] McBurney, D. H., & White, T. L. (2007). *Research Methods.* Thomson Wadsworth, Belmont, CA.

take these factors into account in estimating the incidence of noncompliant claims overall will not be accurate.

The sampling frame for the estimates of noncompliance reported in the draft report is described as "a computer file containing 86,533 student-months representing all claims provided by school-based health providers in New Jersey with payment dates from July 27, 2003, through October 4, 2006." The sample unit was an individual student-month representing all services provided to an individual student for a month during the audit period that were billed for Federal Medicaid reimbursement by Maximus.

Despite the heterogeneity of types of claims filed and likely correlations among types of claims and types of claim deficiencies and disability groups, the only variable used to define the sampling frame for the audit was the level of reimbursement. The population of student-months identified for the audit was stratified in this way:

Table 1. OIG sample results and estimates

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 (<$1400)	70,445	$16,332,459	50	$11,202	28	$4,830
2 (>$1400)	16,088	$15,891,145	50	$50,881	25	$14,679
Total	86,553	$32,223,604	100	$62,083	53	$19,509

This sampling frame does not accurately estimate noncompliant claims because key factors likely to be highly correlated with noncompliance estimates such as type of service--rehabilitation, evaluation, and transportation--and disability groups are not taken into account along with the dollar amount of the claims.

Even this 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 Table 2, this was not done for this analysis. The total value of claims in Stratum 1 was 51% of the total. In the sample, however, the value of claims for Stratum 1 was only 18 % of the total value. The sample that was drawn does not accurately reflect the relative value of claims in each stratum.

Table 2. 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	70,445	$16,332,459	51%	50	$11,202	18%	28	$4,830
2	16,088	$15,891,145	49%	50	$50,881	82%	25	$14,679
Total	86,553	$32,223,604	100%	100	$62,083	100%	53	$19,509

The draft report is silent as to the justification for selecting a sample size of only 50 student-month claims from a stratum with a total of 70,445 student-months and a sample size of only 50 student-month claims from a stratum with a total of 16,088 student-months for a total of only 100 student-month claims from a total of 86,533 student-month claims. These samples do not appear large enough for an accurate estimate of overpayment for unallowable school-based Medicaid claims in New Jersey. As discussed in the analysis of the sampling methodology, 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 the results found for this very small sample of claims generalize across the entire population of school-based Medicaid claims in New Jersey during the period under investigation.

The sampling frame chosen for this investigation does not seem adequate to provide a valid estimate of the amount of overpayment associated with unallowable claims for school-based 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.

Analysis of Citations for no Referral

The State does not concur with the auditor's interpretation of acceptable referral documentation. The audit results cited instances where a student's referral was determined to be outdated. There is no definitive guidance as to how long a referral from a qualified physician or licensed practitioner is valid to support services, as per the federal Medicaid guidelines at 42 CFR§ 440.110(c). The New Jersey State Plan does not have any limitations on the dates for referrals, and does not contradict CMS regulations. Therefore, citations 1-4 and 1-10 where a referral was found on file but was deemed to be out of date should be reconsidered and discounted from the findings. For citation 1-4, the OIG was provided a copy of the referral for the four (4) ST services with a total FFP of $75.42; and for citation 1-10, the OIG was provided a copy of the referral(s) for the two (2) OT and two (2) PT services with a total federal financial participation (FFP) of $102.48.

Additionally, some of the citations, specifically 1-28, 2-15 and 2-29, are related to speech referrals that were made by individuals having the ASHA certification and not a NJ state license. While we agree that the provider of the referral did not have the NJ license, we believe that the federal standard is to accept the ASHA certification for speech therapy. Therefore those referrals should be deemed in compliance. For citation 1-28 there are six (6) ST services with a total FFP of $163.21 that we believe should be allowed; for citation 2-15 there are five (5) ST services with a total FFP of $408.03 that we believe should be allowed; and for citation 2-29 there are seven (7) ST services with a total FFP of $175.98 that we believe should be allowed.

In addition, the audit results did not indicate what serves as acceptable documentation of a referral for services. In some cases, the IEP was indicated as being the source of referral. However, there is no indication of other documentation that was accepted by the team. For the purposes of this audit, further guidance should be given to the State as to what documentation is acceptable for the purposes of substantiating a referral for services. The districts should then be allowed additional time to produce the documentation requested. Until further guidance can be provided, the fifteen claims cited strictly for a lack of referral should be put aside and discounted from the findings, for a total FFP of $377.10. Citation numbers for this issue include 1-2 and 1-25.

Additional Documentation Provided to the OIG – the OIG Agrees that the Services are Allowable

Additional documentation to support citations 1-27, 2-32, and 2-45 was located and forwarded to the auditor, who agreed that the following services are allowable:

- Three (3) OT services for citation 1-27 - total FFP is $75.82
- Fifteen (15) ST services for citation 2-32 – total FFP is $1,224.08
- Six (6) PT services for citation 2-32 - total FFP is $244.82 (3 PT overlaps with 15 ST)
- Three (3) PT services for citation 2-45 - total FFP is $244.82

Attendance
In citation 2-39 there was service documentation in place, but the attendance data did not match, per the auditor. It seems the service documentation should take precedence, and that this is a valid claim. There are multiple reasons that attendance data may be in error, including attendance policy discrepancies and system and logistical challenges in collecting and maintaining attendance data. Valid service documentation data should be accepted as proof of service delivery. Therefore, we believe that the 1 counseling service with a total FFP of $81.61 should be allowed.

II. RECOMMENDATION:

New Jersey should provide proper and timely guidance on Federal Medicaid criteria to its school-based health providers.

RESPONSE:

New Jersey has taken a number of steps to provide guidance to the school districts. Several staff are devoted to administering the project, including coordination of relevant State agency efforts and communication to school districts. This includes an updated provider manual, a reference website, and training sessions. Since the time period of this audit, New Jersey has taken additional steps including:

- The State issued a competitive bid process and in 2005 hired a new vendor to administer the project. Together we have updated the Handbook which now includes citations to both Federal and State guidelines.
- Training sessions are done both regionally and on a one-on-one basis with district administrators.
- Regional meetings are held twice a year and are well attended by districts. The vendor is required to cover the regulations of the program at these meetings.
- In addition, each district submitting claims has participated in an administrator training with the vendor, where the regulations are covered directly with the district.
- The State updated the reference website to now include the Provider Handbook, as well as other policy documents that explicitly state how to correctly implement the program.
- The vendor has provided a toll free number and an online message board for districts to access.
- The State implemented an electronic tool for school districts to use to document health related services and implemented mandatory compliance checks where districts provide additional data before claims are processed.

III. RECOMMENDATION:

New Jersey should improve its monitoring of school-based health providers' claims to ensure compliance with Federal and State requirements.

RESPONSE:

New Jersey has improved its monitoring of the school-based health providers. The current vendor has implemented stronger post claiming quality assurance procedures, which includes a yearly on-site monitoring of a sample set of districts provided by the State. Any lapses in compliance are explicitly stated to the district with suggestions on how to align their internal processes to match Federal and State regulations. Claims that do not comply with Federal and State requirements are appropriately adjusted.

The professionalism and courtesy of the auditors throughout this audit is noteworthy and greatly appreciated. The opportunity to review and comment on this draft audit report is also greatly appreciated. If you have any questions or require additional information, please contact me or David Lowenthal at 609-588-7933.

Sincerely,

John R. Guhl
Director

JRG:L
c: Jennifer Velez
David Lowenthal