DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

April 20, 2012

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

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver Program From January 1, 2005, Through December 31, 2007 (A-02-10-01029)

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 program. 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-02-10-01029.

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

April 23, 2012

Report Number: A-02-10-01029

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 Program 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-02-10-01029 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 PROGRAM FROM JANUARY 1, 2005, THROUGH DECEMBER 31, 2007

Daniel R. Levinson
Inspector General

April 2012
A-02-10-01029

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 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 individuals with intellectual and developmental disabilities. Without HCBS, these individuals would 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 (qualified specialist) must certify that the beneficiary was 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. In prior audits, we reviewed the two highest paid providers in the CCW program during this period. In this audit, we reviewed 281,014 beneficiary-months of service with a total Medicaid-paid amount greater than $100, totaling $1,273,784,688 ($636,892,344 Federal share), for the remaining providers in the CCW program. 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 claims for Medicaid reimbursement for CCW program services complied with certain Federal and State requirements.

SUMMARY OF FINDINGS

The State agency claimed Federal Medicaid reimbursement for some CCW program services that did not comply with certain Federal and State requirements. Of the 146 beneficiary-months in our random sample, the State agency properly claimed Medicaid reimbursement for all CCW program services in 23 beneficiary-months. However, the State agency claimed Medicaid reimbursement for services that were not allowable for the remaining 123 beneficiary-months. Of these 123 beneficiary-months, 28 contained more than 1 deficiency.

The claims for unallowable services were made because: (1) the division and most providers did not ensure that they claimed reimbursement only 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 $60,740,637 in Federal Medicaid reimbursement for CCW program services that did not comply with certain Federal and State requirements during calendar years 2005 through 2007.

RECOMMENDATIONS

We recommend that the State agency:

- refund $60,740,637 to the Federal Government;
- require the division and providers to ensure that they claim reimbursement only 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 specialists 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 a qualified specialist's approval or certification, the "Community Care Waiver Certification" was unsigned.

The State agency's comments appear in their entirety as Appendix D.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although 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 in 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 received 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 individuals with intellectual and developmental disabilities. Without HCBS, these individuals would 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 (qualified specialist), 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 (CY) 2005 through 2007, the State agency claimed Federal reimbursement for providers totaling $1.4 billion for services provided under the CCW program.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our review covered the State agency's claims for Medicaid reimbursement for HCBS provided under the CCW program during CYs 2005 through 2007. During this period, the State agency claimed $1,273,784,688 ($636,892,344 Federal share) for services provided in 281,014 beneficiary-months.[3]

[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 (short period of rest or relief for a caregiver); day habilitation (assistance with improvement in self-help, socialization, and adaptive skills in a nonresidential setting); supported employment (support to perform in a paid work setting); environmental and vehicle adaptation; personal emergency response systems; individual support (in a residential facility or a beneficiary's home); and integrated therapy services.

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

The scope of our audit did not require us to perform a medical review or an evaluation of the medical necessity for the services 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 the providers' 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 65 CCW provider offices throughout the State and at the division's offices in Trenton, New Jersey, from June 2010 to March 2011.

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 division and provider 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;

- obtained from the State's Medicaid Management Information System a sampling frame of 339,457 beneficiary-months with CCW program services for which the State agency claimed reimbursement totaling $1,389,894,715 ($694,947,358 Federal share) during CYs 2005 through 2007;

- removed all beneficiary-months for the two providers reviewed separately—Elwyn New Jersey and Bancroft NeuroHealth[4]—and all beneficiary-months of service with total Medicaid payments of less than or equal to $100 from our sampling frame;

[4] *Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver by Elwyn New Jersey From January 1, 2005, Through December 31, 2007* (A-02-09-01033, July 27, 2011) and *Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver by Bancroft NeuroHealth From January 1, 2005, Through December 31, 2007* (A-02-09-01034, March 22, 2012).

- determined that our revised sampling frame consisted of 281,014 beneficiary-months totaling $1,273,784,688 ($636,892,344 Federal share) during CYs 2005 through 2007;

- selected a stratified random sample of 146 beneficiary-months and for each beneficiary-month:

  - determined whether the beneficiary was assessed by a qualified 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; and

- estimated the unallowable Federal Medicaid reimbursement paid in the total population of 281,014 beneficiary-months.

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 performed by providers that did not comply with certain Federal and State requirements. Of the 146 beneficiary-months in our random sample, the State agency properly claimed Medicaid reimbursement for CCW program services in 23 beneficiary-months. For the remaining 123 beneficiary-months, the State agency improperly claimed Medicaid reimbursement totaling $446,554 ($223,277 Federal share) for services that did not comply with certain Federal and State requirements. Of these 123 beneficiary-months, 28 contained more than 1 deficiency, for a total of 157 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) the division and most providers did not ensure that they claimed reimbursement only 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 $60,740,637 in Federal Medicaid reimbursement for CCW program services performed by providers that did not comply with certain Federal and State requirements during CYs 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.[5]

For 120 beneficiary-months, the State agency claimed reimbursement for services that were not adequately documented. For these services, providers did not maintain service notes to support the services billed.

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 21 beneficiary-months, the State agency claimed reimbursement for services that were not provided. For these beneficiary-months, the State agency claimed reimbursement for both community support and respite care services when the beneficiary received only one of the two services. Specifically, the providers' records indicated that the community support services were

[5] 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.

not provided for 11 beneficiary-months and the respite care services were not provided for 10 beneficiary-months.

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 specialist 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 nine beneficiary-months, the State agency claimed reimbursement for some services provided to beneficiaries for whom neither the division nor the provider could provide approved or complete individual habilitation plans. Specifically, eight individual habilitation plans were not approved by qualified specialists and one individual habilitation plan was incomplete.

Level-of-Care Assessment Not Documented

Pursuant to section1915(c) 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, require 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 received HCBS. According to the State's waiver agreement with CMS, an eligible CCW program beneficiary must be assessed and certified by a qualified specialist 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 seven 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 specialist.

CAUSES OF UNALLOWABLE CLAIMS

The State agency did not ensure that it claimed reimbursement only for allowable and documented CCW program services provided by CCW providers. Specifically, for some services, providers did not maintain either documentation to support the services billed or records indicating that services were provided. In addition, the division did not ensure that individual habilitation plans were complete and approved for CCW program services.

Lastly, the division 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.[6]

RECOMMENDATIONS

We recommend that the State agency:

- refund $60,740,637 to the Federal Government;
- require the division and providers to ensure that they claim reimbursement only 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 in their entirety as Appendix D.

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.

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

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 specialists 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 a qualified specialist 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 with a total Medicaid-paid amount greater than $100 provided by Community Care Waiver (CCW) program providers for which the New Jersey Department of Human Services (State agency) received Medicaid reimbursement under New Jersey's CCW program during calendar years 2005 through 2007.

SAMPLING FRAME

The sampling frame was an Access file containing 281,014 beneficiary-months of service with a total Medicaid-paid amount greater than $100 totaling $1,273,784,688 ($636,892,344 Federal share). We eliminated from the sampling frame all beneficiary-months for the two highest paid providers of service in the State, Elwyn New Jersey and Bancroft NeuroHealth, which we reviewed separately. 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 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 to the State agency on behalf of beneficiaries enrolled in the New Jersey CCW program. To accomplish this, we separated the sampling frame into two strata, as follows:

- Stratum 1: beneficiary-months with total payments greater than $100 and less than or equal to $15,000—280,968 beneficiary-months totaling $1,273,065,349 ($636,532,675 Federal share).

- Stratum 2: beneficiary-months with total payments greater than $15,000—46 beneficiary-months, totaling $719,339 ($359,669 Federal share).

SAMPLE SIZE

We selected a sample of 146 beneficiary-months of service, as follows:

- 100 beneficiary-months from stratum 1 and

- 46 beneficiary-months from stratum 2.

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 the first stratum. After generating 100 random numbers for this stratum, we selected the corresponding frame items. We selected for review all 46 beneficiary-months in stratum 2. We then created a list of 146 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	280,968	$636,532,675	100	$226,058	77	$32,021
2	46	$359,669	46	$359,670	46	$191,256
Total	**281,014**	**$636,892,344**	**146**	**$585,728**	**123**	**$223,277**

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

Point Estimate	$90,160,370
Lower Limit	$60,740,637
Upper Limit	$119,580,104

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

Legend

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

Office of Inspector General Review Determinations for the 146 Sampled Beneficiary-Months

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

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S1-28	X				1
S1-29	X				1
S1-30					0
S1-31	X				1
S1-32	X				1
S1-33					0
S1-34					0
S1-35	X				1
S1-36	X				1
S1-37					0
S1-38	X				1
S1-39	X				1
S1-40					0
S1-41	X				1
S1-42					0
S1-43	X				1
S1-44	X				1
S1-45					0
S1-46	X				1
S1-47					0
S1-48					0
S1-49	X				1
S1-50	X				1
S1-51	X				1
S1-52	X				1
S1-53					0
S1-54	X				1
S1-55	X				1
S1-56	X				1
S1-57	X				1
S1-58	X				1
S1-59	X				1
S1-60		X	X	X	3
S1-61	X				1
S1-62	X				1
S1-63					0
S1-64	X				1

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S1-65	X				1
S1-66	X		X		2
S1-67	X				1
S1-68					0
S1-69	X				1
S1-70	X				1
S1-71	X				1
S1-72					0
S1-73	X				1
S1-74	X				1
S1-75	X				1
S1-76	X				1
S1-77	X		X	X	3
S1-78	X				1
S1-79	X				1
S1-80	X				1
S1-81					0
S1-82					0
S1-83	X				1
S1-84	X				1
S1-85	X				1
S1-86	X				1
S1-87	X		X	X	3
S1-88					0
S1-89					0
S1-90	X				1
S1-91	X				1
S1-92	X				1
S1-93	X		X	X	3
S1-94	X				1
S1-95	X				1
S1-96	X		X	X	3
S1-97	X				1
S1-98	X				1
S1-99	X				1
S1-100	X		X	X	3
S2-1	X				1

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S2-2	X				1
S2-3	X				1
S2-4	X				1
S2-5	X	X			2
S2-6	X	X			2
S2-7	X				1
S2-8	X				1
S2-9	X				1
S2-10	X				1
S2-11	X				1
S2-12	X				1
S2-13	X	X			2
S2-14	X	X			2
S2-15	X	X			2
S2-16	X				1
S2-17	X	X			2
S2-18	X	X			2
S2-19	X	X			2
S2-20	X				1
S2-21	X				1
S2-22	X				1
S2-23	X				1
S2-24	X	X			2
S2-25	X	X			2
S2-26	X	X			2
S2-27	X				1
S2-28	X				1
S2-29	X				1
S2-30	X				1
S2-31	X				1
S2-32	X				1
S2-33	X	X			2
S2-34	X	X			2
S2-35	X	X			2
S2-36	X	X			2
S2-37	X	X			2
S2-38		X			1

Sample Beneficiary-Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	No. of Deficiencies
S2-39	X	X			2
S2-40	X	X			2
S2-41	X	X			2
S2-42	X				1
S2-43	X				1
S2-44	X				1
S2-45	X				1
S2-46	X				1
Category Totals	**120**	**21**	**9**	**7**	**157**
123 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

October 20, 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-02-10-01029

Dear Mr. Edert:

This serves as response to your letter dated July 28, 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 From January 1, 2005, Through December 31, 2007."* Your letter provides the opportunity to comment on this 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 the Community Care Waiver (CCW) program complied with certain Federal and State requirements.

The draft audit report concluded that New Jersey's claims for reimbursement for some CCW program services did not fully comply with certain Federal and State requirements. While 14 beneficiary-months of the 146 beneficiary-months in the random sample were properly claimed for Medicaid reimbursement for all CCW program services, the remaining 132 beneficiary-months were not allowable for Medicaid reimbursement for services. Additionally, of these 132 beneficiary months, 34 contained more than 1 deficiency. The draft report states that claims for unallowable services were made because (1) the Division of Developmental Disabilities (Division) and most providers 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 ICF/MR level of care. Based upon the sample results, the auditor estimated that New Jersey was improperly reimbursed $90,363,264 in Federal Medicaid funds for CCW program services that did not comply with certain Federal and State requirements 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 $90,363,264 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 respectively requests that the amount of the refund be recalculated based upon the review of the supporting documentation retrieved by Division staff following the OIG Exit Conference. The majority of the supporting documentation was located in storage facilities where purged files are maintained. 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) of the Act, 42 U.S.C. paragraph 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. Costs must be adequately documented in order to be allowable under Federal awards. For 129 beneficiary-months, the State agency claimed reimbursement for some services that were not adequately documented. For these services, providers did not maintain service notes to support services billed.

Response:

The DMAHS concurs with some but not all of the auditor's findings. The state retrieved archived records that provide documentation of services rendered. See attached excel sheet and supporting documentation. The Division respectfully requests that these cites be removed based upon the documentation provided. †

Services Not Provided

Finding:

Pursuant to section 2497.1 of CMS's *State Medicaid Manual* states, Federal financial participation is available only for allowable actual expenditures made on behalf of eligible recipients for covered services rendered by certified providers. For 21 beneficiary-months, the State agency claimed Federal reimbursement for some services that were not provided. Claims were submitted for reimbursement for both respite care and community support services when the beneficiary only received one of the two services. Specifically, the providers' records

† Office of Inspector General note: The State agency provided the spreadsheet and supporting documentation under separate cover.

indicated that the community support services were not provided for 11 beneficiary months and the respite care services were not provided for 10 beneficiary months.

Response:

The DMAHS concurs with the auditor's findings. However, the Division identified a deficit in the system in late 2007 and built in an edit in the form of a pre-claim duplicative report that allows the Division to identify attendance records which are submitted for respite and individual supports provided to the same individual simultaneously. At that time, the provider agencies are contacted and verification is received for the actual service rendered before billing occurs. Billing is then claimed only for the correct service rendered. The errors noted occurred prior to the institution of the duplicative report for these procedure codes.

Individual Habilitation Plan Not Complete (IHP)

Finding:

Pursuant to the State's waiver agreement with CMS, an eligible CCW program beneficiary must have an individual habilitation plan completed every 12 months by a qualified mental retardation professional (QMRP), and the Division and the CCW program service provider must maintain documentation of the individual habilitation plans for at least 3 years. For 15 beneficiary months, the State agency claimed reimbursement for some services when neither the Division nor the provider could provide approved or completed individual habilitation plans.

Response:

The DMAHS agrees with some, but not all of the auditor's findings. Several of the IHPs were located in storage facilities and/or provider agencies storage facilities. Please see supporting documentation provided and noted on the excel chart. 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 qualified mental retardation professional 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 13 beneficiary months, the State agency claimed reimbursement for services provided to beneficiaries for whom the ICF/MR level of care assessment was not approved by a qualified mental retardation professional.

Response:

The DMAHS agrees with some, but not all of the auditors findings. Several of the IHPs were approved and signed by the habilitation plan coordinator (HPC), but the HPC did not also sign the ICF/MR recertification section. At the exit conference our Waiver Administrator, made the argument that the HPC is the Qualified Mental Retardation Professional and his/her 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. Please refer to the excel chart for specifics. The Division respectfully requests that these cites be removed based upon the documentation provided mitigating the findings. The Division maintains and respectfully requests that these cites be reconsidered for removal based upon the documentation provided that mitigates the findings.

CAUSES OF UNALLOWABLE CLAIMS

Recommendation 2:

The OIG recommends that the State agency require the Division and providers to ensure that they only claim for documented, allowable CCW program services:

Where services were not documented many of the deficiencies reflected a lack of a day program objective requiring daily training and documentation. Case Managers will be trained by the Quality Unit staff regarding the need for Day Habilitation programs to be in compliance with the Supported Employment/Day Program Manual. Additionally, the CCW Monitor reviews 288 cases annually. DDD modified the electronic application in October 2011 to capture day habilitation attendance reporting accuracy by the CCW Monitor.

Recommendations 3 and 4:

The OIG recommends that the State agency 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.

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

The Division submits that in conjunction with the DMAHS and the waiver administrators for the other four (4) 1915(c) Home and Community Based Service 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 Service 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 288 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 at 609-588-2550.

Sincerely.

Valerie Harr

Valerie Harr
Director

VH:H
c: Jennifer Velez
Richard Hurd
Maribeth Robenolt