

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**NEW JERSEY CLAIMED  
MEDICAID REIMBURSEMENT FOR  
ADULT PARTIAL HOSPITALIZATION  
SERVICES THAT DID NOT COMPLY  
WITH FEDERAL AND STATE  
REQUIREMENTS**

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# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*New Jersey claimed at least \$30.7 million in Federal Medicaid reimbursement over 4 years for adult partial hospitalization services that were unallowable.*

### WHY WE DID THIS REVIEW

During a prior review of New Jersey’s claims for Medicaid clinical services provided to adults with mental illnesses, we identified a significant number of services improperly submitted for Federal Medicaid reimbursement. On the basis of those results, we decided to review similar services provided on a hospital-outpatient basis, known as partial hospitalization services.

The objective of this review was to determine whether the New Jersey Department of Human Services (State agency) claimed Federal Medicaid reimbursement for adult partial hospitalization services that complied with Federal and State requirements.

### BACKGROUND

In New Jersey, the State agency administers the Medicaid program. The State agency offers two types of partial hospitalization services to Medicaid beneficiaries with serious mental illnesses: (1) psychiatric acute partial hospital services to stabilize a beneficiary’s acute symptoms and prevent inpatient psychiatric hospitalization and (2) partial hospital services to assist beneficiaries to, as New Jersey puts it, “achieve community integration through valued living, learning, working and social roles.”

To qualify for Medicaid reimbursement, hospital outpatient services must be provided by an institution licensed or formally approved as a hospital by the State’s authority for setting standards, which in New Jersey is the Department of Health (DOH). The Centers for Medicare & Medicaid Services’ (CMS) *State Medicaid Manual* establishes guidelines for partial hospitalization services, including individualized treatment planning and documentation.

New Jersey law requires providers to document the nature and extent of each service provided and any other information that the State agency may require by regulation and limits payment of the State’s partial hospitalization rate to 24 months, after which a lower rate—one used for partial care services—must be billed. State regulations require (1) supporting documentation for each service; (2) staffing ratios; (3) face-to-face individual visits with a psychiatrist or an advanced practice nurse; (4) referral and certification; and (5) daily acute partial hospitalization and weekly partial hospitalization progress notes.

### HOW WE CONDUCTED THIS REVIEW

During calendar years 2010 through 2013, the State agency claimed Federal Medicaid reimbursement totaling \$66,871,674 (\$33,773,409 Federal share) for 418,788 claims for partial hospitalization services. We reviewed a simple random sample of 100 of these claims.

## WHAT WE FOUND

All 100 of the State agency's claims for Federal Medicaid reimbursement for partial hospitalization services did not comply with Federal and State requirements, and 92 contained more than 1 deficiency:

- For 87 claims, services did not meet the Federal requirement that hospital outpatient services be provided by a licensed hospital.
- For 83 claims, services were not documented or supported.
- For 59 claims, services did not meet staffing ratio requirements.
- For 21 claims, services were improperly paid at the partial hospitalization rate.
- For 13 claims, progress notes were not documented.
- For seven claims, requirements for face-to-face visits with a psychiatrist were not met.
- For three claims, referrals and certifications were not documented.
- For one claim, adult services were paid at a higher rate—one used for treating children.

The deficiencies occurred because the State agency did not (1) work with DOH to ensure that partial hospitalization services are provided by appropriately licensed hospitals, (2) adequately monitor the partial hospitalization program to ensure that providers complied with Federal and State requirements, and (3) have adequate controls to ensure that services were paid at the proper payment rate.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$30,744,840 in Federal Medicaid reimbursement for partial hospitalization services that did not meet Federal and State requirements.

## RECOMMENDATIONS

We recommend that the State agency:

- refund \$30,744,840 to the Federal Government,
- work with the State's DOH to ensure partial hospitalization services are provided by appropriately licensed hospitals,
- issue guidance to providers on Federal and State requirements for claiming Medicaid reimbursement for partial hospitalization services,

- improve its monitoring of partial hospitalization services providers to ensure compliance with Federal and State requirements,
- review and revise payment controls to ensure the correct rates are paid for partial hospitalization services, and
- work with CMS to identify claims outside of our audit period that were paid at an incorrect rate or for services that were not provided by a facility licensed as a hospital.

## **STATE AGENCY COMMENTS AND OUR RESPONSE**

In written comments on our draft report, the State agency disagreed with our first recommendation and did not indicate concurrence or nonconcurrence with our remaining recommendations. However, the State agency indicated that it will continue to work with its Federal partners and hospitals to ensure that its partial hospitalization services program complies with State and Federal law and policy.

The State agency stated that, under its Medicaid program, partial hospitalization services are not hospital services. It also contended that partial hospitalization services for 13 claims associated with 4 providers were allowable because the services were delivered in hospitals licensed by DOH. The State agency also asserted that we incorrectly applied State law governing the 24-month limit on reimbursement. Further, the State agency contended that noncompliance with State law is not an appropriate grounds for a financial disallowance. Specifically, the State agency argued that 2 CFR part 225 (Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*) (1) does not apply to payments to private Medicaid providers, (2) no longer requires compliance with State law, and (3) does not apply when State law does not authorize recoupment of payments. The State agency also asserted that we did not provide sufficient information for it to respond to our finding of claims “not documented or supported” and that we erred in reviewing claim files. The State agency further stated that, during our review of sample claims, we misinterpreted documents and overlooked relevant documents. Finally, under separate cover, the State agency provided 154 pages of documentation.

After reviewing the State agency’s comments and additional documentation, we determined that a conflict existed between State agency and DOH officials regarding the licensure of four facilities that provided partial hospitalization services. Based on the State agency’s comments and further review of DOH information, we revised our finding for the 13 claims associated with these providers. To address this conflict, we combined the second and third recommendations in our draft report into a single recommendation that the State agency work with DOH to ensure that partial hospitalization services are provided by appropriately licensed hospitals. We also accepted additional documentation for one other claim; however, none of our revisions to our sample claim determinations impacted our overall errors, as all of the claims had multiple deficiencies. We maintain that our remaining findings and recommendations are valid. Finally, we note that we provided the State agency with all of the information it requested in August 2016 within 1 week and 60 days of additional time to comment on the draft report.

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## INTRODUCTION

### WHY WE DID THIS REVIEW

During a prior review of New Jersey's claims for Medicaid clinical services provided to adults with mental illnesses,<sup>1</sup> we identified a significant number of services improperly submitted for Federal Medicaid reimbursement. On the basis of these results, we decided to review similar services provided on a hospital-outpatient basis, known as partial hospitalization services.

### OBJECTIVE

Our objective was to determine whether the New Jersey Department of Human Services (State agency) claimed Federal Medicaid reimbursement for adult partial hospitalization services that 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 requirements.

#### New Jersey's Medicaid Partial Hospitalization Services Program

In New Jersey, the State agency administers the Medicaid program. The State agency offers two types of partial hospitalization services to Medicaid beneficiaries with serious mental illnesses: (1) psychiatric acute partial hospital services to stabilize a beneficiary's acute symptoms and prevent inpatient psychiatric hospitalization and (2) partial hospital services to assist beneficiaries to "achieve community integration through valued living, learning, working and social roles" (New Jersey Administrative Code (NJAC) 10:52a-1.1(b)2). For partial hospitalization services to be eligible for Medicaid reimbursement, beneficiaries must receive 2 to 5 hours (units) of services per day. Services include group therapy, prevocational services,<sup>2</sup> psychiatric services, and nursing services.

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<sup>1</sup> *New Jersey Claimed Medicaid Adult Partial Care Services That Were Not in Compliance With Federal and State Requirements* (A-02-13-01029, December 27, 2016).

<sup>2</sup> Prevocational services are (1) interventions, strategies, and activities that assist individuals with general work behaviors and skills needed to improve work and life skills or (2) qualified therapeutic subcontract work (NJAC 10:52-2.10a(c)-(e), (g) and NJAC 10:52a-4.3(b)4).

## **Federal and State Requirements Relating to Partial Hospitalization Services**

To qualify for Medicaid reimbursement, outpatient hospital services must be provided by an institution licensed or formally approved as a hospital by the State's authority for setting standards,<sup>3</sup> which in New Jersey is the Department of Health (DOH). CMS's *State Medicaid Manual* (the Manual) establishes guidelines for partial hospitalization services, including individualized treatment planning and documentation.<sup>4</sup>

Principles and standards for determining allowable costs incurred by State and local governments under Federal awards are established by 2 CFR part 225 (Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*). To be allowable, costs must be authorized or not prohibited by State or local laws and regulations (2 CFR part 225,<sup>5</sup> App. A, C.1.c).

State law requires providers to document the nature and extent of each service provided and any other information that the State agency may require by regulation.<sup>6</sup> Further, billing of the partial hospitalization services rate is limited to 24 months, after which a lower rate—one used for partial care services—must be billed.<sup>7</sup> State regulations require (1) supporting documentation for each service; (2) staffing ratios; (3) face-to-face individual visits with a psychiatrist or an advanced practice nurse; (4) referral and certification; and (5) daily acute partial hospitalization and weekly partial hospitalization progress notes.<sup>8</sup>

For details on Federal and State requirements relating to adult partial hospitalization services, see Appendix A.

### **HOW WE CONDUCTED THIS REVIEW**

During calendar years (CYs) 2010 through 2013, the State agency claimed Federal Medicaid reimbursement totaling \$66,871,674 (\$33,773,409 Federal share) for 418,788 claims for partial hospitalization services. We reviewed a simple random sample of 100 of these claims. Specifically, we reviewed documentation to determine whether partial hospitalization services were provided in accordance with Federal and State requirements.

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<sup>3</sup> 42 CFR § 440.20(a).

<sup>4</sup> In the Manual § 4221(A), CMS explains the need for specific documentation guidelines for outpatient psychiatric services. According to CMS, there have been “instances of billing for services without sufficient documentation to establish that the services were clearly related to the patient’s psychiatric condition. With the ongoing effort to encourage furnishing psychiatric treatment in the least restrictive setting possible, there is an increasing need for coverage guidelines specifically directed at outpatient programs.”

<sup>5</sup> On Dec. 26, 2013, OMB consolidated and streamlined its guidance, which is now located at 2 CFR part 200. The Department of Health and Human Services has codified the guidance in regulations found at 45 CFR part 75, which became effective on Dec. 26, 2014.

<sup>6</sup> N.J. Rev. Stat. § 30:4D-12.

<sup>7</sup> 2008 N.J. Public Law, chapter 35 (page 125).

<sup>8</sup> NJAC 10:52-1.17(e) and 10:52a, subchapters 3 and 4.

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 B contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

## FINDINGS

All 100 of the State agency’s claims for Federal Medicaid reimbursement for partial hospitalization services did not comply with Federal and State requirements, and 92 contained more than 1 deficiency. Table 1 summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

**Table 1: Summary of Deficiencies in Sampled Claims**

Deficiency	Number of Unallowable Claims <sup>a</sup>
Services not provided by a licensed hospital	87
Services not documented or supported	83
Services did not meet staffing requirements	59
Services improperly paid at the partial hospitalization rate	21
Progress notes not maintained	13
Face-to-face requirements not met	7
Referral and certification requirements not documented	3
Adult services paid at the children’s services rate	1

<sup>a</sup> The total exceeds 100 because 92 claims contained more than 1 deficiency.

The deficiencies occurred because the State agency did not (1) work with DOH to ensure that partial hospitalization services are provided by appropriately licensed hospitals, (2) adequately monitor the partial hospitalization program to ensure that providers complied with Federal and State requirements, and (3) have adequate controls to ensure that services were paid at the proper payment rate.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$30,744,840 in Federal Medicaid reimbursement for partial hospitalization services that did not meet Federal and State requirements.<sup>9</sup>

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<sup>9</sup> To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total at least 95 percent of the time.

## SERVICES NOT PROVIDED BY A LICENSED HOSPITAL

Medicaid partial hospitalization services are claimed as hospital outpatient services, which are defined as services provided by an institution licensed or formally approved as a hospital by the State's authority for setting standards (42 CFR § 440.20). The box below describes Medicaid hospital outpatient standards detailed in 42 CFR part 482 and 42 CFR § 440.20. In New Jersey, DOH is responsible for licensing hospitals.

For 87 of the 100 claims in our sample (associated with 21 providers), services were not provided by institutions licensed by DOH as hospitals. Instead, these providers were licensed by the State agency's Division of Mental Health as partial care licensees. For example, some services were provided at clinics located in shopping centers or converted churches, which might not have been able to meet hospital licensure requirements.

For the remaining 13 claims (associated with 4 providers), services were provided inside a hospital licensed by DOH. We note that DOH does not license partial hospitalization facilities or programs.<sup>10</sup> However, according to the State agency, partial hospitalization services provided inside a licensed hospital are authorized by the hospital's license. Thus, there appears to be a conflict between the State agency and DOH regarding whether partial hospitalization services require a specific license from DOH. Because of this conflict, we are not recommending disallowance of these 13 claims; however, we are recommending that the State agency resolve the conflict with DOH.

### MEDICAID HOSPITAL OUTPATIENT STANDARDS

Medicaid hospital outpatient services must be integrated with inpatient services. Further, a hospital outpatient service provider must meet several conditions of participation (e.g., must have performance improvement policies, food service, infection control, and building safety standards). The State's standards-setting agency must also license or formally approve the provider's location as a hospital.

## SERVICES NOT DOCUMENTED OR SUPPORTED

A beneficiary's plan of care must include a written description of treatment objectives, including the treatment regimen and specific medical or remedial services, therapies, and activities used to meet the objectives. The plan of care must also include a projected schedule for service delivery that includes the frequency and duration of each type of planned therapeutic session or encounter.<sup>11</sup> For services provided that are not specifically included in the beneficiary's plan of

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<sup>10</sup> DOH officials said that several years ago DOH licensed a children's partial hospitalization program and put it on the hospital license. According to N.J. Rev. Stat. § 26:2H-12.a.(1), a provider must possess a valid license that specifies the kinds of health care services it is authorized to provide. DOH officials also said that recently another provider requested DOH to license a partial hospitalization program, but DOH did not because it does not have licensing standards for partial hospitalization programs.

<sup>11</sup> The Manual § 4221(C), N.J. Rev. Stat. § 30:4D-12(d), and NJAC 10:52-1.17.

care, the provider should have documentation to explain how the services being billed relate to the treatment regimen and objectives contained in the beneficiary's plan of care.<sup>12</sup>

Providers are required to prepare records to fully disclose the nature and extent of each service provided. Individual services must be documented daily and amount to 2 to 5 hours (units) per day, exclusive of meals and breaks. To satisfy these requirements, at a minimum providers must document: (1) specific services provided, (2) the date and time services were provided, (3) the duration of services, (4) the practitioner's signature, (5) the setting in which services were provided, and (6) any significant deviation from the treatment described in the beneficiary's plan of care.<sup>13</sup>

For 83 of the 100 claims in our sample, services were not documented or supported.<sup>14</sup> Specifically:

- For 71 claims, services provided were not included in the specific therapies and activities identified in the beneficiary's plan of care.<sup>15</sup> The claims and related documentation did not include detailed explanations of how these services related to the treatment regimen and objectives of the beneficiary's plan of care or explain the deviation from the treatment described in the plan of care.
- For 21 claims, required elements (e.g., duration of services and practitioner's signature) were not documented.
- For 12 claims, the units of services billed exceeded the units of service supported.<sup>16</sup>
- For eight claims, prevocational documentation requirements were not met.
- For four claims, there was no documentation to support that services were provided or that the beneficiary received services on the date of service billed.
- For two claims, documentation did not support the minimum requirements (2 hours) for billing services.

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<sup>12</sup> The Manual § 4221(D).

<sup>13</sup> The Manual § 4221(D), N.J. Rev. Stat. § 30:4D-12(d), NJAC 10:49-9.8, NJAC 10:52-1.17, and NJAC 10:52a-4.11.

<sup>14</sup> The total exceeded 83 because 30 contained more than 1 deficiency.

<sup>15</sup> Services related to these 71 claims were also not included in the beneficiary's projected schedule of services.

<sup>16</sup> For these claims, we allowed the portion of the claim for services that were supported.

## **SERVICES DID NOT MEET STAFFING REQUIREMENTS**

Most of the partial hospitalization claims included in our sample were for group therapy services. State regulations require that the direct staff-to-client ratio for partial hospitalization clients in group activities must not exceed 1:10 (before March 5, 2012) or 1:12 (on or after March 5, 2012).<sup>17</sup> The direct care staff-to-client ratio for acute partial hospitalization clients in group therapy must not exceed 1:10.<sup>18</sup>

For 59 of the 100 claims in our sample, group therapy services did not meet staffing ratio requirements.<sup>19</sup> Specifically:

- For 26 claims, providers did not provide information about the staff-to-client ratio for group therapy services.
- For 17 claims, the staff-to-client ratio for partial hospitalization group services provided before March 5, 2012, exceeded 1:10.
- For 4 claims, the staff-to-client ratio for acute partial hospitalization group services exceeded 1:10.
- For 12 claims, the staff-to-client ratio for partial hospitalization group services provided on or after March 5, 2012, exceeded 1:12.<sup>20</sup>

## **SERVICES IMPROPERLY PAID AT THE PARTIAL HOSPITALIZATION RATE**

Partial hospitalization services for each beneficiary are limited to 24 months. Hospitals may continue to provide these services beyond the 24-month limit but must bill for these services at the partial care rate of \$77 per day instead of the \$175 per day for partial hospitalization services.<sup>21</sup>

For 21 of the 100 claims in our sample, services were paid for clients at the partial hospitalization rate beyond the 24-month limit. Specifically, partial hospitalization services were claimed at the partial hospitalization rate from 2 years, 24 days to over 17 years before our sampled service date.

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<sup>17</sup> NJAC 10:52a-4.3(b)9.

<sup>18</sup> NJAC 10:52a-4.3(a)2i.

<sup>19</sup> To be conservative, we chose not to question claims that had a variance of 2 clients above the applicable ratio (e.g., for a 1:12 ratio, we allowed 14).

<sup>20</sup> For the second, third, and fourth bulleted items related to the 33 claims, the applicable ratio was exceeded by a range of 3 to 22 clients.

<sup>21</sup> 2008 N.J. Public Law, chapter 35 (page 125). The partial care rate is \$15.40 per unit (NJAC 10:66-6.3(f)), and the partial hospitalization services rate is \$35 per unit (NJAC 10:52-4.3(b)(8)); both rates have a maximum of 5 units per day.

## **PROGRESS NOTES NOT MAINTAINED**

Providers must maintain progress notes that include (1) a summary of the beneficiary's participation and clinical progress, (2) a description of any significant events which may have an effect on the beneficiary's goals and objectives, and (3) treatment plan revisions based on the beneficiary's response to treatment plan interventions. Acute partial hospitalization services require daily progress notes, and partial hospitalization services require weekly progress notes.<sup>22</sup>

For 13 of the 100 claims in our sample, the provider did not maintain a progress note. Specifically, for 11 claims a daily progress note for acute partial hospitalization services was not documented, and for 2 other claims, a weekly progress note for partial hospitalization services was not documented.

## **FACE-TO-FACE REQUIREMENTS NOT MET**

For partial hospitalization services, a face-to-face individual encounter with a psychiatrist or advanced practice nurse must take place at least once a month (NJAC 10:52a-4.3(b)1i). For acute partial hospitalization services, a face-to-face individual encounter of at least 15 minutes with a psychiatrist or advanced practice nurse must take place at a minimum of every other week (NJAC 10:52a-4.3(a)1i). Medicaid reimbursement is available only for services that are supported by sufficient documentation to assure that all applicable Federal requirements were met (the Manual § 2497.1).

For 7 of the 100 claims in our sample, providers did not meet minimum requirements for a face-to-face meeting with a psychiatrist or advanced practice nurse. Specifically, for 4 partial hospitalization services claims, the provider did not document a face-to-face encounter with a psychiatrist or advanced practice nurse within 1 month of the sample date. For two acute partial hospitalization services claims, the provider did not document an encounter of at least 15 minutes, and for one other acute partial hospitalization services claim, the provider did not document a face-to-face encounter within 2 weeks of our sampled date.

## **REFERRAL AND CERTIFICATION REQUIREMENTS NOT DOCUMENTED**

A beneficiary must have a certification from the beneficiary's interdisciplinary team (i.e., medical team) justifying the need for partial hospitalization services in order to be eligible for these services (NJAC 10:52a-3.2(d)). For acute partial hospitalization services, a beneficiary must have a record of a referral or justification of need for services and a certification from the referring treatment team supporting the referral (NJAC 10:52a-3.1(d)). Medicaid reimbursement is available only for services that are supported by sufficient documentation to assure that the expenditure was made on behalf of an eligible recipient for covered services rendered by a certified provider (the Manual § 2497.1).

For 3 of the 100 claims in our sample, an applicable referral or certification was not documented in the associated beneficiary's client file. Specifically, one acute partial hospitalization services claim did not have either a referral or certification, one acute partial hospitalization services

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<sup>22</sup> The Manual § 4221(D), N.J. Rev. Stat. § 30:4D-12(d), and NJAC 10:52a-4.11.

claim did not have a referral, and one partial hospitalization services claim did not have a certification.

## **ADULT SERVICES PAID AT THE CHILDREN'S SERVICES RATE**

Adult partial hospitalization services are provided to beneficiaries age 18 or older (NJAC 10:52-2.10(d)). Similar services provided to beneficiaries under age 18 are considered children's services and are reimbursed at a higher rate.<sup>23</sup> However, the children's services rate may be continued for certain beneficiaries who received services before age 18.

For 1 of the 100 claims in our sample, a provider was paid the children's services rate for services provided to a 20-year-old beneficiary who did not receive partial hospitalization services as a child.<sup>24</sup>

## **INEFFECTIVE STATE AGENCY OVERSIGHT**

The deficiencies occurred because the State agency did not (1) work with DOH to ensure that partial hospitalization services are provided by appropriately licensed hospitals, (2) adequately monitor the partial hospitalization program to ensure that providers complied with Federal and State requirements, and (3) have adequate controls to ensure that services were paid at the proper payment rate.

DOH officials stated that DOH does not license partial hospitalization facilities or programs. Further, the State agency's reviews of the providers included in our sample did not adequately test certain requirements for compliance, such as staffing ratios; whether services provided were included in the specific therapies and activities identified in the beneficiary's plan of care; and whether progress notes were maintained.

## **RECOMMENDATIONS**

We recommend that the State agency:

- refund \$30,744,840 to the Federal Government,
- work with the State's DOH to ensure partial hospitalization services are provided by appropriately licensed hospitals,
- issue guidance to providers on Federal and State requirements for claiming Medicaid reimbursement for partial hospitalization services,

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<sup>23</sup> The adult rate for partial hospitalization services is \$35 per unit, and the children's rate for partial hospitalization services is \$73 (NJAC 10:52-4.3b(8)i2 and (9i)).

<sup>24</sup> Such reimbursement would be allowable through age 21 if the beneficiary had received Medicaid services through the New Jersey Department of Children and Families (DCF) before turning age 18 (NJAC 10:52-2.10(e)). However, that was not the case with this claim. We disallowed only the difference between the adult and children's rates.



- improve its monitoring of partial hospitalization services providers to ensure compliance with Federal and State requirements,
- review and revise payment controls to ensure the correct rates are paid for partial hospitalization services, and
- work with CMS to identify claims outside of our audit period that were paid at an incorrect rate or for services that were not provided by a facility licensed as a hospital.

### **STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments, the State agency disagreed with the first recommendation in our draft report and did not indicate concurrence or nonconcurrence with our remaining recommendations. However, the State agency indicated that it will continue to work with its Federal partners and hospitals to ensure that its partial hospitalization services program complies with State and Federal law and policy.

The State agency stated that, under its Medicaid program, partial hospitalization services are not hospital services. It also contended that partial hospitalization services for 13 claims associated with 4 providers were allowable because the services were delivered in hospitals licensed by DOH. The State agency also asserted that we incorrectly applied State law governing the 24-month limit on reimbursement. Further, the State agency contended that noncompliance with State law is not appropriate grounds for a financial disallowance. Specifically, the State agency argued that OMB Circular A-87: (1) does not apply to payments to private Medicaid providers, (2) no longer requires compliance with State law, and (3) does not apply when State law does not authorize recoupment of payments. The State agency also asserted that we failed to provide sufficient information for it to respond to our finding of claims “not documented or supported” and that we erred in reviewing certain claim files. The State agency further stated that, during our review of sample claims, we misinterpreted documents and overlooked relevant documents. Finally, under separate cover, the State agency provided 154 pages of documentation related to 9 progress note errors and 2 face-to-face evaluation errors.

After reviewing the State agency’s comments and documentation, we determined that a conflict existed between State agency and DOH officials regarding the licensure of four facilities that provided partial hospitalization services. Based on the State agency’s comments and further review of DOH information, we revised our finding for the 13 claims associated with these providers. In addition, we combined the second and third recommendations in our draft report<sup>25</sup> into a single recommendation that the State agency work with DOH to ensure that partial hospitalization services are provided by appropriately licensed hospitals. We also accepted additional documentation provided for one other claim; however, none of our revisions to our sample claim determinations impacted our overall errors, as all of the claims had multiple deficiencies. We maintain that our remaining findings and recommendations are valid. Finally,

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<sup>25</sup> We recommended in our draft report that the State agency “work with the State’s DOH to develop hospital licensure standards for partial hospitalization services” and “ensure that partial hospitalization services are provided by a facility licensed as a hospital.”

we note that we provided the State agency with all of the information it requested in August 2016 within 1 week and 60 days of additional time to comment on the draft report. The State agency's comments are included in their entirety as Appendix E.

## **LICENSING REQUIREMENTS FOR PARTIAL HOSPITALIZATION SERVICES**

### **State Agency Comments**

The State agency asserted that State law rather than Federal regulations defines partial hospitalization services and that, in New Jersey, partial hospitalization services are separate and different from outpatient hospital services. Specifically, the State agency stated that partial hospitalization services fall under the “partial care authority” provided in the rehabilitation services and clinic services sections of the Medicaid State plan—not the outpatient hospital services section. The State agency further stated that State law allows a partial hospitalization program site to be licensed by either the Commissioner of the State agency as a mental health program or the Commissioner of DOH as a health care facility. The State agency also contended that partial hospitalization services for 13 claims associated with 4 providers were delivered in hospitals licensed by DOH and were not additionally required to be specifically listed as an authorized service.

### **Office of Inspector General Response**

Despite its assertion that partial hospitalization services are separate and different from outpatient hospital services, the State agency claimed all of its partial hospitalization services as outpatient hospital services on its Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS-64). To receive Federal reimbursement for those services, they must have been provided in accordance with Federal requirements governing outpatient hospital services. As explained in the report, Federal regulations require outpatient hospital services to be provided by an institution licensed or formally approved *as a hospital* by the State's authority for setting standards (42 CFR § 440.20) (emphasis added). Therefore, the services were required to be provided in locations licensed as a hospital to be eligible for Federal reimbursement.

We further note that, contrary to the State agency's assertion, partial hospitalization services are not included under the partial care authority provided in the rehabilitation services and clinic services sections of the Medicaid State plan. The Medicaid State plan does not explicitly provide for partial hospitalization services. However, in a section regarding outpatient mental health services, the Medicaid State plan references NJAC 10:52-4.3, which sets forth the payment provisions for outpatient hospital services, including partial hospitalization services (NJAC 10:52-4.3(b)(8)(i)).<sup>26</sup> Accordingly, the State agency should work with DOH to ensure that licensure requirements, as well as any other State requirements for providing Medicaid-covered partial hospitalization services, promote high quality care and support efficiency and integrity in service delivery.

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<sup>26</sup> Thus, the State Medicaid plan and State regulations incorporate partial hospitalization services within outpatient hospital services. Therefore, we considered all partial hospitalization services not provided by a licensed hospital to be unallowable.

Regarding the State agency's contention that 13 sample claims associated with 4 hospitals were provided in an appropriately licensed hospital, we acknowledge that a conflict exists between DOH and State agency officials regarding the licensure of partial hospitalization services. Based on the State agency's comments and further review of DOH information, we revised our finding for the 13 claims associated with these providers. To address this conflict, we combined the second and third recommendations in our draft report into a single recommendation that the State agency work with DOH to ensure that partial hospitalization services are provided by appropriately licensed hospitals.

## **24-MONTH LIMIT ON PARTIAL HOSPITAL REIMBURSEMENT**

### **State Agency Comments**

According to the State agency, we incorrectly applied State law governing the 24-month limit on partial hospital reimbursement because the limit is only on continuous partial hospital services; thus, a beneficiary is not prohibited from reentering the program because of a relapse and receiving 2 additional years of services. The State agency stated that none of the 21 claim files established that any of the sampled claims we determined to be errors were delivered to a beneficiary after they had already received 24 months of continuous partial hospital services. The State agency asserted that for five of these sampled claims (numbers 37, 54, 58, 84, and 99), no documentation existed to indicate that services were provided more than 24 months before the sampled service date.

### **Office of Inspector General Response**

We only disallowed claims for which documentation supported that the beneficiary had received partial hospitalization services for more than 24 continuous months before the sampled service date. A State regulation requires that the 24-month limit on partial hospitalization services includes time spent in Acute Partial Hospitalization (APH) and Partial Hospitalization (PH).<sup>27</sup> Regarding the five sampled claims cited by the State agency, we obtained documentation indicating the associated beneficiary was in the PH or APH program for more than 24 continuous months before the sampled service date. Specifically, the beneficiaries either transferred from APH to PH or between different providers' PH programs.

## **NONCOMPLIANCE WITH STATE LAW AS GROUNDS FOR DISALLOWANCE**

### **State Agency Comments**

The State agency stated that private Medicaid providers are not subject to the principles of OMB Circular A-87 because Medicaid providers are not Federal grantees or subgrantees. According to the State agency, OMB eliminated the provision of OMB Circular A-87 regarding compliance with State laws. The State agency stated that OMB did not intend to require grantees to comply with State laws in revised OMB guidance known as the Uniform Guidance (UG).

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<sup>27</sup> NJAC 10:52a-4.4 (b).

## Office of Inspector General Response

The Departmental Appeals Board (DAB) has long upheld CMS disallowances under the Medicaid program based on providers' noncompliance with applicable State regulations based on the provisions of OMB Circular A-87.<sup>28</sup> Further, we note that OMB did not eliminate the provision regarding compliance with State laws. Rather, the provision was moved to another section of the Code of Federal Regulations.

Under 2 CFR § 200.403, 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.<sup>29</sup> OMB has verified that it intended compliance with applicable Federal and State laws to remain as part of the UG.<sup>30</sup> Therefore, compliance with State laws continues to be required under the UG.

## FOLLOW-UP INFORMATION PROVIDED BY OFFICE OF INSPECTOR GENERAL

### State Agency Comments

The State agency stated that we failed to provide sufficient information so that the State agency could respond to the finding that 83 claims were "not documented or supported." The State agency requested we provide additional information for the 83 claims and give the State agency a reasonable period of time to respond before the final audit report is issued.

### Office of Inspector General Response

We provided the State agency with all of the information it requested in August 2016 and 60 days of additional time to comment on the draft report. Specifically, the State agency requested information on some sampled claims in August 2016, nearly 1 month after we issued the draft report. We provided the requested information within 1 week and subsequently granted

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<sup>28</sup> Most recently, the DAB upheld CMS's disallowance of certain claims based on OMB Circular A-87 and the plain language of New York's regulations. Those State regulations had specific documentation requirements that must be met by providers of continuing day treatment services for claims to be reimbursable. See New York State Department of Health, DAB No. 2637 (2015); citing New York Department of Social Services, DAB No. 1112 (1989), and New York State Department of Social Services, DAB No. 1235 (1991).

<sup>29</sup> OMB consolidated various cost principles applicable to different types of entities into the UG, which is located at 2 CFR part 200. The Department of Health and Human Services (HHS) codified the guidance in its regulations at 45 CFR part 75, establishing uniform administrative requirements, cost principles, and audit requirements for HHS awarding agencies and their grantees. The UG has a general effective date of December 26, 2014, and does not apply to the time period covered by this audit (45 CFR § 75.110(a)).

<sup>30</sup> The issue was specifically addressed in guidance for the UG in the form of a frequently asked question: "Section 200.403 does not specify a requirement for compliance with Federal, State, local, tribal, and other laws and regulations. Is this requirement otherwise addressed in the Uniform Guidance?" The response was "Yes. Compliance with applicable laws and regulations is included at Sections 200.303 Internal Controls and 200.404 Reasonable costs." (Frequently Asked Questions, *For the OMB's Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, 2 CFR 200, available at <https://cfo.gov/wp-content/uploads/2015/09/9.9.15-Frequently-Asked-Questions.pdf>. Accessed on September 9, 2016.)

the State agency two 1-month extensions for it to formulate its response to the draft report. The State agency again requested additional information when it sent its comments in October 2016. We provided the requested additional information within 1 week.

## **REVIEW OF CLAIM FILES**

### **State Agency Comments**

The State agency stated that during our review of sample claims, we misinterpreted documents and overlooked relevant documents. Specifically, the State agency asserted that we did not find progress notes for nine claims but that it found and included these notes with its comments. The State agency provided evaluations for two claims we concluded did not have a face-to-face evaluation. Finally, for 41 claims for which we found that group therapy services did not meet minimum staffing requirements, the State agency acknowledged that many files had group therapy attendance logs indicating that more than 10 or 12 individuals were in the session. However, the State agency contended that, because the documents do not indicate staffing ratios, we cannot determine if minimum staffing requirements were violated.

### **Office of Inspector General Response**

While we were onsite at partial hospitalization providers' locations, we reviewed the provider's progress notes. These were the same progress notes that the State agency sent us copies of with its comments on the draft report. Based on that previous review of the documentation, we maintain that the claims did not meet Federal and State requirements. The State agency provided an additional evaluation for one of the face-to-face evaluation errors (sample number 63) that was not given to us during our site visit. After reviewing the evaluation, we removed this error and adjusted our finding accordingly.<sup>31</sup> For many of the 41 claims for which staffing ratios did not meet minimum requirements, the State agency admitted that attendance logs showed that more than 10 or 12 individuals attended the group therapy session on the date in question. For 16 of the 41 claims, the provider could not support that group therapy staffing ratio requirements were met, and the State agency did not provide any documentation to support that ratio requirements were met. For the remaining 25 claims, attendance logs indicated that staffing-to-client ratios did not meet minimum requirements.

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<sup>31</sup> As noted above, the revision did not impact our overall errors, as all of the claims that we revised had multiple deficiencies.

## **APPENDIX A: FEDERAL AND STATE REQUIREMENTS RELATING TO ADULT PARTIAL HOSPITALIZATION SERVICES**

Section 1905(a)(2) of the Social Security Act (the Act) authorizes hospital outpatient services consistent with State law. Federal regulations (42 CFR § 440.20) define hospital outpatient services in relevant part as services that are provided by an institution that is licensed or formally approved as a hospital by the State's authority for setting standards. In New Jersey, the Health Care Facilities Planning Act (N.J. Stat. Ann. § 26:2H) establishes the Department of Health as the authority responsible for licensing hospitals.

CMS's Manual § 4221 establishes guidelines for outpatient programs of psychiatric treatment, including hospital outpatient services. The Manual states that the following guidelines help ensure appropriate use of outpatient psychiatric programs:

- The provider should perform an intake assessment for each beneficiary being considered for entry.
- The provider should develop an individualized plan of care that describes the treatment regimen and the projected schedule for service delivery, including the frequency and duration of each type of planned session or encounter.
- The provider should prepare written documentation that supports each medical or remedial therapy, service, activity, or session that is billed. At a minimum, the documentation should include (1) the specific service, (2) the date and actual time the service is provided, (3) who provided the service, (4) the setting in which the service was provided, (5) the amount of time it took to deliver the service, (6) the relationship of the service to the treatment regimen described in the plan of care, and (7) updates describing the patient's progress. For services that are not specifically in the beneficiary's treatment regimen, the provider should prepare a detailed explanation of how the services being billed relate to the treatment regimen and objectives in the beneficiary's plan of care.

The regulation at 2 CFR part 225 (OMB Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*) establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. That regulation also provides that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations (App. A, C.1.c). OMB Circular No. A-87 was relocated to 2 CFR part 225 and made applicable by 45 CFR § 92.22(b). On December 26, 2013, OMB consolidated and streamlined its guidance, which is now located at 2 CFR part 200. HHS has codified the guidance in regulations found at 45 CFR part 75, which became effective on December 26, 2014.

Section 1902(a)(27) of the Act and Federal regulations (42 CFR § 431.107) require States to ensure providers keep medical records necessary to fully disclose the extent of services provided to beneficiaries. New Jersey law (N.J. Rev. Stat. § 30:4D-12(d)) and regulations (NJAC 10:49-9.8) require providers to maintain individual records necessary to fully disclose the nature and extent of services provided. New Jersey law (N.J. Rev. Stat. § 30:4D-12(d)) also requires providers to maintain any other information that the State agency may require by regulations.

New Jersey law (P.L. 2008 c.35) and regulations (NJAC 10:52a-4.4(b) limit billing of the partial hospitalization rate to 24 months, after which the lower partial care rate must be billed. NJAC 10:52-4.3(b)(8) establishes the acute partial hospitalization services rate as \$65 per unit (hour) and the partial hospitalization services rate as \$35 per unit (hour). NJAC 10:66-6.3(f) establishes the partial care services rate as \$15.40 per unit (hour).

State agency regulations require providers to maintain specified documentation to ensure appropriate use of partial hospitalization services. NJAC 10:52-1.17 states that providers must prepare an intake assessment and an individualized plan of care. The plan of care must include the treatment regimen—the specific medical and remedial services, therapies, and activities and the projected schedule for service delivery, including the frequency and duration of each type of planned session or encounter. The provider also must prepare documentation that supports each service, including at a minimum: (1) the specific service, (2) the date and actual time the service is provided, (3) who provided the service, (4) the setting in which the service was provided, (5) the amount of time it took to deliver the service, and (6) significant deviations from the treatment described in the plan of care.

NJAC 10:52-2.10a (c)-(e) and (g) and NJAC 10:52a-4.3(b)4 define prevocational services as interventions, strategies, and activities that assist individuals to acquire general work behaviors, attitudes, and skills needed to take on the role of worker and in other life domains. Prevocational services include therapeutic subcontract work activity, which consists of paid tasks performed within sight of a qualified mental health services worker. Services or interventions that are not considered prevocational are technical or occupational skills training, college preparation, student education, and individualized job development.

For acute partial hospitalization services, NJAC 10:52a-3.1(d) requires a referral or justification of need for services by the local designated screening center, a psychiatric emergency service, or an inpatient psychiatric facility if the treating psychiatrist or advanced practice nurse clearly justifies an acute clinical need. Additionally, the referring treatment team must prepare a certification containing the clinical evidence necessary to support the referral.

For partial hospitalization services, NJAC 10:52a-3.2(d) requires a certification from the interdisciplinary team containing the clinical evidence to support the necessity of services.

NJAC 10:52a-4.3(a)2i establishes a maximum staff-to-client ratio in acute partial hospital therapy groups of 1:10.

NJAC 10:52a-4.3(b)9 establishes a maximum staff-to-client ratio in partial hospital therapy groups of 1:10 (before March 5, 2012) or 1:12 (on or after March 5, 2012).

NJAC 10:52a-4.3(a)1i requires for acute partial hospitalization services a face-to-face, individual encounter with a psychiatrist or an advanced practice nurse at least every other week for at least 15 minutes. NJAC 10:52a-4.3(b)1i requires for partial hospitalization services a face-to-face, individual encounter with a psychiatrist or an advanced practice nurse at least once a month.

NJAC 10:52a-4.4(b)1 requires for partial hospitalization services that beneficiaries receive no less than 2 hours of services per day and no more than 5 hours of services per day.

NJAC 10:52a-4.11 requires providers to document (1) a summary of the beneficiary's participation and clinical progress, (2) a description of any significant events that may have an effect on the beneficiary's goals and objectives, and (3) treatment plan revisions that are based on the beneficiary's response to treatment plan interventions. Each of these progress note entries shall be legible, signed and dated, and include staff title and credentials. For acute partial hospitalization services, daily progress notes are required; for partial hospitalization services, weekly progress notes are required. In addition, for each group therapy session the group facilitator must maintain a record of participation.

NJAC 10:52-2.10(e) establishes that beneficiaries who had been receiving services from the Department of Children and Families (DCF) before their 18th birthday can continue services under the supervision of DCF until their 21st birthday if they meet certain criteria. NJAC 10:52-2.10(d) defines adult acute partial hospitalization and partial hospitalization services as services provided to beneficiaries 18 years of age or older with no DCF involvement before their 18th birthday.



## **APPENDIX B: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

Our review covered 418,788 adult partial hospitalization claim lines, totaling \$66,871,674 (\$33,773,409 Federal share), submitted by 34 adult partial hospitalization services providers in New Jersey during CYs 2010 through 2013. (In this report, we refer to these lines as claims.)

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System (MMIS) file for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims data in the MMIS to the State's claim for reimbursement on the CMS-64.

During our audit, we did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at the State agency's offices in Trenton, New Jersey, and at partial hospitalization services providers throughout New Jersey from May through July 2015.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with State agency officials to gain an understanding of the State's partial hospitalization program;
- obtained an electronic file that contained 523,085 Medicaid partial hospitalization claims submitted by 34 providers in New Jersey during our audit period from the State agency's MMIS;
- reconciled the adult partial hospitalization services claimed for Federal reimbursement by the State agency on the CMS-64 for our audit period with the data obtained from the MMIS file;
- excluded 104,288 claims associated with service dates before July 1, 2009, and 9 claims that had a Medicaid paid amount of less than \$20;
- identified a sampling frame of 418,788 claims, totaling \$66,871,674 (\$33,773,409 Federal share);
- selected a simple random sample of 100 claims from our sampling frame of 418,788 claims, and for each of the 100 claims obtained and reviewed beneficiary clinical records to determine if claims complied with Federal and State requirements;

- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 418,788 claims;
- discussed the licensure of partial hospitalization services providers with officials from the DOH and the State agency; and
- discussed our results with State agency officials.

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 C: STATISTICAL SAMPLING METHODOLOGY**

### **POPULATION**

The population was adult partial hospitalization claims submitted by providers in New Jersey and paid during CYs 2010 through 2013 that the State agency claimed for Federal Medicaid reimbursement.

### **SAMPLING FRAME**

The sampling frame was an Access file containing 418,788 claims for partial hospitalization services submitted by 34 providers in New Jersey and paid during our audit period. The total Medicaid reimbursement for the 418,788 claims was \$66,871,674 (\$33,773,409 Federal share). The Medicaid claims were extracted by our advanced audit techniques staff from the State agency's Medicaid payment files provided to us by staff of the State agency's MMIS fiscal agent.

### **SAMPLE UNIT**

The sample unit was an individual Federal Medicaid claim.

### **SAMPLE DESIGN**

We used a simple random sample.

### **SAMPLE SIZE**

We selected a sample of 100 claims.

### **SOURCE OF RANDOM NUMBERS**

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

### **METHOD FOR SELECTING SAMPLE ITEMS**

We consecutively numbered the sample units in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

### **ESTIMATION METHODOLOGY**

We used the OAS statistical software to analyze the sample results. We estimated the overpayment associated with the unallowable claims at the lower limit of the two-sided 90-percent confidence interval.

**APPENDIX D: SAMPLE RESULTS AND ESTIMATES**

**Table 2: Sample Details and Results**

<b>Claims in Frame</b>	<b>Value of Frame (Federal Share)</b>	<b>Sample Size</b>	<b>Value of Sample (Federal Share)</b>	<b>Number of Unallowable Claims</b>	<b>Value of Unallowable Claims (Federal Share)</b>
418,788	\$33,773,409	100	\$7,994	100	\$7,976

**Table 3: Estimated Unallowable Costs (Federal Share)<sup>32</sup>**  
*(Limits Calculated for a 90-Percent Confidence Interval)*

Point estimate	\$33,404,541
Lower limit	\$30,744,840
Upper limit	\$33,773,409

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<sup>32</sup>The upper limit of the confidence interval was set at the total Federal share of the sampling frame.

## APPENDIX E: STATE AGENCY COMMENTS



CHRIS CHRISTIE  
Governor

KIM GUADAGNO  
Lt. Governor

**State of New Jersey**  
DEPARTMENT OF HUMAN SERVICES  
PO Box 700  
TRENTON NJ 08625-0700

October 12, 2016

ELIZABETH CONNOLLY  
Acting Commissioner

James P. Edert  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office on Inspector General  
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-02-14-01015*

Dear Mr. Edert:

The New Jersey Department of Human Services (DHS/The State) is in receipt of the Office of Inspector General's ("OIG") draft audit report, *New Jersey Claimed Medicaid Reimbursement for Adult Partial Hospitalization Services That Did Not Comply With Federal and State Requirements, A-02-14-01015* ("Draft Audit Report"). Staff has reviewed the findings and recommendation, and herein, provides its formal response.

The Department disagrees with the recommendation that it refund \$30,829,752 to the federal government.

### **1. The \$30.8 Million Disallowance Recommendation is Unfounded.**

The Draft Audit Report recommended disallowing almost the entirety of the federal reimbursement the State claimed for partial hospital services during the four year audit period (2010 through 2013).

The auditors' findings do not support a \$30.8 million disallowance.

#### **a. The OIG's Auditors Misinterpreted the State's Partial Hospital Services and the Licensing Requirements Applicable to Those Services.**

The auditors found that all 100 claims in the sample were provided at locations that were not properly licensed under state and federal law.

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Federal regulations do not define a “partial hospitalization” service; it is a service defined and governed by State law. State staff explained to the auditors that in New Jersey “partial hospital services” are not required to be provided in a hospital. It is a term of art that represents an alternative to inpatient hospital services. There are two types of providers enrolled in the State’s partial hospital services program: hospitals that provide the services on-site (i.e., on the campus of a licensed hospital), and hospitals that provide the services off- site (i.e., at a location not on the campus hospital).

State law defines partial hospitalization separately and differently from outpatient hospital services and (unlike outpatient hospital) without reference to location. Section 10:52-1.2 of the N.J. Admin. Code separately defines “outpatient hospital services” and “partial hospital” as follows:

“Outpatient hospital services” means medically necessary items or services (preventive, diagnostic, rehabilitative, therapeutic, or palliative) provided to an outpatient by or under the direction of a physician or dentist, except for the medical supervision of nurse midwife services; and/or by a psychiatric hospital or an excluded unit of a general hospital and the institution is licensed or formally approved as a hospital by the New Jersey State Department of Health and Senior Services, or certified by the officially designated authority in the state in which the hospital is located; meets the requirements for participation in Medicare (Title XVIII) as a hospital; and meets the criteria for participation as stated in N.J.A.C. 10:52-1.3. . . .

“Partial hospital” or “PH” means an individualized, outcome-oriented psychiatric service which provides a comprehensive, structured, non-residential, interdisciplinary treatment and psychiatric rehabilitation program to assist beneficiaries who have a serious mental illness in increasing or maximizing independence and community living skills and enhancing the quality of their lives.

Partial hospital services are not described in the state plan provisions governing outpatient hospital services. Rather, partial hospital services fall under the partial care authority provided in the rehabilitation services and the clinic services sections of the state plan.

State law also makes clear that a partial hospitalization program site can “*either* be licensed by the Commissioner of the Department of Human Services as a mental health program . . . *or* be licensed by the Commissioner of the Department of Health . . . as a health care facility.” N.J.A.C. 10:52A-2.1 (“Authority to provide services”) (emphasis added). Accordingly, some partial hospitalization programs operate under a partial care license issued by DHS and some operate under a hospital’s outpatient license.

Disregarding staff input and State law, the Draft Audit Report incorrectly suggests that all partial hospitalization programs were to be provided in a setting that was licensed as a hospital, and concluded that not a single entity sampled had a proper license to provide partial hospital services under state law.

The auditors rejected 87 sample claims that were provided at 21 partial-care-licensed off-site locations that they believed were “not licensed as hospitals” by the State. The auditors acknowledge that all 21 of these providers had a partial care license, and thus all 87 of the sample claims made by the 21 providers were delivered in compliance with state licensure law. Federal law require that partial hospital services be provided in a licensed hospital. The auditors believed that partial hospital services were subject to federal regulations governing outpatient hospital services at 42 C.F.R. § 440.20 and 42 C.F.R. Part 482, including the requirement that outpatient hospital services must be delivered at a facility licensed as a hospital by the State. But, again, partial hospital services are not outpatient hospital services under federal law, and they are not listed under the state plan as such.

In addition, the auditors rejected 13 sample claims associated with four hospitals delivering services within a licensed hospital because the hospital only had a general outpatient license that did not specify authorization to provide partial care services. However, in New Jersey, a partial hospital service can be provided at any site that is appropriately licensed as a hospital under state law, because a hospital license is issued “by the Commissioner of the Department of Health and Senior Services as a health care facility.” N.J. Admin. Code § 10:52A-2.1. State law does *not* require that the hospital specifically list partial hospital services as an authorized ambulatory service.<sup>1</sup>

**b. The OIG’s Auditors Incorrectly Applied State Law Governing the 24-Month Limit on Partial Hospital Reimbursement.**

Citing page 125 of Chapter 35 of 2008 N.J. Public Law and N.J. Admin. Code § 10:52A-4.4, the Draft Audit Report contends that partial hospital services are limited to 24 months for each beneficiary, after which the hospital must claim at the lower partial care services rate. The auditors rejected 21 claims in part because the beneficiary had received partial hospital services for more than two years prior to the date of the sampled claim.

New Jersey’s 24-month cap on partial hospital reimbursement is a cap only on *continuous* partial hospital services. For example, if a beneficiary receives two years of partial hospital services from 2009-2011, that beneficiary is not prohibited from re-entering the program in 2016 (if he or she re-lapses) and receiving an additional two years of continuous services, reimbursed at the partial hospital services rate.

While many of the 21 claims rejected by the auditors were delivered to people who at some point in the past (more than 24 months before the sample date) had received partial hospital services, the claim files do not establish (and the Draft Audit Report does not allege) that any of the 21

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<sup>1</sup> The State also disagrees with the recommendations that the State “develop hospital licensure standards for partial hospitalization services.” The State has standards at 10:52A-2.1. In any case, policy decisions about licensure are within the State’s discretion.

sampled claims were delivered to a client after he or she had already received 24 months of *continuous* partial hospital services. The findings with respect to these 21 claims should therefore be reversed.

In addition, the auditors rejected several sample claims for which there was no evidence in the claim file that the individuals had in fact received such services for more than 24 months prior to the sample claim date. Specifically:

- o Sample 37 (C.G.): sample claim date of April 2012; no documentation in the claim file indicating that the client received services before 2011.
- o Sample 54 (G.F.): sample claim date of May 2010; no documentation in the claim file indicating that the client received services before 2009.
- o Sample 58 (B.M.): sample claim date of February 2013; no documentation in the claim file indicating that the client received services before 2013.
- o Sample 84 (C.W.): sample claim date of March 2010; no documentation in the claim file indicating that the client received services before June 2008.
- o Sample 99 (N.Q.): sample claim date of April 2012; no documentation in the claim file indicating the client received services before 2012.

The OIG cannot provide the State with any documentation indicating that these individuals received partial hospital services for more than 24 continuous months prior to the sample claim date.

Further, the Draft Audit Report acknowledges, these 21 claims are at least eligible for the lower partial care services rate. See OIG, Draft Audit Report, at 6 & n.21 (citing 2008 N.J. Public Law, ch. 35). Accordingly, at the least, the amount of the disallowance based on these 21 claims should be decreased to reflect the difference between the partial care rate and the partial hospital rate.

**c. Noncompliance with State Law is Not an Appropriate Grounds for a Disallowance.**

Much of the noncompliance alleged in the Draft Audit Report relates to *state*, not federal, requirements. Federal law does not provide a basis upon which CMS can recoup for noncompliance with these types of state law requirements.

In support of its position, the Draft Audit Report cites Office of Management and Budget (“OMB”) Circular A-87, which states: “To be allowable under Federal awards, costs must . . . [b]e authorized or not prohibited under State or local laws or regulations.” 2 C.F.R. Pt. 225, App’x A, C.1.c (2013). OMB Circular A-87 governs the administrative costs incurred by state and local government grantees. See 2 C.F.R. § 225.5 (explaining that Part 2 “establishes principles and standards for determining costs for Federal awards carried out through grants, cost reimbursement contracts, and other agreements with State and local governments and federally-recognized Indian tribal governments”).<sup>2</sup>

<sup>2</sup> See also 2 C.F.R. § 225.20 (“This part establishes principles and standards to provide a uniform approach for determining costs and to promote effective program delivery, efficiency, and better



OMB A-87 was never intended to apply to private Medicaid providers, who are not federal grantees or sub-grantees. As such, it does not authorize the federal government to take a disallowance based on a private provider's noncompliance with OMB A-87's terms.

Even if OMB A-87 applies to providers, it does not authorize a disallowance based on the state law provisions upon which the auditors rely. Under the plain language of OMB A-87, the federal government's ability to recoup based on state law turns on whether the state law "authorizes" the costs to be reimbursed. For this report, the auditors relied on several different New Jersey statutory and regulatory provisions, including: N.J. Stat. Ann. § 30:4D-12 (record retention); N.J. Admin. Code § 10:52-1.17 (record retention); N.J. Admin. Code § 10:49-9.8 (provider certification and recordkeeping); N.J. Admin. Code § 10:52A-4.11 (documentation requirements specific to partial hospital); N.J. Admin. Code § 10:52A-4.3. State law does not necessarily prohibit reimbursement for the costs of claims that are noncompliant with these provisions,<sup>3</sup> and thus recoupment based on OMB A-87 is unwarranted and inappropriate.<sup>4</sup>

The provision of OMB A-87 relied on by the auditors was eliminated by the OMB in its most recent re-codification of its cost principles. *See* 78 Fed. Reg. 78,590 (Dec. 26, 2013). This makes clear that the OMB has concluded that the federal government does not have an interest in enforcing compliance with state laws. This decision makes sense in light of the problematic policy implications of federal enforcement of state law. For example, penalizing a State for failing to comply with or enforce its own rules discourages States from establishing robust regulatory regimes to help ensure that high-quality health care is safely delivered to Medicaid beneficiaries. Since OMB itself has decided to repeal the relevant provision of the circular, the OIG should not be recommending a disallowance based on noncompliance with that provision.

This conclusion that federal law does not require the State to prove compliance with state law is further supported by Section 2497 of State Medicaid Manual ("SMM"), which outlines documentation requirements for States claiming federal financial participation. Section 2497 expressly limits State's documentation (and document retention) obligations "to assur[ing] that all applicable *Federal* requirements have been met." SMM § 2497.1 (emphasis added).

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relationships between governmental units and the Federal Government. The principles are for determining allowable costs only."); Pt. 225, App'x A, A.1 ("[OMB A-87] establishes principles for determining the allowable costs incurred by State, local, and federally-recognized Indian tribal governments (governmental units) under grants, cost reimbursement contracts, and other agreements with the Federal Government.").

<sup>3</sup> N.J. Admin. Code § 10:49-5.5(a)(13) (explaining the circumstances under which services not properly documents will still be paid for by New Jersey Medicaid).

<sup>4</sup> *Cf. N.Y. State Dep't of Soc. Serv.*, DAB No. 1235 (1991) (explaining that a disallowance was warranted because the State did not explain "circumstances or conditions pursuant to which the [State] would have excused an overpayment sanction"); *N.Y. State Dep't of Soc. Serv.*, DAB No. 1112 (1989) (concluding that payments were not authorized under state law under OMB A-87 because the state regulation at issue (1) did not grant New York discretion to pay for noncompliant services and (2) had served as the basis for the New York's own provider-specific disallowances).

**d. The OIG's Auditors Failed to Provide Sufficient Information for the State to Respond to Their Finding That 83 Sample Claims Were "Not Documented or Supported."**

The auditors rejected 83 of the 100 sample claims on the ground that the services were "not documented and supported." The auditors used "services not documented or supported" as an umbrella term to describe six different types of alleged deficiencies: (1) services did not include the specific therapies or activities in the plan of care; (2) "required elements," such as a practitioner's signature on a form, were missing from the documentation; (3) excess units of service were billed; (4) prevocational documentation requirements were not met; (5) lack of documentation of the services; and (6) documentation did not support the two-hour minimum for billing.

The auditors did not specify, either in the Draft Audit Report or in other communication with the State, which of the 83 claims fall into each of the six categories of deficiency. Therefore, it is impossible for the State to review and analyze the accuracy of the auditors' findings. The State requests that the OIG provide the State with a spreadsheet identifying which of these 83 sample claims fall into which category of alleged deficiency and give the State a reasonable period of time to respond to these findings *before* the Draft Audit Report is finalized.

**e. The OIG's Auditors Erred in Reviewing Dozens of Claim Files.**

The auditors misinterpreted documents and missed relevant documents while conducting their review. Specifically:

- The auditors rejected the following claims because they did not find progress notes in the claim files: Sample 12 (R.W.); Sample 19 (P.R.); Sample 30 (R.W.); Sample 67 (J.W.); Sample 71 (L.S.); Sample 72 (L.S.); Sample 82 (R.C.); Sample 86 (J.B.); and Sample 94 (S.K.). In reviewing these claim files, the State located the progress notes for these sample claims. *See App'x, Exh. 1.*
- For two claims, the auditors concluded that the client did not have a face-to-face evaluation with a psychiatrist or an advance practice nurse ("APN") within a month of the services, even though the claim files included a face-to-face evaluation. Sample 63 (P.C.) was dated May 7, 2012, and the client had a face-to-face evaluation with an APN on May 2, 2012 and then again on May 18, 2012. *See App'x, Exh. 2.* Sample 30 (R.W.) was dated September 9, 2009, and the client had an initial evaluation with a psychiatrist on August 17, 2009. *See App'x, Exh. 3.*
- The auditors rejected dozens of sample claims because they concluded that the group therapy sessions did not meet the State's staffing ratio requirements (1:10 or 1:12, depending on the date and type of group therapy). Many of these claim files have group therapy attendance logs, signed by a group facilitator, that show that more than 10 or 12 individuals attended the group therapy session on the date in question. These make no reference to staffing ratios, so auditors cannot contend that they were violated. As such, these findings should be reversed in the final audit report. Specifically, the claim files for

the following sample claims do not establish that the 1:10 and 1:12 staffing ratios were violated: 1 (D.P.); 11 (C.S.); 4 (R.S.); 14 (J.D.); 15 (A.D.); 16 (C.L.); 19 (P.R.); 23 (D.S.); 24 (R.H.); 26 (R.D.); 28 (W.S.); 37 (C.G.); 38 (R.S.); 40 (T.S.); 43 (V.T.); 46 (G.C.); 47 (R.B.); 48 (M.O.); 49 (C.V.); 51 (T.G.); 52 (R.J.); 55 (R.A.); 57 (L.B.); 58 (B.M.); 62 (G.W.); 63 (P.C.); 64 (P.P.); 66 (A.B.); 68 (R.S.); 69 (C.C.); 70 (M.R.); 71 (L.S.); 72 (L.S.); 78 (J.L.); 79 (J.G.); 82 (R.C.); 92 (J.B.); 93 (M.M.); 95 (J.S.); 99 (N.Q.); 100 (S.T.).

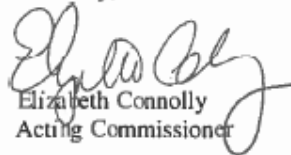
**2. The State Will Continue to Work to Ensure that Partial Hospital Services Comply with State and Federal Law and Policy.**

The Draft Audit Report recommended that the State “ensure that partial hospital services are provided by a facility licensed as a hospital”; “issue guidance to providers on Federal and State requirements for claiming Medicaid”; “improve its monitoring of partial hospital services”; “review and revise payment controls to ensure the correct rates are paid for partial hospital services”; and “work with CMS to identify claims outside of our audit period that were paid at an incorrect rate or for services that were not provided by a facility licensed as a hospital.”

The State will continue to work with both its federal partners and hospitals to ensure that its partial hospital services program complies with state and federal law and policy.

If you have any questions, please do not hesitate to contact me or Richard Hurd at 609-588-2550.

Sincerely,

  
Elizabeth Connolly  
Acting Commissioner

EC:02