DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

March 21, 2012

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

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver at Bancroft NeuroHealth From January 1, 2005, Through December 31, 2007 (A-02-09-01034)

Attached, for your information, is an advance copy of our final report on Medicaid payments for services provided under New Jersey's section 1915(c) Community Care Waiver at Bancroft NeuroHealth. 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-02-09-01034.

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

March 22, 2012

Report Number: A-02-09-01034

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 and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver at Bancroft NeuroHealth From January 1, 2005, Through December 31, 2007*. 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 Brenda Tierney, Audit Manager, at (518) 437-9390, extension 222, or through email at Brenda.Tierney@oig.hhs.gov. Please refer to report number A-02-09-01034 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 PAYMENTS FOR SERVICES PROVIDED UNDER NEW JERSEY'S SECTION 1915(C) COMMUNITY CARE WAIVER AT BANCROFT NEUROHEALTH FROM JANUARY 1, 2005, THROUGH DECEMBER 31, 2007

Daniel R. Levinson
Inspector General

March 2012
A-02-09-01034

Office of Inspector General

http://oig.hhs.gov

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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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.

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 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 a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

Section 1915(c) of the Act authorizes Medicaid home and community-based services (HCBS) waiver programs. A State's HCBS waiver program must be approved by CMS and allows a State to claim Federal reimbursement for services not usually covered by Medicaid.

The New Jersey Department of Human Services (State agency) administers New Jersey's (the State) Medicaid program and provides oversight for compliance with Federal requirements. The State's Community Care Waiver (CCW) program allows the State agency to claim Medicaid reimbursement for HCBS provided to mentally retarded or developmentally disabled individuals who would otherwise require institutionalization in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

The State agency administers the CCW program through its Division of Developmental Disabilities (division). Under the CCW program, each beneficiary is required to have a plan of care (individual habilitation plan) and a level-of-care assessment completed every 12 months. For an individual to be assessed as eligible for the CCW program, a qualified mental retardation professional must certify that the beneficiary is assessed to need an ICF/MR level of care. The division must maintain documentation of each habilitation plan and assessment for at least 3 years.

During calendar years 2005 through 2007, the State agency claimed Federal reimbursement totaling $1.4 billion for services provided under the CCW program. During this period, Bancroft NeuroHealth (Bancroft), a CCW program service provider located in Haddonfield, New Jersey, received Medicaid reimbursement for 7,057 beneficiary-months totaling $41.6 million ($20.8 million Federal share). A beneficiary-month includes all CCW program services for a State beneficiary for 1 month.

OBJECTIVE

Our objective was to determine whether the State agency's claim for Medicaid reimbursement for CCW program services provided by Bancroft complied with certain Federal and State requirements.

SUMMARY OF FINDINGS

The State agency claimed Federal Medicaid reimbursement for some CCW program services provided by Bancroft that did not comply with certain Federal and State requirements. Of the 113 beneficiary-months in our random sample, the State agency properly claimed Medicaid reimbursement for all CCW program services in 40 beneficiary-months. However, the State agency claimed Medicaid reimbursement for services that were not allowable for the remaining 73 beneficiary-months. Specifically, services totaling $116,364 (Federal share) in 73 beneficiary-months did not comply with certain Federal and State requirements. Of these 73 beneficiary-months, 34 contained more than 1 deficiency.

The claims for unallowable services were made because: (1) Bancroft and the division did not ensure that they only claimed for documented, allowable CCW program services, (2) the division did not ensure that CCW program services were provided only to beneficiaries with completed and approved individual habilitation plans, and (3) the division did not ensure and document that all beneficiaries were assessed and certified to require an ICF/MR level of care.

Based on our sample results, we estimated that the State agency improperly claimed $2,654,293 in Federal Medicaid reimbursement for CCW program services provided by Bancroft that did not comply with certain Federal and State requirements during calendar years 2005 through 2007.

RECOMMENDATIONS

We recommend that the State agency:

- refund $2,654,293 to the Federal Government;
- require Bancroft and the division to ensure that they only claim for documented, allowable CCW program services;
- require the division to ensure that CCW program services are provided only to beneficiaries for whom there is a completed and approved individual habilitation plan; and
- require the division to ensure and document that all CCW program beneficiaries approved for services have been assessed and certified to need an ICF/MR level of care.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with part of our first recommendation and described actions that it has taken or planned to take to address the remaining findings and recommendations. Under separate cover, the State agency provided additional documentation to support services that we questioned in our draft report for lacking adequate documentation. In addition, the State agency disagreed with our findings related to incomplete individual habilitation plans and CCW program services provided to beneficiaries

who were not assessed and certified to require an ICF/MR level of care. Specifically, the State agency indicated that a habilitation plan coordinator's signature in the attendance section of the beneficiary's individual habilitation plan indicated that the plan was complete and demonstrated that the beneficiary's level of care determination had been recertified.

After reviewing the State agency's comments and additional documentation, we revised our findings regarding inadequate documentation and modified our statistical estimates accordingly. We maintain that our remaining findings are valid. Regarding the State agency's comments that a signature in the attendance section of the beneficiary's individual habilitation plan indicated that the plan was complete and demonstrated that the beneficiary's level of care determination had been recertified, we note that this section of the plan is distinct from the "**Community Care Waiver Certification**" (emphasis in original) section on the same page of the plan. The section indicated in the State agency's comments is listed as being intended for attendance purposes, whereas the certification section includes a space for qualified mental retardation professionals to certify that they have reviewed the plan and determined that the beneficiary "continues to have functional limitations and requires active treatment and ICF/MR level services" for a specific period. In every individual habilitation plan where we found an absence of qualified mental retardation professional approval or certification, the "Community Care Waiver Certification" was unsigned.

The State agency's comments appear as Appendix D, except for a spreadsheet containing personally identifiable information.

TABLE OF CONTENTS

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 a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements. The New Jersey Department of Human Services (State agency) administers New Jersey's (the State) Medicaid program and provides oversight for compliance with Federal requirements.

Home and Community-Based Services Waivers

Section 1915(c) of the Act authorizes Medicaid home and community-based services (HCBS) waiver programs. A State's HCBS waiver program must be approved by CMS and allows a State to claim Federal reimbursement for services not usually covered by Medicaid. HCBS are generally provided to Medicaid-eligible beneficiaries in the community rather than an institutional setting.

Section 1915(c)(1) of the Act and Federal regulations (42 CFR § 441.301(b)(1)(iii)) provide that HCBS may be provided only to recipients who have been determined would, in the absence of such services, require the Medicaid covered level of care provided in a hospital, a nursing facility, or an intermediate care facility for persons with mental retardation. Pursuant to section 1915(c)(1) of the Act and Federal regulations (42 CFR § 441.301(b)(1)(i)), HCBS must be furnished under a written plan of care subject to approval by each State's State agency. In addition, Federal regulations (42 CFR § 441.302(c)) require a State agency to provide for an initial evaluation of the recipient's need for the level of care that would be provided in an institution unless the individual receives HCBS. The regulations further require at least annual reevaluations of each recipient receiving HCBS.

According to section 4442.6 of CMS's *State Medicaid Manual*, an assessment of the individual to determine the services needed to prevent institutionalization must be included in the plan of care. In addition, the plan of care must specify the medical and other services to be provided, their frequency, and the type of provider. No Federal financial participation is available under a section 1915(c) waiver for HCBS furnished without a written plan of care.

New Jersey's Community Care Waiver Program

The State's HCBS waiver program includes the Community Care Waiver (CCW) program, which is administered by the State agency through its Division of Developmental Disabilities (division). The division is responsible for the implementation and operation of the CCW

program.[1] The CCW program allows the State agency to claim Medicaid reimbursement on a fee-for-service basis for HCBS provided to mentally retarded or developmentally disabled individuals who would otherwise require institutionalization in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Most of the CCW program services are provided through State contracts with private organizations or individuals.[2]

According to the State's waiver agreement with CMS, to be eligible for the State's CCW program, a beneficiary must be a Medicaid recipient, be diagnosed as mentally retarded or developmentally disabled, and be assessed to need an ICF/MR level of care. In addition, each beneficiary is required to have a plan of care (individual habilitation plan) and a level-of-care assessment completed every 12 months. For the assessment, a qualified mental retardation professional, who may be employed by either the service provider or the division, must certify that the beneficiary was assessed to need an ICF/MR level of care. The division must maintain documentation of each individual habilitation plan and assessment for at least 3 years. The State agency must also ensure financial accountability for funds expended for HCBS, as well as maintain appropriate financial records documenting the cost of services provided under the waiver.

During calendar years 2005 through 2007, the State agency claimed Federal reimbursement totaling $1.4 billion for services provided under the CCW program.

Bancroft NeuroHealth

Bancroft NeuroHealth (Bancroft), located in Haddonfield, New Jersey, provides individual support, day programs, and supported employment services for people with developmental disabilities and medical challenges. Bancroft was the second largest provider of services under the State's CCW program during calendar years 2005 through 2007. During this period, Bancroft received Medicaid reimbursement for CCW program services totaling $41.6 million ($20.8 million Federal share).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's claim for Medicaid reimbursement for CCW program services provided by Bancroft complied with certain Federal and State requirements.

[1] According to its waiver agreement with CMS, the State agency's Division of Medical Assistance and Health Services has "final responsibility" for the oversight of the program.

[2] The CCW program includes case management, respite care, day habilitation (assistance with improvement in self-help, socialization, and adaptive skills in a nonresidential setting), supported employment, environmental and vehicle adaptation, personal emergency response systems, individual support (in a residential facility or a beneficiary's home), and integrated therapies services.

Scope

Our review covered the State agency's claims for Medicaid reimbursement for HCBS provided to State residents by Bancroft under the CCW program during calendar years 2005 through 2007. During this period, the State agency claimed $41.6 million ($20.8 million Federal share) for services provided by Bancroft in 7,057 beneficiary-months.[3] We will be issuing a separate report (A-02-09-01033) on CCW service claims submitted by Elwyn New Jersey from January 1, 2005, through December 31, 2007.

The scope of our audit did not require us to perform a medical review or an evaluation of the medical necessity for the services that Bancroft provided and claimed for reimbursement.

We did not assess the State agency's overall internal control structure or all the internal controls over the CCW program. Rather, we limited our review of internal controls to those applicable to our objective. We reviewed Bancroft's and the division's internal controls for documenting CCW program services billed and claimed for reimbursement. We did not assess the appropriateness of HCBS payment rates.

We performed our fieldwork at Bancroft's offices in Haddonfield, New Jersey, and at the division's office in Trenton, New Jersey.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State Medicaid HCBS waiver laws, regulations, and guidance;

- met with CMS financial and program management officials to gain an understanding of the HCBS waiver approval, administration, and assessment processes;

- met with State agency officials to discuss the State agency's administration and monitoring of the CCW program;

- interviewed Bancroft and division officials regarding their CCW program policies and procedures;

- reconciled the CCW program services claimed for Federal reimbursement by the State agency on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, to the population of all payments for CCW program services made to providers statewide obtained from the State's Medicaid Management Information System for the quarter ended June 30, 2007;

[3] A beneficiary-month includes all CCW program services for a beneficiary for 1 month. A beneficiary-month could include multiple services.

- obtained from the State's Medicaid Management Information System a sampling frame of 7,057 beneficiary-months with CCW program services for which Bancroft claimed reimbursement totaling $41.6 million ($20.8 million Federal share) from January 1, 2005, through December 31, 2007;

- selected a stratified random sample of 113 beneficiary-months from the sampling frame of 7,057 beneficiary-months and for each beneficiary-month:

  - determined whether the beneficiary was assessed by a qualified mental retardation specialist to be eligible for the CCW program,

  - determined whether CCW program services were provided in accordance with an approved individual habilitation plan,

  - determined whether the staff members who provided the services met qualification and training requirements,

  - determined whether documentation supported the CCW program services billed, and

  - identified services that were not provided or documented in accordance with Federal and State requirements;

- estimated the unallowable Federal Medicaid reimbursement paid in the total population of 7,057 beneficiary-months; and

- provided the results of our review to Bancroft officials.

Appendix A contains the details of our sample design and methodology. Appendix B 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 objectives. 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 agency claimed Federal Medicaid reimbursement for some CCW program services provided by Bancroft that did not comply with certain Federal and State requirements. Of the 113 beneficiary-months in our random sample, the State agency properly claimed Medicaid reimbursement for CCW program services in 40 beneficiary-months. For the remaining 73 beneficiary-months, the State agency improperly claimed Medicaid reimbursement totaling $116,364 (Federal share) for services that did not comply with certain Federal and State requirements. Of the 73 beneficiary-months, 34 contained more than 1 deficiency, for a total of

121 deficiencies. Appendix C contains a summary of deficiencies, if any, identified for each sampled beneficiary-month.

The claims for unallowable services were made because: (1) Bancroft and the division did not ensure that they only claimed for documented, allowable CCW program services; (2) the division did not ensure that CCW program services were provided only to beneficiaries with completed and approved individual habilitation plans; and (3) the division did not ensure and document that all beneficiaries were assessed and certified to require an ICF/MR level of care.

Based on our sample results, we estimated that the State agency improperly claimed $2,654,293 in Federal Medicaid reimbursement for CCW program services provided by Bancroft that did not comply with certain Federal and State requirements during calendar years 2005 through 2007.

UNALLOWABLE COMMUNITY CARE WAIVER PROGRAM SERVICES

Services Not Documented

Section 1902(a)(27) of the Act (42 U.S.C. § 1396a(a)(27)) mandates that States have agreements with Medicaid providers under which providers agree to keep such records as are necessary to disclose fully the extent of the services provided to individuals receiving assistance under the State plan. Pursuant to Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Tribal Governments*, Att. A, § C.1.j (2 CFR § 225, App. A § C.1.j), costs must be adequately documented to be allowable under Federal awards. According to section 2500.2 of CMS's *State Medicaid Manual*, States are to report only expenditures for which all supporting documentation, in readily reviewable form, has been compiled and that is immediately available when the claim is filed.[4]

For 52 beneficiary-months, the State agency claimed reimbursement for services that were not adequately documented. For these services, Bancroft did not maintain service notes to support the services billed.

Individual Habilitation Plan Not Complete or Available

Pursuant to section 1915(c)(1) of the Act and Federal regulations (42 CFR § 441.301(b)(1)(i)), HCBS are to be provided only under a written plan of care subject to approval by a State Medicaid agency. According to the State's waiver agreement with CMS, an eligible CCW program beneficiary must have an individual habilitation plan completed by a qualified mental retardation professional every 12 months, and the division and the CCW program service provider must maintain documentation of the individual habilitation plans for at least 3 years.

For 35 beneficiary-months, the State agency claimed reimbursement for services provided to beneficiaries for whom neither the division nor Bancroft could provide approved or complete

[4] Supporting documentation includes at a minimum the following: date of service; name of recipient; Medicaid identification number; name of provider agency and person providing the service; nature, extent, and units of service; and place of service.

individual habilitation plans. Specifically, 32 individual habilitation plans were not approved by qualified mental retardation professionals, 2 were missing pages, and 1 was not provided.

Level-of-Care Assessment Not Documented

Pursuant to section 1915(c)(1) of the Act and 42 CFR § 441.301(b)(1)(iii), HCBS are to be provided only to a recipient who would, in the absence of these services, need the Medicaid level of care provided in a hospital, nursing facility, or ICF/MR. Federal regulations (42 CFR §§ 441.302(c) and 441.303(c)) require a State agency to provide for an initial evaluation and periodic reevaluations, at least annually, of the recipient's need for the level of care that would be provided in an institution unless the individual receives HCBS. According to the State's waiver agreement with CMS, an eligible CCW program beneficiary must be assessed and certified by a qualified mental retardation professional to need an ICF/MR level of care every 12 months, and the division must maintain documentation of the assessments for at least 3 years.

For 33 beneficiary-months, the State agency claimed reimbursement for CCW program services provided to beneficiaries for whom the ICF/MR level-of-care assessment was not approved by a qualified mental retardation professional.

Waiver Services Not Provided

Section 1902(a)(27) of the Act (42 U.S.C. § 1396a(a)(27)) mandates that States have agreements with Medicaid providers under which providers agree to keep such records as are necessary to disclose fully the extent of the services provided to individuals receiving assistance under a State plan. According to section 2497.1 of CMS's *State Medicaid Manual*, Federal financial participation is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers.

For one beneficiary-month, the State agency claimed reimbursement for services under the CCW program that were not provided. Specifically, for the beneficiary-month, the beneficiary received day habilitation services. However, the services were billed to both the State's Medicaid program and the CCW program. Bancroft's records indicated that it used the reimbursement from the CCW program for another beneficiary's day habilitation services.

CAUSES OF UNALLOWABLE CLAIMS

The State agency did not ensure that it claimed reimbursement only for allowable and documented CCW program services provided by Bancroft. Specifically, for some services, Bancroft either did not maintain documentation to support the services billed or records indicating that services were provided. Because of its cost reimbursement contract with the division, Bancroft received fixed monthly payments based on an annual budget regardless of how many beneficiaries it served. The division, through the State agency, claimed reimbursement under the CCW program based on Bancroft's monthly attendance reports but did not verify that the services were actually provided or adequately documented in daily training records and progress notes.

In addition, the division did not ensure that individual habilitation plans were complete and approved for CCW program services. The division also did not ensure and document that all CCW program beneficiaries were assessed and certified to need an ICF/MR level of care. Specifically, for some beneficiaries, the CCW certification section of the individual habilitation plan was incomplete, and no other documentation was available to indicate that the required annual level-of-care assessment was performed. For our audit period, the State agency did not have a standard form for assessing a program applicant's level of care, and the CCW certification section of the individual habilitation plan was the only documentation of the beneficiary's need for an ICF/MR level of care.[5]

RECOMMENDATIONS

We recommend that the State agency:

- refund $2,654,293 to the Federal Government;

- require Bancroft and the division to ensure that they only claim for documented, allowable CCW program services;

- require the division to ensure that CCW program services are provided only to beneficiaries for whom there is a completed and approved individual habilitation plan; and

- require the division to ensure and document that all CCW program beneficiaries approved for services have been assessed and certified to need an ICF/MR level of care.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with part of our first recommendation and described actions that it has taken or planned to take to address the remaining findings and recommendations. Under separate cover, the State agency provided additional documentation to support services that we questioned in our draft report for lacking adequate documentation.

In addition, the State agency disagreed with our findings related to incomplete individual habilitation plans and CCW program services provided to beneficiaries who were not assessed and certified to require an ICF/MR level of care. Specifically, the State agency indicated that a habilitation plan coordinator's signature in the attendance section of the beneficiary's individual habilitation plan indicated that the plan was complete and the level of care determination had been recertified.

The State agency's comments appear as Appendix D, except for a spreadsheet containing personally identifiable information.

[5] The State agency issued a Self Care Assessment Tool in November 2005, but it was not approved by CMS until after our audit period.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments and additional documentation, we revised our findings regarding inadequate documentation and modified our statistical estimates accordingly. We maintain that our remaining findings are valid.

Regarding the State agency's comments that a signature in the attendance section of the beneficiary's individual habilitation plan indicated that the plan was complete and demonstrated that the beneficiary's level of care determination had been recertified, we note that this section of the plan is distinct from the "**Community Care Waiver Certification**" (emphasis in original) section on the same page of the plan. The section described in the State agency's comments is listed as being intended for attendance purposes, whereas the certification section includes a space for qualified mental retardation professionals to certify that they have reviewed the plan and determined that the beneficiary "continues to have functional limitations and requires active treatment and ICF/MR level services" for a specific period. In every individual habilitation plan where we found an absence of qualified mental retardation professional approval or certification, the "Community Care Waiver Certification" was unsigned.

APPENDIXES

APPENDIX A: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of beneficiary-months of service provided by Bancroft NeuroHealth (Bancroft) for which the New Jersey Department of Human Services (State agency) received Medicaid reimbursement under New Jersey's Community Care Waiver (CCW) program during calendar years 2005 through 2007.

SAMPLING FRAME

The sampling frame was an Access file containing 7,057 beneficiary-months of service totaling $41,640,164 ($20,820,082 Federal share). The data for beneficiary-months of service under the New Jersey CCW program were extracted from the New Jersey Medicaid Management Information System.

SAMPLE UNIT

The sample unit was a beneficiary-month during calendar years 2005 through 2007 for which the State agency claimed Medicaid reimbursement for services provided by Bancroft under the CCW program. A beneficiary-month is defined as all CCW program services for one beneficiary for 1 month.

SAMPLE DESIGN

We used a stratified random sample to review Medicaid payments made for services provided by Bancroft on behalf of beneficiaries enrolled in the New Jersey CCW program. To accomplish this, we separated the sampling frame into three strata, as follows:

- Stratum 1: beneficiary-months with total payments less than or equal to $5,000—1,869 beneficiary-months totaling $4,194,810 ($2,097,405 Federal share).

- Stratum 2: beneficiary-months with total payments greater than $5,000 and less than or equal to $10,000—5,175 beneficiary-months totaling $37,305,344 ($18,652,672 Federal share).

- Stratum 3: beneficiary-months with total payments greater than $10,000—13 beneficiary-months, totaling $140,010 ($70,005 Federal share).

SAMPLE SIZE

We selected a sample of 113 beneficiary-months of service, as follows:

- 50 beneficiary-months from stratum 1,

- 50 beneficiary-months from stratum 2, and

- 13 beneficiary-months from stratum 3.

SOURCE OF RANDOM NUMBERS

The source of the random numbers was the Office of Audit Services statistical software, RAT-STATS 2007. We used the random number generator for our stratified random sample.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each of the first two strata. After generating 50 random numbers for each stratum, we selected the corresponding frame items. We selected for review all 13 beneficiary-months in stratum 3. We then created a list of 113 sampled items.

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate our estimates. We used the lower limit of a 90-percent confidence interval to estimate the overpayment associated with the unallowable services in the beneficiary-months.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Stratum	Beneficiary-Months in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Beneficiary-Months With Unallowable Services	Value of Unallowable Services (Federal Share)
1	1,869	$2,097,405	50	$56,222	38	$29,329
2	5,175	$18,652,672	50	$178,159	24	$28,311
3	13	$70,005	13	$70,005	11	$58,724
Total	**7,057**	**$20,820,082**	**113**	**$304,386**	**73**	**$116,364**

Estimated Value of Unallowable Services (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	$4,085,242
Lower Limit	$2,654,293
Upper Limit	$5,516,190

APPENDIX C: SUMMARY OF DEFICIENCIES FOR EACH SAMPLED BENEFICIARY-MONTH

Legend

1	Services Not Documented
2	Individual Habilitation Plan Not Complete or Available
3	Level-of-Care Assessment Not Documented
4	Services Not Provided

Office of Inspector General Review Determinations for the 113 Sampled Beneficiary-Months

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

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S1-33					0
S1-34	X				1
S1-35	X	X	X		3
S1-36	X	X	X		3
S1-37	X				1
S1-38					0
S1-39	X				1
S1-40	X				1
S1-41	X				1
S1-42	X				1
S1-43	X				1
S1-44	X				1
S1-45	X				1
S1-46					0
S1-47	X				1
S1-48					0
S1-49		X	X		2
S1-50					0
S2-1	X				1
S2-2	X				1
S2-3					0
S2-4	X	X	X		3
S2-5	X				1
S2-6					0
S2-7					0
S2-8					0
S2-9					0
S2-10					0
S2-11					0
S2-12		X	X		2
S2-13					0
S2-14					0
S2-15					0
S2-16					0
S2-17	X				1
S2-18		X	X		2
S2-19					0
S2-20				X	1
S2-21					0
S2-22					0
S2-23	X				1
S2-24	X	X	X		3
S2-25		X	X		2

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S2-26	X				1
S2-27	X				1
S2-28					0
S2-29	X				1
S2-30	X	X	X		3
S2-31					0
S2-32					0
S2-33	X				1
S2-34					0
S2-35	X				1
S2-36					0
S2-37					0
S2-38	X				1
S2-39	X				1
S2-40	X				1
S2-41					0
S2-42					0
S2-43					0
S2-44					0
S2-45	X				1
S2-46	X				1
S2-47	X				1
S2-48					0
S2-49	X				1
S2-50					0
S3-1		X	X		2
S3-2		X	X		2
S3-3		X	X		2
S3-4					0
S3-5		X	X		2
S3-6		X	X		2
S3-7		X	X		2
S3-8		X	X		2
S3-9		X	X		2
S3-10		X	X		2
S3-11		X	X		2
S3-12		X	X		2
S3-13					0
Category Totals	**52**	**35**	**33**	**1**	**121**
73 Beneficiary-Months in Error					

APPENDIX D: STATE AGENCY COMMENTS

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

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

JENNIFER VELEZ
Commissioner

VALERIE HARR
Director

September 16, 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 K. Javits Federal Building
26 Federal Plaza – Room 3900
New York, NY 10278

Report Number: A-02-09-01034

Dear Mr. Edert:

This serves as response to your letter dated July 20, 2011 concerning the Department of Health and Human Services, Office of the Inspector General's (OIG) draft report entitled "Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915 (c) Community Care Waiver by Bancroft NeuroHealth New Jersey from January 1, 2005 through December 31, 2007." Your letter provides the opportunity to comment on the draft report.

The objective of this review was to determine whether the Division of Medical Assistance and Health Services (DMAHS) claim for Medicaid reimbursement for Community Care Waiver (CCW) program services provided by Bancroft NeuroHealth (Bancroft) complied with certain Federal and State requirements.

The draft audit report concluded that New Jersey's claims for reimbursement for some CCW program services provided by Bancroft did not fully comply with certain Federal and State requirements. While 38 beneficiary-months of the 113 beneficiary-months in the random sample were properly claimed for Medicaid reimbursement for all CCW program services, the remaining 75 beneficiary-months were not allowable for Medicaid reimbursement for services. The draft report states that claims for unallowable services were made because (1) Bancroft and the Division did not ensure that they only claimed for documented, allowable CCW program services, (2) the Division did not ensure that CCW program services were provided only to beneficiaries with completed and approved IHPs (IHP), and (3) the Division did not ensure and document that all

beneficiaries were assessed and certified to require an ICF/MR level of care. Based upon the sample results, the auditor estimated that the State agency was improperly reimbursed $2,861.908 in Federal Medicaid funds for CCW program services provided by Bancroft during the calendar years 2005 through 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 and Health Services' responses:

Recommendation 1:

The OIG recommends that New Jersey refund $2,861,908 to the Federal Government:

The State concurs with some but not all of the findings concerning claims for unallowable community care waiver program services. The State respectfully requests that the amount of the refund be re-calculated based upon evidence retrieved from archived files demonstrating that services were rendered. The documentation for these claims has been forwarded to the auditor under separate cover. Our response to each of the auditor's findings is as follows:

UNALLOWABLE COMMUNITY CARE WAIVER PROGRAM SERVICES

Services Not Documented

Finding:

Section 1902(a)(27)(A) of the Act, 42 U.S.C. paragraph 1396(a)(27) mandates that States have agreements with Medicaid providers under which providers agree to keep such records as necessary to fully disclose the extent of the services provided to individuals receiving assistance under the State plan. Costs must be adequately documented in order to be allowable under Federal awards. For 54 beneficiary-months, the State agency claimed reimbursement for services that were not adequately documented. For these services, Bancroft did not maintain service notes to support the services billed.

Response:

The DMAHS concurs with some but not all of the auditor's findings. The State retrieved archived records (submitted under separate cover) that provide documentation of services rendered. See attached excel spreadsheet for summary of documentation. The Division respectfully requests that these cites be removed based upon the documentation provided.

Individual Habilitation Plan (IHP) Not Complete

Finding:

Pursuant to the State's waiver agreement with CMS, an eligible CCW program beneficiary must have an IHP completed by a QMRP (QMRP) every 12 months, and the Division and the CCW program services provider must maintain documentation of the IHPs for at least 3 years. For 38 beneficiary-months, the State agency claimed reimbursement for services provided to beneficiaries for whom neither the Division nor Bancroft could provide approved or complete IHPs. Specifically, 34 IHPs were not approved by QMRPs, 3 were missing pages, and 1 was not provided.

Response:

The DMAHS agrees with some, but not all of the auditor's findings. Several of the IHP's were approved by the habilitation plan coordinator (HPC). The signature of the HPC, the QMRP, was available in the top portion of the Attendance sheet. Please see documentation provided under separate cover and the attached summary sheet. The Division respectfully requests that these cites be removed based upon the documentation provided.

Level of Care Assessment Not Documented

Finding:

Pursuant to the State's waiver agreement with CMS, an eligible CCW program beneficiary must be assessed and certified by a QMRP to need ICF/MR level of care every 12 months, and the Division must maintain documentation of the assessments for at least 3 years. For 36 beneficiary-months, the State agency claims reimbursement for CCW program services provided to beneficiaries for whom the ICF/MR level-of-care assessment was not approved by a QMRP.

Response:

The DMAHS agrees with some, but not all of the auditor's findings. Several of the IHP's were approved and signed by the HPC, but the HPC did not also sign the ICF/MR recertification section. At the exit conference, the Division's Waiver Administrator indicated that the HPC is the QMRP and their signature in the attendance section demonstrates that the level of care determination has been re-certified. Service Plans that contain the QMRP signature in the attendance section have been provided under separate cover. Please refer to the attached summary sheet for specifics.

The Division respectfully requests that these cites be removed based upon the documentation provided.

Services not provided

Finding:

Pursuant to section 2497.1 of the CMS's State Medicaid Manual, Federal financial participation is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. For one beneficiary-month, the State agency claimed reimbursement for services under the CCW program that were not provided. Specifically, for the beneficiary-month, the beneficiary received day habilitation services. However, the services were billed to both the State's Medicaid program and the CCW program. Bancroft's records indicated that it used the reimbursement from the CCW program for another beneficiary's day habilitation services.

Response:

The DMAHS agrees with the auditor's findings.

CAUSES OF UNALLOWABLE CLAIMS

Recommendation 2:

The OIG recommends the New Jersey require Bancroft and the Division to ensure that they only claim for documented, allowable CCW program services.

Response:

For all cites where services were not documented Bancroft did not maintain service notes to support the services billed. Specifically, the Daily Training Records in day habilitation programs conflicted with the attendance record. The Division will provide a written statement to Bancroft regarding the requirement that daily Training Records must be recorded daily in order to be consistent with the attendance records. In addition, the Division will provide training to Bancroft day training supervisors regarding documentation of services and consistency between documents (e.g., daily training records and attendance records).

Recommendation 3:

The OIG recommends that New Jersey require the Division to ensure that CCW program services are provided only to beneficiaries for whom there is a completed and approved IHP.

Recommendation 4:

The OIG recommends that New Jersey require the Division to ensure and document that all CCW program beneficiaries approved for services have been assessed and certified to need an ICF/MR level of care.

Response to Recommendations 3 & 4:

The Division submits that in conjunction with the DMAHS and the Division's Waiver Administrators for the other four (4) 1915(c) Home and Community Based Services Waivers, mandatory trainings were conducted for all case managers statewide serving any of the 1915(c) HCBS waivers. The training addressed the six basic assurances. Level of Care and Service Planning for case managers were addressed in the training. This training was based upon the "Training for Case Managers: Home and Community-Based Services (HCBS) Waiver Assurances to Improve Quality" developed by the University of Southern Maine, Muskie School of Public Services, out of a contract with CMS. Trainings were conducted with case management supervisors on September 22, 2010 and September 24, 2010. Trainings were conducted with case managers on October 19, 2010, October 21, 2010. October 26, 2010 and December 14, 2010.

Additionally, the Division has implemented quality monitoring systems to ensure that Plans of Care are completed timely, and that individuals have been assessed and certified to need an ICF/MR level of care. An electronic platform that tracks two tiers of oversight was developed and is currently being implemented. This platform allows Case Management Supervisors to review monthly a five percent sampling of Plans of Care and ICF/MR Level of Care determinations in addition to the Community Care Waiver Monitor reviewing 268 cases annually. The Division is in the process of developing reports for these applications.

If you have any questions or require additional information, please contact me or Richard Hurd, Chief of Staff at 609-588-2550.

Sincerely,

Valerie Harr
Director

VH:H
c Jennifer Velez
Richard H. Hurd