Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW JERSEY SIGNIFICANTLY IMPROVED ITS OVERSIGHT OF MEDICAID ADULT PARTIAL CARE SERVICES EXCEPT FOR THOSE PROVIDED USING TELEHEALTH DURING THE COVID-19 PUBLIC HEALTH EMERGENCY

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Report in Brief
Date: March 2024
Report No. A-02-22-01007

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

New Jersey Significantly Improved Its Oversight of Medicaid Adult Partial Care Services Except for Those Provided Using Telehealth During the COVID-19 Public Health Emergency

Why OIG Did This Audit

During a prior audit of Medicaid adult partial care services, we found that New Jersey claimed Medicaid reimbursement for services that did not comply with Federal and State requirements. We recommended that New Jersey refund $94.8 million in Federal Medicaid funds, issue guidance to partial care providers, and improve its monitoring of providers. We performed this audit to determine if New Jersey improved its program oversight and implemented our prior audit recommendations. We included telehealth service performed during COVID-19.

Our objectives were to determine whether New Jersey adequately implemented the recommendations made in our prior audit report and ensured Medicaid adult partial care services complied with Federal and State requirements.

How OIG Did This Audit

Our audit covered $61.3 million in Federal Medicaid reimbursement for 1,378,671 adult partial care claims, that were paid from January 1, 2019, through December 31, 2020. We reviewed a stratified random sample of 100 claims to determine if claims for these services complied with Federal and State requirements.

For each sampled claim, we reviewed service documentation obtained from providers.

What OIG Found

New Jersey adequately implemented the procedural recommendations made in our prior report; however, New Jersey has not refunded our recommended disallowance of $94.8 million in Federal Medicaid funds.

Of the 100 claims in our sample, 56 claims complied with Federal and State requirements, but 44 claims did not. Most of the deficiencies we identified occurred because New Jersey misapplied Federal telehealth flexibilities by issuing guidance not approved by CMS that changed the rate for telehealth services. Based on our sample results, we estimated that New Jersey was improperly reimbursed at least $18.8 million in Federal Medicaid funds for adult partial care services that did not meet Federal and State requirements.

What OIG Recommends and New Jersey Comments

We recommend that New Jersey work with CMS to refund the recommended disallowance of $94.8 million from our prior audit, refund to the Federal Government $18.8 million associated with deficiencies identified in the current audit, and provide training or guidance to address noncompliance issues it identifies during site visits to ensure Medicaid enrollees receive required services with the necessary amount of care.

New Jersey disagreed with our monetary recommendations; however, it agreed with our recommendation that it provide training or guidance to providers. Regarding the current audit, New Jersey stated that reviewing telehealth claims was not part of the audit's objectives and that it did not need a Medicaid State plan amendment for the temporary per diem payment for telehealth services. For in-person services, New Jersey stated that providers maintained proper plans of care and daily documentation to support services provided.

After reviewing New Jersey's comments, we maintain that our findings and recommendations are valid. Our objective did not exclude telehealth claims. Also, New Jersey's Medicaid State plan amendment for the COVID-19 Public Health Emergency stated that the rate for telehealth claims would be the same as in-person services. Regarding in-person claims, we maintain that providers did not include services within plans of care or did not support the number of services claimed.

The full report can be found on the OIG website.

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INTRODUCTION

WHY WE DID THIS AUDIT

During a prior audit of Medicaid adult partial care services in New Jersey, we found that the New Jersey Department of Human Services (State agency) claimed Medicaid reimbursement for services that did not comply with Federal and State requirements.[1] We recommended that the State agency refund $94.8 million in Federal Medicaid funds, issue guidance to partial care providers, and improve its monitoring of providers to ensure compliance with Federal and State requirements. We performed this audit to determine if the State agency improved its program oversight and implemented our prior audit recommendations. Additionally, since New Jersey implemented telehealth services for its adult partial care program during the COVID-19 public health emergency (PHE), we included these services as part of this audit.

OBJECTIVES

Our objectives were to determine whether the State agency adequately implemented the recommendations made in our prior audit report and ensured Medicaid adult partial care services complied with Federal and State requirements.

BACKGROUND

Medicaid Program

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

New Jersey's Medicaid Adult Partial Care Program

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

[1] *New Jersey Claimed Medicaid Adult Mental Health Partial Care Services That Were Not in Compliance With Federal and State Requirements* (A-02-13-01029), issued Dec. 27, 2016.

Federal and State Requirements Related to Adult Partial Care Services

The Social Security Act (the Act) § 1903 establishes Federal grants payments to States for a proportion of expenditures for medical assistance under an approved Medicaid State plan. In July 2020, CMS approved New Jersey's disaster relief State Plan Amendment (SPA) (#NJ 20-0003), which added a section to New Jersey's Medicaid State plan on disaster relief for the COVID-19 PHE.[2] Section D(5) of the SPA states that, during the PHE, Medicaid would reimburse for any service provided via telehealth and associated telecommunication at the same rate that would have been paid had the service been provided in-person. If New Jersey wanted to reimburse telehealth services differently than in-person services, a separate SPA would have been required.[3] With the expiration of the PHE in May 2023, New Jersey no longer authorizes providers to render partial care services via telehealth.

Providers must meet State regulatory documentation requirements in order to receive reimbursement for services.[4] Providers must develop an individualized plan of care that describes the treatment and projected schedule for delivering adult partial care services.[5] Providers must also prepare written documentation of individual services on a daily basis, with progress documented weekly. Supporting documentation for each service billed must include type of service, date, time, duration, and rendering practitioner or provider.[6] Services must be adequately documented and fully disclose the nature and extent of the service provided.[7]

Prior to the PHE, the State agency reimbursed partial care services at a per-unit (hourly) rate of almost $18 with a maximum payment of about $90 for five units (hours). During the PHE, when the State agency issued guidance allowing telehealth for partial care services, it enabled providers to bill five units of partial care services with procedure code H0035GTUC to indicate that the services were provided using telehealth. According to State agency guidance, the five units represented a per diem rate; therefore, providers were paid about $90 regardless of whether they provided 5 minutes or 5 hours of service.[8]

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[2] CMS approved the SPA on July 23, 2020, with a retroactive effective date of Mar. 1, 2020.

[3] CMS Medicaid Guidance for Telehealth. Available online at: https://www.medicaid.gov/medicaid/benefits/telehealth/index.html. Accessed on Aug. 1, 2023.

[4] New Jersey Revised Statutes Annotated (N.J. Rev. Stat.) § 30:4D-12(d) and (e).

[5] New Jersey Administrative Code (NJAC) 10: 66-2.7(k).

[6] NJAC 10:66-2.7(l).

[7] 45 CFR § 75.403(g); N.J. Rev. Stat. § 30:4D-12(d) and (e).

[8] New Jersey Department of Human Services, "Revised COVID-19 Policy Guidance: Temporary Adjustment to Allow Telehealth for Partial Care and Partial Hospitalization Services" (issued Apr. 17, 2020), effective Mar. 13, 2020. Subsequently, the State agency issued guidance instructing providers to bill one unit for the same per diem payment of about $90. New Jersey Department of Human Services, "Newsletter" (May 2020).

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

HOW WE CONDUCTED THIS AUDIT

Our audit covered $61,305,779 in Federal Medicaid reimbursement for 1,378,671 adult partial care claims that were paid from January 1, 2019, through December 31, 2020. We reviewed a stratified random sample of 100 claims to determine if claims for these services complied with Federal and State requirements.[9] For each sampled claim, we reviewed service documentation obtained from providers. We also determined whether the State agency adequately implemented the recommendations made in our prior audit report.

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

Appendix A contains our audit scope and methodology, Appendix C describes our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

The State agency adequately implemented the procedural recommendations made in our prior audit report; however, it has not refunded our recommended financial disallowance of $94,830,718 in Federal Medicaid funds. In addition, we found that the State agency did not always ensure that Medicaid adult partial care services complied with Federal and State requirements. Of the 100 claims in our sample, 56 claims complied with Federal and State requirements, but 44 claims did not. Specifically, services billed were not supported (37 claims), services were not in the plan of care (7 claims), weekly notes were not provided (4 claims), and the plan of care was not provided (1 claim).[10]

Most of the deficiencies we identified occurred because the State agency misapplied Federal telehealth flexibilities by reimbursing for telehealth services differently than in-person services without CMS approval of the new reimbursement method. The remaining deficiencies occurred because the State agency did not always use site visits or quality assurance audits to

[9] One stratum consisted of 1,003,378 claims billed under procedure code H0035 (in-person adult partial care services), from which we randomly selected 70 claims. A second stratum consisted of 375,293 claims billed under procedure code H0035GTUC (telehealth adult partial care services), from which we randomly selected 30 claims. While evaluating the claims in our sample, we determined that four of the 70 claims billed as in-person services were actually for telehealth services.

[10] The total number of deficiencies exceeds 44 because 4 claims had more than 1 deficiency.

provide guidance and training to ensure Medicaid enrollees receive required services and the necessary amount of care. Based on our sample results, we estimated that the State agency was improperly reimbursed at least $18,826,714 in Federal Medicaid funds for adult partial care services that did not meet Federal and State requirements.[11]

THE STATE AGENCY SIGNIFICANTLY IMPROVED ITS OVERSIGHT OF THE ADULT PARTIAL CARE SERVICES PROGRAM BUT HAS NOT REFUNDED OUR PRIOR RECOMMENDED DISALLOWANCE

In our prior audit report, we recommended that the State agency:

- issue guidance to the partial care provider community on Federal and State requirements for claiming Medicaid reimbursement for partial care services,

- improve its monitoring of partial care providers to ensure compliance with Federal and State requirements, and

- refund $94,830,718 to the Federal Government.

The State agency implemented the procedural recommendations made in our prior audit report by significantly improving its oversight of the partial care services program, as indicated by its improved compliance with Federal and State requirements. In our prior audit, we found that 92 of 100 sampled claims did not comply with Federal or State requirements. For this audit, we found that 44 of the 100 sampled claims did not comply with Federal or State requirements. The State agency issued additional guidance to providers following our prior audit. Also, the State improved its monitoring of providers by hiring an independent firm that performed 89 quality assurance audits of providers for State fiscal years 2016 through 2018. State agency staff followed up on the independent firm's audit findings and recovered improper payments identified by the firm's audits. However, the State agency has not refunded our recommended disallowance of $94,830,718. During the current audit's exit conference, State agency officials stated that they did not concur with the recommended disallowance in the prior audit and plan to contact CMS about it. We note that CMS sustained the disallowance in an Office of Inspector General (OIG) Clearance Document (OCD) dated December 27, 2016, although it has not collected the disallowance.[12]

[11] To be conservative, we recommend recovery at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

[12] In its OCD, CMS agreed to recover the recommended disallowance as a sustained amount. When a State agrees in writing with OIG or CMS to refund a sustained overpayment, the State should refund the unallowable expenditure on its next quarterly Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. If a State does not concur with OIG, CMS contacts the appropriate State officials to discuss the audit findings and obtain documentation to substantiate the State's position. When CMS does not agree with the State's decision to nonconcur, CMS must clear the recommendation and initiate the disallowance process. CMS closes the OCD after the State has taken action necessary to fully implement all the audit recommendations.

PROVIDERS COMPLIED WITH FEDERAL AND STATE REQUIREMENTS FOR MOST SAMPLED IN-PERSON CLAIMS BUT NOT FOR MOST SAMPLED TELEHEALTH CLAIMS

Providers must develop an individualized plan of care that describes the treatment and projected schedule for delivering adult partial care services.[13] Providers must also prepare written documentation of individual services on a daily basis, with progress documented weekly. Supporting documentation for each service billed must include type of service, date, time, duration, and rendering practitioner or provider.[14] Services must be adequately documented and fully disclose the nature and extent of the service provided.[15]

Of the 100 claims in our stratified sample, 56 complied with Federal and State requirements, but 44 did not. [16] Specifically, 30 claims for telehealth services and 14 claims for in-person services did not comply with billing and documentation requirements. See table below for a detailed summary of deficiencies.

Table: Summary of Deficiencies

	Type of Deficiency			
Service Type	**Services Not Supported**	**Services Not in Plan of Care**	**No Weekly Progress Notes**	**No Plan of Care**
Telehealth	30	-	4	1
In Person	7	7	-	-
Total	37	7	4	1

Services Not Supported

Providers must meet State regulatory documentation requirements to receive reimbursement for services.[17] Services must be adequately documented and fully disclose the nature and extent of the service provided.[18]

As described earlier, CMS requires States to submit a SPA if they want to provide reimbursement for services delivered through telehealth differently (e.g., rate and manner

[13] NJAC 10: 66-2.7(k).

[14] NJAC 10:66-2.7(l).

[15] 45 CFR § 75.403(g); N.J. Rev. Stat. § 30:4D-12(d) and (e).

[16] Refer to footnote 10.

[17] N.J. Rev. Stat. § 30:4D-12(d) and (e).

[18] 45 CFR § 75.403 (g); N.J. Rev. Stat. 30 §§ 4D-12(d) and (e).

changed) than they reimburse for in-person services.[19] The State agency issued guidance in April 2020 allowing partial care services to be delivered through telehealth and for providers to bill these services at a per diem rate of 5 units of service, thereby changing the rate and manner for which services were reimbursed.[20] However, the State agency did not submit a SPA to CMS prior to issuing the guidance. CMS officials agreed that this was a change in the rate and manner that should have been approved through a SPA. Further, it was not included in the State agency's disaster relief SPA.

For 37 claims in our sample, services were not supported. Specifically, for 30 claims for telehealth services, the State agency paid providers 5 units of service when less than 5 units of service were documented.[21] For example, for three of the claims, the State paid the per diem rate of almost $90 although providers documented only 5 minutes of service for each of the claims. Also, for seven claims for in-person services, the units of service billed exceeded the units supported.

Services Not in Plan of Care

For temporary deviations from the services included in the enrollee's plan of care, the provider must have documentation to explain the reason for the deviation.[22]

For seven claims in our sample, in-person services billed were not in the enrollee's plan of care and no documentation was included in the enrollee's case file to explain the deviation. For example, an enrollee was in an art activities group that was not part of the enrollee's plan of care and no documentation was provided to explain this deviation.

[19] CMS Medicaid Guidance for Telehealth. Available online at: https://www.medicaid.gov/medicaid/benefits/telehealth/index.html. Accessed on Aug. 1, 2023.

[20] New Jersey Department of Human Services, "COVID-19 Policy Guidance: Temporary Adjustment to Allow Telehealth for Partial Care and Partial Hospitalization Services" (Apr. 13, 2020), and "Revised COVID-19 Policy Guidance: Temporary Adjustment to Allow Telehealth for Partial Care and Partial Hospitalization Services" (Apr. 17, 2020).

[21] We determined the number of units provided for the telehealth claims as follows: We did not count any units of service for 13 claims for which there was no documentation of service time. For 14 claims for which there was documentation of between 5 and 60 minutes of service time, we counted 1 unit of service. For two claims for which there was documentation of up to 120 minutes of service time, we counted two units of service. For one claim for which there was documentation of 180 minutes of service time, we counted three units.

[22] NJAC 10: 66-2.7(k).

No Weekly Progress Note

Providers must prepare written documentation of individual services daily, with progress notes documented weekly. Supporting documentation for each service billed must include type of service, date, time, duration, and rendering practitioner or provider.[23]

For four claims in our sample, weekly progress notes for the associated telehealth services were not provided.

No Plan of Care

Providers must develop an individualized plan of care that describes the treatment and projected schedule for delivering adult partial care services.[24]

For one claim in our sample, the plan of care was not provided for the associated telehealth services.

CONCLUSION

While the State agency adequately implemented the procedural recommendations made in our prior audit report by significantly improving its oversight of the partial care services program, as indicated by improved provider compliance, it has not refunded our recommended disallowance of $94,830,718. In addition, for this audit, the State agency did not always ensure that Medicaid adult partial care services complied with Federal and State requirements. Based on our sample results, we estimated that the State agency was improperly reimbursed at least $18,826,714 for Medicaid adult partial care services that did not meet Federal and State requirements. As a result, Medicaid enrollees may not have received required services and the necessary amount of care.

RECOMMENDATIONS

We recommend the New Jersey Department of Human Services:

- work with CMS to refund the recommended disallowance of $94,830,718 from our prior audit,

- refund to the Federal Government $18,826,714 associated with deficiencies identified in the current audit, and

[23] NJAC 10: 66-2.7(l).

[24] NJAC 10: 66-2.7(k).

- provide training or guidance to providers to address noncompliance issues it identifies during site visits or audits to ensure Medicaid enrollees receive required services with the necessary amount of care.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our monetary recommendations; however, it agreed with our recommendation that it provide training or guidance to providers to address noncompliance issues it identifies during site visits or audits to ensure Medicaid enrollees receive required services with the necessary amount of care.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid.

A summary of the State agency's comments and our responses follows. The State agency's comments, excluding attachments, are included as Appendix E.[25]

PRIOR AUDIT RECOMMENDED REFUND

State Agency Comments

The State agency did not concur with our recommendation to refund $94,830,718 from the prior audit and stated that it stands behind its original response. The State agency contended that a disallowance is unwarranted since OIG's recommendation is based on a limited sample size and five findings, unreasonable standards on entities, noncompliance with State law, and missing documentation for claims submitted for reimbursement more than 3 years before the start of the audit period.

Office of Inspector General Response

We maintain that the findings and recommendations in our prior audit are valid for the reasons we stated in response to the State agency's comments on that report. Small sample sizes, e.g., smaller than 100, have routinely been upheld by the Departmental Appeals Board and Federal courts.[26] The legal standard for use of sampling and extrapolation is that it must be based on a

[25] We are providing the State agency's comments, in their entirety, to CMS.

[26] *See Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012) (upholding a sample size of 95 claims); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 (S.D. Tex. 2012) (upholding a sample size of 30 claims).

statistically valid methodology, not the most precise methodology.[27] We properly executed our statistical sampling methodology in that we defined our sampling frame and sample unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

Further, our prior audit found a substantial number of errors. Specifically, we found that 92 of 100 sampled claims did not comply with Federal and State requirements, including 19 claims for which we identified multiple errors, that were collectively grouped into five finding categories. For costs to be allowable, they must "be necessary and reasonable for the performance of the Federal award," and for a cost to be reasonable, consideration must be given to, among other things, "Federal, state, local, tribal, and other laws and regulations" (45 CFR §§ 75.403-404). Finally, although Federal regulations require States to maintain documentation for 3 years, the State agency requires providers to retain records for 5 years (N.J. Rev. Stat. § 30:4D-12(d)). The service dates associated with the sample claims were within the State agency's 5-year document-retention period.

After reviewing the State agency's comments, we maintain the validity of our prior report findings and recommendation to refund $94,830,718. CMS indicated in October 2020 that it contacted the State agency regarding the resolution of these audit findings and is awaiting the State agency's response.

CURRENT AUDIT RECOMMENDED REFUND

State Agency Comments

The State agency did not concur with our recommendation to refund $18,826,714 associated with deficiencies identified in the current audit. First, the State agency stated that reviewing telehealth claims was not part of the audit's objectives. Second, the State agency stated that a CMS blanket waiver and State law and executive actions adopted for the COVID-19 PHE authorized per diem payments for telehealth services.[28] Third, the State agency stated that Federal law and guidance did not require States to submit a SPA to provide telehealth services, and that OIG did not reference any Federal law to conclude that per diem payments were not allowed, but instead relied on a State regulation waived by the State agency. Finally, with respect to telehealth services, the State agency stated that telehealth per diem payments allowed providers to maintain services and their staff, prevented avoidable hospitalizations,

[27] *See John Balko & Assoc. v. Sebelius*, 2012 U.S. Dist. LEXIS 183052 at *34-35 (W.D. Pa. 2012), *aff'd* 555 F. App'x 188 (3d Cir. 2014); *Maxmed Healthcare, Inc. v. Burwell*, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), *aff'd*, 860 F.3d 335 (5th Cir. 2017); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012); *Galindo v. Burwell*, 2017 U.S. Dist. LEXIS 221932 at *43-47 (S.D. Tex. 2017), *adopted by* 2018 U.S. Dist. LEXIS 168908 (S.D. Tex. 2018).

[28] CMS, "COVID-19 Emergency Declaration Blanket Waivers."

and kept patients connected to their providers so they could receive normal services post-COVID-19.

Regarding our findings related to in-person services, the State agency generally restated its objections to our prior audit's findings and recommendations. Further, the State agency stated that providers maintained a proper plan of care and daily documentation to support services provided. Finally, the State agency noted that the current audit demonstrated full compliance with the changes recommended by the prior audit.

Office of Inspector General Response

Contrary to the State agency's assertion, the inclusion of telehealth claims was covered under our audit's objectives. We had two objectives: First, we determined whether the State agency adequately implemented the recommendations made in our prior audit report. Second, we determined whether the State agency ensured Medicaid adult partial care services complied with Federal and State requirements. This second objective did not exclude telehealth services.

We also note that CMS's blanket waiver did not authorize the State agency to adopt per diem payments for telehealth services. The blanket waiver relaxed requirements for Medicare and Medicaid conditions of participation, among other things. It also relaxed some requirements for Medicare payment—not Medicaid payment. However, the blanket waiver stated that a State agency could submit a separate waiver to gain flexibilities such as SPA notice and effective date provisions for the PHE.

In making our audit determinations, we did not rely on a State regulation waived by the State agency. Rather, we relied on SPAs. As noted in the body of the report, the State agency submitted a SPA to request authorization to provide telehealth services, which CMS approved. In the SPA, the State agency represented that it would "reimburse for any service provided via telehealth and associated telecommunication at the same rate that would be paid had the service been provided in-person." During our audit period, the State agency's State Medicaid plan did not authorize per diem payments. In fact, the State agency did not request a change to per diem payment methodology until it submitted a SPA effective January 1, 2021, after our audit period.

As explained in footnote 21 of the report, we took a conservative approach by allowing for one whole unit when provider documentation only supported partial service time. This conservative approach allowed the State agency to be reimbursed for any time spent on the associated service.

Regarding in-person partial care services, we maintain that our findings and recommendations are valid. Although providers maintained plans of care and daily documentation, we found that for seven sampled items, services were not included in the associated plan of care, and that for seven items, the units of service billed exceeded the units supported. Thus, 14 claims did not comply with billing and documentation requirements.

TRAINING OR GUIDANCE TO ADDRESS NONCOMPLIANCE

The State agency concurred with our recommendation to provide training or guidance to providers to address noncompliance issues it identifies during site visits or audits to ensure Medicaid enrollees receive required services with the necessary amount of care. We acknowledge the State agency's efforts for continuing to provide training and guidance to partial care providers.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $61,305,779 in Federal Medicaid reimbursement for 1,378,671 adult partial care claims, that were paid from January 1, 2019, through December 31, 2020, with services performed after June 30, 2018. We reviewed a stratified random sample of 100 claims to determine if claims for these services complied with Federal and State requirements. We reviewed the service documentation obtained from providers for each sampled claim.

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

During our audit, we did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we limited our review to those controls related to the State agency's actions as they related to our audit objectives.

We assessed the reliability of the data by reconciling the claims data for adult partial care services used in our audit from CMS's Transformed Medicaid Statistical Information System (T-MSIS) to New Jersey's claims for Federal Medicaid reimbursement on its Form CMS-64 and performing tests on the data. We determined that the data were sufficiently reliable for the purposes of responding to our objectives.

We conducted our audit work from May 2022 through October 2023.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal and State requirements;
- interviewed State agency officials to gain an understanding of guidance and monitoring activities related to its adult partial care services program and obtained related documents;
- met with CMS officials to gain an understanding of CMS's approved service definition and payment amounts for partial care services;
- obtained from CMS's T-MSIS claims adult partial care services performed by providers in New Jersey during our audit period;

- created a sampling frame of 1,378,671 claims for adult partial care services with Federal Medicaid reimbursement totaling $61,305,779;

- reconciled the claims for Federal Medicaid reimbursement of adult partial care services claimed by the State agency on its Form CMS-64 covering our audit period to data obtained from CMS's T-MSIS file; [29]

- selected a stratified random sample of 100 claims, and for each claim, reviewed service documentation obtained from providers to determine if the associated services complied with Federal and State requirements;

- interviewed providers regarding State agency guidance and monitoring activities;

- estimated the total amount of improper Federal Medicaid reimbursement for adult partial care services claims in our sampling frame;

- determined if our prior audit recommendations were adequately implemented; and

- discussed our results with CMS and State agency officials.

[29] Our sampling frame included Medicaid adult partial care services during our audit period that (1) were billed under procedure codes H0035 (in-person) and H0035GTUC (telehealth), (2) were billed under claim type 8700, (3) were billed under Category for Federal Reimbursement "01" on Form CMS-64, and (4) contained Federal reimbursement amounts greater than $17.

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

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

Section 1903 of the Act authorizes Federal grants to States for a proportion of expenditures for medical assistance under an approved Medicaid State plan, and for expenditures necessary for administration of the State plan.

Federal regulations 45 CFR § 75.403 and 45 CFR § 75.404 establish principles and standards for determining allowable costs incurred by State and local governments under Federal awards. To be allowable, they must be necessary and reasonable for the performance of the Federal award, which includes consideration of requirements imposed by "Federal, state, local, tribal, and other laws and regulations." Per 45 CFR § 75.403(g) costs must be adequately documented.

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

NJAC 10: 66-1.6 requires (a) an individual record be prepared and retained by an independent clinic that fully discloses the kind and extent of the service provided to a Medicaid or NJ FamilyCare fee-for service enrollee, as well as the medical necessity for the service, and (b) at a minimum, an enrollee's record include a progress note for each visit which supports the procedure code(s) billed, except where specified otherwise.

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

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

NJAC 10: 66-2.7(l) states that the provider must document individual services under partial care daily. The provider must develop and maintain legibly written documentation to support each medical or remedial therapy service, activity, or session that is billed. At a minimum, this documentation must consist of: (1) the specific services provided; (2) the date and time services

are provided; (3) the duration of services provided (e.g., 1 hour, half hour); (4) the signature of the practitioner or provider rendering services; (5) the setting in which services are provided; and (6) a notation of unusual occurrences or any significant deviation from the treatment described in the plan of care.

NJAC 10: 66-2.7(l)(2) states that the provider must write progress notes in the client's record at least weekly.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame contained 1,378,671 claims with Medicaid payments totaling $115,531,906 ($61,305,779 Federal share) that were paid from January 1, 2019, through December 31, 2020, with services performed after June 30, 2018. The sampling frame included Medicaid claims that (1) were billed under procedure codes H0035 (in-person) and H0035GTUC (telehealth), (2) were billed under claim type 8700, (3) were billed under Category for Federal Reimbursement "01" on the Form CMS-64, and (4) contained Federal reimbursement amounts greater than $17.

SAMPLE UNIT

The sample unit was a Medicaid claim for an adult partial care service.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample and divided the sampling frame into two strata based on whether the claim was billed under procedure code H0035 or H0035GTUC:

Stratum	Procedure Code	Number of Claims in Frame	Value of Frame (Total)	Value of Frame (Federal Share)	Sample Size
1	H0035	1,003,378	$82,148,206	$42,541,057	70
2	H0035GTUC	375,293	$33,383,701	$18,764,722	30
Totals		**1,378,671**	**$115,531,906**[30]	**$61,305,779**	**100**

SOURCE OF THE RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in each stratum by the claim's unique identification number and then consecutively numbered the items in each stratum in the sampling frame. After generating 100 random numbers according to our sample design, we selected the corresponding frame items.

[30] Due to rounding, the individual stratum values listed in this table do not add up to the total amount claimed.

ESTIMATION METHODOLOGY

We used the OIG, OAS statistical software to estimate the total amount of improper Medicaid payments (Federal share) made for adult partial care services in the sampling frame. To be conservative, we recommend recovery of improper payments at the lower limit of the two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual improper payment amount 95 percent of the time.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Stratum Number	Number of Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Improper Claim Payments	Value of Improper Claim Payments (Federal Share)
1	1,003,378	$42,541,057	70	$3,003	17	$453
2	375,293	$18,764,722	30	$1,511	27	$1,239
Total	**1,378,671**	**$ 61,305,779**	**100**	**$4,514**	**44**	**$1,692**

Estimated Value of Improper Claim Payments in the Sampling Frame (Federal Share)
(Limits Calculated at the 90-Percent Confidence Level)

Point Estimate	$21,992,149
Lower Limit	$18,826,714
Upper Limit	$25,157,583

APPENDIX E: STATE AGENCY COMMENTS

PHILIP D. MURPHY
Governor

TAHESHA L. WAY
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
P.O. BOX 700
TRENTON, NJ 08625-0700

SARAH ADELMAN
Commissioner

January 5, 2024

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

RE: Draft Audit Report No. A-02-22-01007

Dear Ms. Tierney:

The New Jersey Department of Human Services ("DHS") is in receipt of the draft audit report issued by the Office of Inspector General ("OIG") entitled *New Jersey Significantly Improved Its Oversight of Medicaid Adult Partial Care Services Except For Those Provided Using Telehealth During the COVID-19 Public Health Emergency*, A-02-22-01007. Thank you for the opportunity to respond.

DHS appreciates OIG's acknowledgement that the Division of Medical Assistance and Health Services ("DMAHS") significantly improved its oversight of the adult partial care services program since the time of the prior audit, A-02-13-01029, which was issued in December, 2016.

Please see DHS's responses to the draft recommendations and findings below.

OIG Recommendation

"We recommend that [DHS] work with CMS to refund the recommended disallowance of $94,830,718 from our prior audit."

Response

DHS does not concur with this recommendation and stands behind its original response to this audit. Please see our response to the original audit for more detail, but DHS generally contends that a disallowance is unwarranted due to:

1. The OIG's significant recoupment recommendation is based on a limited sample size and five findings from its review of 100 of the more than 3.8 million partial care claims

for services rendered during the four-year audit period, calendar years 2009 through 2012.

2. The audit report imposes unreasonable standards on entities providing dynamic and comprehensive services to individuals with serious mental illness.
3. Noncompliance with State law is not appropriate grounds for a disallowance.
4. OIG should not recommend recoupment based on missing documentation of claims submitted more than three years before the start of the audit period.

DHS is happy to discuss further with CMS why a disallowance is unwarranted.

OIG Recommendation

"We recommend that [DHS] refund the Federal Government $18,826,714 associated with deficiencies identified in the current audit."

Response

DHS does not concur with this recommendation. The stated objectives of the OIG audit "were to determine whether New Jersey adequately implemented the recommendations made in our prior audit report and ensured Medicaid adult partial care services complied with Federal and State requirements." New Jersey fully complied with implementing the recommendations made in the prior report. OIG's draft findings relate to telehealth claiming which is a separate and unrelated matter.

Of the 100 total records sampled, the OIG identified 44 perceived errors, 36 of which were related to the temporary per diem payment for telemedicine. OIG cites a purported deficiency related to SPA approval for how telehealth could be billed. However, its recommendation that the State refund significant amounts related to telehealth claims ignores that DHS was forced to urgently find ways to deliver necessary services to beneficiaries during the onset of an unprecedented public health emergency. Given the need to avoid in-person contact, telehealth became an essential service-delivery tool that was used in many new contexts. Recognizing this dynamic, CMS afforded states the needed flexibility to shift to telehealth service delivery quickly. DHS' focus was on enabling providers to deliver necessary services to meet the needs of beneficiaries, without focusing on rigid timeframes. Telemedicine was the only way to ensure continued necessary treatment and the per diem payment was the most viable way to ensure providers could continue to provide these needed services.

To that end, New Jersey availed itself of the authority granted States under CMS' COVID-19 Emergency Declaration Blanket Waiver, a true copy of which is attached as Exhibit A. The blanket waiver specifically provides:

> The Administration is taking aggressive actions and exercising regulatory flexibilities to help healthcare providers contain the spread of 2019 Novel Coronavirus Disease (COVID-19). CMS is empowered to take proactive steps through 1135 waivers as well as, where applicable, authority granted under section 1812(f) of the Social Security Act (the Act) and rapidly expand the Administration's aggressive efforts against COVID-19. As a result, the following blanket waivers are in effect, with a retroactive effective date of March 1, 2020,

> through the end of the emergency declaration. For general information about waivers, see Attachment A to this document. These waivers DO NOT require a request to be sent to the 1135waiver@cms.hhs.gov mailbox or that notification be made to any of CMS' regional offices.

The blanket waiver obviated the need for States to request a State Plan Amendment.

In addition to the authority granted New Jersey under the blanket waiver, New Jersey State Executive Order No. 103 granted DMAHS (and other State agencies) broad authority to waive or suspend any existing rule where its enforcement would be detrimental to the public, "notwithstanding the provisions of the Administrative Procedure Act or any law to the contrary." Executive Order No. 103 is attached as Exhibit B. Thereafter, on March 19, 2020, New Jersey enacted legislation expanding access to Telehealth services. See, P.L. 2020, c.3. The telehealth legislation authorized appropriate State Agencies to "waive any requirement of State law or regulation as may be necessary to facilitate the provision of health care services using telemedicine and telehealth during the state of public health emergency declared in response to COVID-19…"

DMAHS complied with all of the above and on March 21, 2020, it gave formal notice of New Jersey's Temporary Changes in the Provision of Partial Care and Partial Hospitalization Services via Telecommunication. The temporary changes and rule relaxations were memorialized in State Medicaid's COVID-19 Policy Guidance: *Temporary Adjustment to Allow Telehealth for Partial Care and Partial Hospitalization Services*, dated April 13, 2020 and amended by a Revised Guidance dated April 17, 2020. Additional notice was provided via State Medicaid Newsletter, Vol. 30, No. 11 (attached as Exhibit C), which states:

> Effective March 21, 2020 and throughout the COVID-19 state of emergency, partial care or partial hospitalization services that are provided via a telecommunication device shall be reimbursed with a per diem rate. Partial Care services shall initially be billed using 5 units of H0035GTUC to receive the per diem rate and are limited to 25 units (5 days) per calendar week. Hospitals shall bill using 5 units of REV code 912 or 913 and are limited to 25 units (5 days) per calendar week. Effective 5/15/20, for partial care only, H0035GTUC shall be billed with 1 unit per day and shall be limited to 5 units per calendar week. The per diem reimbursement rate for H0035GTUC shall not change. Hospitals shall continue to bill using 5 units per day. All billing changes shall continue for the duration of the COVID-19 state of emergency. Services may be provided on Saturday or Sunday as long as service dates do not exceed the equivalent of 5 days per calendar week.

The results of the telehealth changes New Jersey made during the public health emergency were necessary and consistent with the blanket CMS waiver, State policy revisions, State rule relaxations and State Statute. Absent the CMS blanket waiver, and the State's adjustments, consumers could not receive the necessary Partial Care services. To be clear, there was no way community providers could schedule, orchestrate and conduct lengthy (5-hour), telephonic, group sessions with the target population. Any effort to ignore the blanket CMS waiver, the State's Executive Order and the State's revised Telehealth statute would result in the denial of Partial Care

services to the certain detriment of individuals with a mental illness for many months. Contrary to the findings, New Jersey acted lawfully, with extremely positive results:

- Post-COVID evaluation demonstrates that the partial care program successfully prevented avoidable hospitalizations during a difficult and chaotic time.
- The number of mental health admissions to an acute care setting did not increase and partial care members continued to receive education about management of their psychiatric medications.
- Programs that compete daily to employ psychiatrists in an extremely competitive market were able to maintain their staff and therefore maintained access for this vulnerable population.
- Patients remained connected to their mental health providers and successfully resumed normal services post-COVID with minimal to no disruption in their medication regimen.

OIG believes that the State's reliance on New Jersey State waivers and policy amendments are inadequate and that a State Plan Amendment was required. However, OIG neglects to reference any federal regulation and instead references only State Medication regulation N.J.A.C. 10: 66-2.7(k), which requires five (5) or more hours of program participation. With respect to the State regulation:

- New Jersey does not require federal approval to modify or waive a State Medicaid rule.
- OIG does not have the authority to instruct New Jersey on how it should conform its conduct to State law (including P.L. 2020, c.3), EO 103 or any other State policy. See, Johnson v. Guhl, 166 F.Supp. 2d 42 (D.N.J. 2001), aff'd 357 F.3d 403 (3d. Cir. 2004).
- OIG cannot stop New Jersey's enforcement of its waivers or compel it to comply with the N.J. Administrative Procedures Act. Id.
- New Jersey's waivers, and the State's interpretation of such waivers, is entitled to deference and should be acknowledged and enforced by OIG, unless such waivers or relaxations contradicted federal law.

In this instance, New Jersey's temporary revision conformed to CMS's telehealth guidance, did not contradict the State's SPA, and did not violate any other federal rule or law. Again, OIG does not reference the New Jersey SPA or any federal regulation in support of its finding that any change in the State's Medicaid regulation required a plan amendment. Instead, OIG cites general CMS guidance (at htttps://www.medicaid.gov/medicaid/benefits/telehealth/index.html). It is important to note that this guidance explains:

> For most Medicaid benefits, federal Medicaid law and regulations do not specifically address telehealth delivery methods or the criteria for implementation of telehealth. As a result, states have broad flexibility in designing the parameters of telehealth delivery methods to furnish services…
>
> Unless required by regulation or policy, states are not required to submit a (separate) SPA for coverage or reimbursement of Medicaid coverable services delivered through telehealth

> if they decide to reimburse for services delivered through telehealth in the same way/amount that they pay for face-to-face services…
>
> States may submit a coverage SPA to better describe the services they choose to cover through telehealth, such as which providers/practitioners are identified by the state to use telehealth to deliver services; where it is provided; how it is provided, etc. In this case, and in order to avoid unnecessary SPA submissions, it is recommended that a brief description of the framework of telehealth may be placed in an introductory section of the state plan, e.g., Section 3 – Services: General Provisions 3.1 Amount, Duration and Scope of Services, and then a reference made to coverage through telehealth in the applicable benefit sections of the state plan.

New Jersey's State Plan Amendment does not restrict mental health Partial Care or behavioral telehealth services. Nor does it mandate five (5) or more hours of partial care program participation. That is, the mental health Partial Care State Plan Amendment does not fix a minimum unit of service or otherwise define a mental health partial care unit of service – telehealth or otherwise. The only SPA restrictions relevant to partial care are: a limit of 1 non-psychotherapy unit per day, 3 psychotherapy units per day, and 5 psychotherapy units per week. New Jersey maintained each of those SPA limits in its temporary rule change and as a result, it did not alter its CMS-approved billing framework. Thus, a State Plan Amendment was not required, New Jersey acted within its authority and the partial care telehealth services should not be disallowed.

Errors that did not consist of improper billing for telehealth units consisted of:

- 4 records missing a weekly summary note
- 1 record unable to produce a plan of care
- 7 records that provided a specific intervention that was not listed in plan of care.

As stated in our previous audit response, interventions listed should be the general steps that can be taken to address a member's identified needs. This does not mean that interventions may not be utilized to address urgent situations as long as the steps taken are properly documented in the daily documentation or weekly note. With that said, despite the challenges of providing telemedicine to this population, providers maintained a proper plan of care and daily documentation to support services provided. During an unprecedented public health emergency, which involved staffing shortages, limited transportation, as well as uncertainty as to how long this environment would continue, 88 out of 100 records demonstrated full compliance with the changes recommended during the previous audit. Along with demonstrated improvement in documentation, the programs continued to serve a population that was, in general, hesitant of in-person visits to treatment facilities during this state of emergency.

OIG Recommendation

"We recommend that [DHS] provide training or guidance to providers to address noncompliance issues it identifies during site visits or audits to ensure Medicaid enrollees receive required services with the necessary amount of care."

Response

DHS concurs with this recommendation as it always provides guidance to providers to address any noncompliance issues and to ensure enrollees receive necessary care. DHS will continue to provide training and guidance to Partial Care providers, and will continue to work to improve its monitoring of providers, to ensure compliance with state and federal law. The State already has in place a robust auditing program for partial care providers. In addition to partial care programs being reviewed quarterly with attention to the participation and active programming, the initial evaluation, the plan of care development, daily and group documentation, weekly documentation and periodic reviews required by regulation, staff also sit in on active groups and monitor the activity. DHS staff monitor the quality of programming, including that clients are encouraged to participate. This information is shared with the program director at the end of the visit and is generally included in the yearly summary. DHS also meets with a large provider group representing partial care programs on a quarterly basis to address concerns including changes in regulations or areas of concern raised during audits.

Thank you again for the opportunity to comment on the draft audit report. DHS appreciates OIG's acknowledgement that DMAHS significantly improved its oversight of the adult partial care services program since the time of the prior audit.

Sincerely,

Sarah Adelman

Sarah Adelman
Commissioner

CC Jennifer Langer Jacobs
Valerie Mielke
Allan Brophy