

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MORE THAN ONE-THIRD OF
NEW JERSEY'S FEDERAL MEDICAID
REIMBURSEMENT FOR PROVIDING
COMMUNITY-BASED TREATMENT
SERVICES WAS UNALLOWABLE**

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Office of Inspector General

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Report in Brief

Date: January 2020

Report No. A-02-17-01020

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



Why OIG Did This Audit

Prior OIG audits of New Jersey's Medicaid mental health services identified a significant number of improper claims. On the basis of these audits, we initiated an audit of similar mental health services provided under New Jersey's Programs of Assertive Community Treatment (PACT).

Under its PACT program, New Jersey offers community-based, intensive, comprehensive, integrated mental health rehabilitation services through a multidisciplinary team of professionals (known as a PACT team) to Medicaid beneficiaries with serious and persistent mental illness.

Our objective was to determine whether New Jersey's claims for Federal Medicaid reimbursement of payments for PACT services complied with Federal and State requirements.

How OIG Did This Audit

Our audit covered \$69.3 million (\$36 million Federal share) in claims paid during 2013 through 2016. We reviewed a random sample of 100 claims for monthly PACT services to determine whether they complied with Federal and State requirements.

More Than One-Third of New Jersey's Federal Medicaid Reimbursement for Providing Community-Based Treatment Services Was Unallowable

What OIG Found

Of New Jersey's 100 sampled claims for Federal Medicaid reimbursement of payments for PACT services, 50 complied with Federal and State requirements, but 50 did not. Of the 100 claims, 21 contained more than 1 deficiency. We found PACT program services provided were not adequately supported or documented (36 claims), plan of care requirements were not met (17 claims), PACT teams did not include staff from required clinical disciplines (8 claims), and providers did not obtain prior authorization for beneficiaries (5 claims), among other findings. We also identified potential quality-of-care issues related to PACT services. Specifically, PACT team psychiatrists associated with 33 of our sample claims did not provide the minimum amount of face-to-face psychiatric time required for their caseload. Also, despite defining the PACT program as rehabilitative, New Jersey did not require periodic reauthorizations or reevaluations of beneficiaries' program eligibility.

The deficiencies occurred because New Jersey did not inform PACT providers of all Federal and State requirements for providing PACT services and did not adequately monitor or have procedures in place to ensure that providers claimed PACT services in accordance with these requirements.

On the basis of our sample results, we estimated that New Jersey improperly claimed at least \$14.9 million in Federal Medicaid reimbursement.

What OIG Recommends and New Jersey Comments

We recommend that New Jersey (1) refund \$14.9 million to the Federal Government, (2) reinforce program guidance to PACT providers, (3) improve its monitoring of the PACT program, and (4) consider developing regulations for periodic reassessments to determine whether beneficiaries continue to require PACT services.

New Jersey generally disagreed with our findings and assessment of the causes of the deficiencies. Specifically, New Jersey disagreed with our first and final recommendations, agreed with our second recommendation, partially agreed with our third recommendation, and described steps it had taken or will take to implement our second and third recommendations. After reviewing New Jersey's comments and additional documentation, we revised our findings and recommendations accordingly. We maintain that our findings and recommendations, as revised, are valid.

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INTRODUCTION

WHY WE DID THIS AUDIT

Prior Office of Inspector General (OIG) audits of Medicaid mental health services in New Jersey identified a significant number of claims improperly submitted for Federal Medicaid reimbursement.¹ On the basis of these audits, we initiated an audit of similar mental health services provided under New Jersey's Programs of Assertive Community Treatment (PACT).

OBJECTIVE

Our objective was to determine whether the New Jersey Department of Human Services' (State agency) claims for Federal Medicaid reimbursement of payments for PACT 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 requirements.

New Jersey's Medicaid Programs of Assertive Community Treatment

In New Jersey, the State agency administers the Medicaid program. Under PACT, the State agency offers to Medicaid beneficiaries with serious and persistent mental illness community-based, intensive, comprehensive, integrated mental health rehabilitation services² through a multidisciplinary team of professionals. The "PACT team" merges clinical and rehabilitative expertise to provide mental health treatment, rehabilitation, and support services that are tailored to beneficiaries' needs.

PACT services providers are paid monthly based on a rate per beneficiary served.³ On an annual basis, the State agency reviews documentation from PACT services providers for

¹ Appendix B contains a list of related OIG reports.

² Federal regulations define rehabilitative services as services recommended by a licensed practitioner for maximum reduction of physical or mental disability and restoration of a beneficiary to his or her best possible functional level (42 § 440.130(d)).

³ PACT monthly reimbursement rates during our audit period ranged from \$1,377 to \$1,488 per beneficiary.

compliance with State requirements related to elements such as clinical supervision, face-to-face contacts, comprehensive service planning, and PACT team composition.

Federal and State Requirements

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 225,⁴ App. A, C.1.c).

Claims for Federal Medicaid reimbursement must be supported by adequate documentation to assure that all applicable Federal requirements have been met.⁵ 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 to be reimbursed.⁶ To be enrolled in PACT, Medicaid beneficiaries must receive prior authorization from the State agency. PACT services providers must deliver a range of services based on a beneficiary's need for one or more services indicated in their plan of care. PACT services must be provided by PACT teams composed of a minimum of five separate clinical, therapeutic, and rehabilitative disciplines: psychiatry, nursing, counseling, substance abuse, and mental health rehabilitation or occupational/vocational services. The plan of care is based, in part, on a nursing assessment and must contain the signatures of all participants involved in the development of the plan, including the psychiatrist.⁷ Further, a plan of care must be reviewed and revised every 3 months during the beneficiary's first year in the program and every 6 months thereafter, so long as the beneficiary's mental status is stable and their level of functioning shows continuing improvement.

PACT services providers may not bill a monthly claim unless they meet a minimum service requirement of at least 2 hours of face-to-face contact with or on behalf of the associated beneficiary.⁸ PACT services providers are required to maintain support of all payment claims, including the name and title of the PACT team member who provided services; dates of service; and the duration of face-to-face contact. Providers must also comply with additional requirements specific to beneficiaries residing in State-licensed boarding homes.

⁴ On December 26, 2013, OMB consolidated and streamlined its guidance, which is now located at 2 CFR part 200. The Department of Health and Human Services (HHS) has codified the guidance in regulations found at 45 CFR part 75, which became effective on December 26, 2014.

⁵ CMS *State Medicaid Manual* (SMM) § 2497.

⁶ NJ Revised Statutes (NJ Rev. Stat.) § 30:4D-12.

⁷ New Jersey Administrative Code (NJAC) 10:76-1.4(a) and (d), and NJAC 10:37J-2.6(b)(2).

⁸ Medicaid State plan 4.19-B and NJAC 10:76-2.6.

For further details on Federal and State requirements relating to PACT services, see Appendix C.

HOW WE CONDUCTED THIS AUDIT

During calendar years (CYs) 2013 through 2016,⁹ the State agency claimed Federal Medicaid reimbursement totaling \$69.3 million (\$36 million Federal share) for 49,944 monthly PACT services claims. We reviewed a random sample of 100 of these claims.¹⁰ Specifically, we reviewed documentation to determine whether PACT services were provided in accordance with Federal and State requirements.

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

FINDINGS

Of the 100 sampled State agency claims for Federal Medicaid reimbursement of payments for PACT services, 50 complied with Federal and State requirements, but the remaining 50 did not. Table 1 (following page) summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

⁹ This audit period encompassed the most current data available at the time we initiated our audit.

¹⁰ The sampled claims were associated with 13 providers, which represents all PACT providers in New Jersey during our audit period.

Table 1: Summary of Deficiencies in Sampled Claims

Deficiency	Number of Unallowable Claims^a
Services not adequately supported or documented	36
Plan of care requirements not met	17
Required clinical disciplines not included on PACT team	8
Prior authorization requirements not met	5
No documentation of compliance with boarding home requirements	5
Documentation did not support 2 hours of face-to-face contact	2
No nursing assessment	1

^a The total exceeds 50 because 21 claims contained more than 1 deficiency.

Additionally, we identified potential quality-of-care issues related to PACT services. Specifically, psychiatrists associated with 33 of our sample claims did not provide the minimum amount of face-to-face psychiatric time required for their caseload.¹¹ Finally, despite defining PACT as rehabilitative, the State agency did not require periodic reauthorizations or reevaluations of beneficiaries' program eligibility.

The deficiencies occurred because the State agency did not inform PACT providers of all Federal and State requirements for providing PACT services, and its monitoring procedures were not adequate to identify all instances when providers did not claim PACT services in accordance with these requirements. In fact, the monitoring procedures did not include checking whether some requirements were met. As a result, PACT providers did not follow requirements for providing PACT services.

On the basis of our sample results, we estimated that the State agency improperly claimed at least \$14.9 million¹² in Federal Medicaid reimbursement for PACT services that did not meet Federal and State requirements.¹³

¹¹ The associated claims for this quality-of-care error were not used in calculating the unallowable costs.

¹² Specifically, we estimated that the State agency improperly claimed at least \$14,888,980.

¹³ 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 are designed to be less than the actual overpayment total 95 percent of the time.

SERVICES DID NOT COMPLY WITH FEDERAL AND STATE REQUIREMENTS

Services Not Adequately Supported or Documented

PACT services must be based on an individual's needs for one or more services indicated in their plan of care.¹⁴ PACT services providers may not bill for a monthly claim unless they meet a minimum service requirement of at least 2 hours of face-to-face contact with or on behalf of the associated beneficiary.¹⁵ PACT services providers are required to maintain support for all payment claims, including the name and title of the PACT team member who provided services, dates of service, and the duration of face-to-face contact.¹⁶

Providers are also required to maintain progress notes for each individual contact that address the date, time, and location where the service was provided; the duration of the contact; and the name of the PACT team member who provided services. Progress notes must also address the type of visit and the services provided; the beneficiary's condition at the time of contact; interventions and their relationship to the beneficiary's treatment plan goals and objectives; and communication with other service providers, including other health care providers.¹⁷ For 36 claims¹⁸ in our sample, services were not adequately supported or documented. Specifically:

- For 25 claims, services provided during the sampled month were not included in the beneficiary's plan of care, and the provider did not document how these services related to objectives of the beneficiary's treatment regimen and plan of care. (See Figure 1.)

Figure 1: Examples of Services Not Included in Plans of Care

Services not included in beneficiaries' plans of care and not related to treatment regimen:

- Group trips to movies, lunches, museums, etc.
- Socials at local restaurant.
- General transportation.

¹⁴ Medicaid State Plan Addendum to Attachment 3.1-A pg. 13(d).5.

¹⁵ Medicaid State Plan Attachment 4.19-B pg. 24.2.

¹⁶ NJ Rev. Stat. § 30:4D-12(d) and (e); and NJAC 10:76-1.4 (a), (b) and (d).

¹⁷ NJAC 10:37J-2.6(e).

¹⁸ The total number of claims with support or documentation deficiencies exceeds 42 because 19 claims contained more than 1 type of deficiency.

- For 21 claims, the duration of services was not supported. For example, one provider's practice was to record 60 minutes in a beneficiary's progress notes for every face-to-face visit, regardless of the actual time spent with the beneficiary. In one instance, the provider recorded 60 minutes for dropping off medications to the sampled beneficiary.¹⁹
- For 10 claims, required elements for supporting documentation (e.g., time and duration of services) were incomplete.

These deficiencies occurred because providers were not aware of all PACT requirements or did not adhere to the requirements. In addition, the State agency did not have procedures to ensure that providers complied with PACT requirements.

Plan of Care Requirements Not Met

The beneficiary's plan of care must contain the signatures of all participants involved in the development of the plan, including the psychiatrist.²⁰ Further, the plan must be reviewed and revised every 3 months during the beneficiary's first year in PACT. So long as the beneficiary's mental status is stable, and their level of functioning shows continuing improvement, plan revisions may be done at least every 6 months after the first year.

For 17 claims in our sample, plan of care documentation requirements were not met. Specifically, the beneficiary's plan of care was not signed by the beneficiary's psychiatrist (10 claims), was not reviewed and revised within the required period (4 claims),²¹ or did not cover the sampled service month (3 claims).²²

These deficiencies occurred because providers did not adhere to PACT requirements, or psychiatrists did not fulfill certain obligations such as signing and reviewing the plan of care. In addition, the State agency did not have procedures for monitoring providers for compliance with plan-of-care requirements.

¹⁹ We also noted that it was the provider's practice to record an additional 30 minutes in the beneficiary's progress notes if contact was made with someone on behalf of the beneficiary (e.g., landlord, family member).

²⁰ NJAC 10:76-1.4 (a) and (d), NJAC 10:37J-2.6 (b)(2).

²¹ The plans of care for the four claims were revised annually. As a result, the revisions occurred 1 to 8 months after the required revision period.

²² No plans of care were in place for our sampled service month. Specifically, the plans of care were either not provided (one claim) or did not cover our sampled month (two claims).

Required Clinical Disciplines Not Included on PACT Team

PACT services must be provided by PACT teams consisting of a minimum of five separate clinical, therapeutic, and rehabilitative disciplines: psychiatry, nursing, counseling, substance abuse, and mental health rehabilitation or vocational/occupational services.²³ At a minimum, each PACT team must consist of a licensed psychiatrist; two registered nurses; a dual disorder (substance abuse) specialist; one rehabilitation, vocational, or occupational specialist; two mental health specialists; and two clinicians.²⁴

For eight claims in our sample, the PACT team did not include staff members from each of the five required disciplines. Specifically, the associated PACT team did not include a representative from the substance abuse discipline (four claims), a representative from the psychiatric discipline (three claims), and a representative from the mental health rehabilitation discipline (one claim).

Providers stated that these deficiencies occurred because of frequent staff turnover. In addition, some providers stated that they were not aware that an advanced practice nurse (APN) could not perform the duties of the psychiatrist.

Prior Authorization Requirements Not Met

To be enrolled in PACT, Medicaid beneficiaries must receive prior authorization from the State agency.²⁵ PACT services providers must obtain prior authorization by completing the State agency's Referral and Intake Outcome Form and submitting the form to its local State agency office, where it is evaluated by a State agency analyst. If the form is approved by the State agency, the PACT services provider may enroll the beneficiary in PACT.²⁶ The Referral and Intake Outcome Form should include the name of the PACT services provider, the specific PACT team, and the signature of the approving State agency analyst.

For five claims in our sample, the provider did not obtain prior authorization for the associated beneficiary to receive PACT services. For example, one provider relied on an authorization form obtained by the beneficiary's previous provider that listed a specific PACT team made up of staff employed by that provider.

These deficiencies occurred because the State agency did not have controls in place to verify compliance with prior authorization requirements. Further, providers circumvented the authorization process by using prior authorizations for beneficiaries who changed providers or

²³ Medicaid State Plan Addendum to Attachment 3.1-A pg. 13(d).5a, NJAC 10:76 2.2 (a).

²⁴ NJAC 10:37J-2.8(d).

²⁵ Medicaid State Plan Addendum to Attachment 3.1-A pg. 13(d).5.

²⁶ NJAC 10:76-2.5.

were discharged from the program and later readmitted. Providers may not have been able to obtain prior authorizations for these beneficiaries if the beneficiaries' conditions had improved since the State agency approved their enrollment in PACT, meaning they would no longer qualify for PACT services under a new authorization.

No Documentation of Compliance With Boarding Home Requirements

For PACT services provided to a Medicaid beneficiary in a State-licensed boarding home where they reside, a PACT team member must (1) collaborate with appropriate boarding home staff to ensure that the beneficiary is receiving prescribed medications and discuss symptoms and behaviors, (2) regularly review boarding home records, and (3) meet in person at least once per month with boarding home staff to discuss the status of the beneficiary and record the results of these meetings in the consumer's PACT record.²⁷

For five claims in our sample for which beneficiaries resided in a State-licensed boarding home, the provider's progress notes did not contain evidence that the PACT team member met with boarding home staff and reviewed the associated beneficiary's medications, behaviors, and records during the entire sampled month.

This occurred because PACT services providers did not have procedures in place to ensure that a PACT team member complied with applicable State requirements. Additionally, the State agency's monitoring efforts did not include steps to verify that providers complied with these PACT program requirements.

Documentation Did Not Support 2 Hours of Face-to-Face Contact

PACT services providers may not bill for a monthly claim unless they meet a minimum service requirement of at least 2 hours of face-to-face contact with the associated beneficiary or on behalf of the beneficiary (e.g., beneficiary's family member, landlord). Providers must document each individual face-to-face contact in the beneficiary's progress notes.²⁸

For two claims in our sample, documentation did not support that the PACT team met the required minimum 2 hours of face-to-face contact. Specifically, the documentation supported 1½ and 1¾ hours of face-to-face contact for the monthly claim.

These deficiencies occurred because the providers associated with the two claims did not have adequate procedures to verify that PACT team members documented the minimum face-to-face time requirement before submitting monthly claims. Further, the State agency's monitoring efforts did not include adequately reviewing documentation to support that minimum face-to-face time requirements were met.

²⁷ NJAC 10:76-2.1(a), NJAC 10:37J-2.5(d)(5).

²⁸ Medicaid State Plan Attachment 4.19-B pg. 24.2, NJAC 10:76-2.6, NJAC-10:76-2.1(a) and NJAC 10:37J-2.6(e).

No Nursing Assessment

Beneficiaries enrolled in PACT must have a plan of care based, in part, on a nursing assessment. The nursing assessment must be prepared and documented in the beneficiary's clinical record.²⁹

For one claim in our sample, the associated beneficiary's case file did not contain a nursing assessment. Without a nursing assessment, the beneficiary's individualized needs may not be adequately addressed in their plan of care.

STATE AGENCY DID NOT ENSURE QUALITY OF CARE

Psychiatrists Did Not Meet Minimum Hourly Requirements

PACT team psychiatrists must provide a minimum of 10 hours of face-to-face psychiatric time each week for a caseload of 56 beneficiaries, increased on a prorated basis for larger caseloads.³⁰

Psychiatrists associated with 33 of our sample claims did not meet the minimum required face-to-face time based on their assigned caseload. For example, one psychiatrist's caseload included 274 beneficiaries. To meet the minimum required psychiatric time, the psychiatrist would need to have worked 49 hours per week for the month associated with our sample claim.³¹ However, the psychiatrist worked 40 hours during each of the first 3 weeks of the month associated with our sample claim and 38 hours during the final week. As a result, the psychiatrist may not have met the needs of all 274 beneficiaries in his caseload. Further, because of the psychiatrist's caseload, the PACT services provider assigned an APN to perform evaluations on some beneficiaries.³² For other sample claims, a different PACT provider's team psychiatrist who did not meet face-to-face time requirements opted to perform psychiatric evaluations on multiple beneficiaries at a restaurant.

²⁹ NJAC 10:37J-2.6(a)(2)(viii)(2).

³⁰ NJAC 10:37J- 2.8. The 10 hours includes face-to-face with beneficiaries, PACT team members, or both. The ratio is increased on a pro-rated basis. For example, a psychiatrist with a caseload of 112 clients would have to work 20 hours.

³¹ Based on the minimum of 10 hours for every 56 beneficiaries, the psychiatrist would need to work 49 hours per week to serve 274 beneficiaries $((274 / 56) * 10 = 49)$.

³² As described earlier, APNs may not perform the duties of the psychiatrist.

Beneficiaries Were Not Reevaluated for Services

The Social Security Act requires that payment for Medicaid services be consistent with efficiency, economy, and quality of care.³³ In addition, Federal regulations define rehabilitative services as services recommended by a licensed practitioner for maximum reduction of physical or mental disability and restoration of a beneficiary to their best possible functional level.³⁴ State regulations for PACT, which the State agency defines in its Medicaid State plan as a rehabilitative program, stipulate that the prior authorization of services shall cover all dates that services were provided to ensure proper reimbursement.³⁵

Although State regulations stipulate that a prior authorization should cover all dates of service, they do not specify a timeframe for which authorized services are eligible for Medicaid reimbursement. Essentially, this results in indefinite authorizations for PACT services for which providers are not required to reevaluate beneficiaries' eligibility. Since the purpose of the PACT program is to restore the beneficiaries to their best possible functional level, lack of reevaluations over long periods of time may place beneficiaries' quality of care at risk. In addition, beneficiaries may be receiving unnecessary intensive services when less intensive services might be sufficient. Table 2 indicates the number of years from the date of the prior authorization to the sampled month of services for our 100 sampled claims.

Table 2: Years Between Prior Authorization and Sampled Service Month (100 Claims)

Missing or Not Signed	10+ Years	5-10 Years	2 To 5 Years	Under 2 Years
7	29	22	19	23

PACT services providers informed us that they did not submit requests for new authorizations for some beneficiaries because, according to the providers, the beneficiaries would no longer qualify for PACT services under a new authorization. We also observed that, in some cases, providers relied on prior authorizations obtained by beneficiaries' previous providers; therefore, they did not reevaluate the beneficiaries' need for PACT services.

State agency officials contended that beneficiaries are, in effect, continually assessed while they are enrolled in PACT. However, the only assessment that PACT team psychiatrists are required to conduct is an annual psychiatric assessment (NJAC 10:37J-2.6(d)). Further, as described earlier in the report, annual psychiatric assessments were not always performed by a psychiatrist.

³³ Section 1902(a)(30)(A).

³⁴ 42 CFR § 440.130(d) (emphasis added).

³⁵ NJAC 10:76-2.5(d).

RECOMMENDATIONS

We recommend that the New Jersey Department of Human Services:

- refund \$14,888,980 to the Federal Government;
- reinforce guidance to the provider community regarding Federal and State requirements for claiming Medicaid reimbursement for PACT services;
- improve its procedures for monitoring PACT services providers, including implementing procedures to identify deficiencies similar to those identified in this report; and
- consider developing regulations for periodic reassessments to determine whether beneficiaries enrolled in PACT continue to require PACT services.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency generally disagreed with our findings and assessment of the causes of the deficiencies. The State agency disagreed with OIG's assessment that New Jersey did not inform PACT providers of all Federal and State requirements for providing PACT services and did not adequately monitor or have procedures in place to ensure that providers claimed PACT services in accordance with these requirements.

In response to our recommendations, the State agency disagreed with our first recommendation, agreed with our second recommendation, partially agreed with our third recommendation, disagreed with our final recommendation, and described steps it had taken or will take to implement our second and third recommendations. The State agency contended that we are invalidating the entire monthly bundled rate in instances where documentation is available for more than 10 hours of face-to-face intervention with the beneficiary. The State agency agreed with our finding regarding claims for which documentation did not support that the PACT team met the required minimum 2 hours of face-to-face contact. The State agency indicated that PACT providers were notified of PACT regulations when they were updated, amended, or revised, and it asserted that PACT providers acknowledged understanding these regulations after being provided notice. In addition, the State agency commented that it provides mandatory training for new PACT provider employees and conducts robust monitoring of the PACT program through periodic audits or State Medicaid audits, and it described its related procedures. Finally, the State agency contended that PACT teams conduct an ongoing assessment of each beneficiary's mental illness, eligibility, treatment plans, and readiness for discharge throughout the length of service. Under separate cover, the State agency

subsequently provided additional documentation³⁶ related to some sample claims for which it disagreed with our determinations.

We maintain that our findings and recommendations, as revised, are valid. Although the State agency provided notices to PACT providers regarding changes to PACT regulations, these notices were not descriptive and did not provide guidance or interpretation of the citations. Additionally, throughout our audit, most PACT providers indicated that although they were familiar with certain PACT regulations, they were not aware of Medicaid requirements for documenting PACT services. Further, we determined that the State agency's monitoring of PACT services providers for compliance with Medicaid requirements was not robust.³⁷ In most cases, the State agency only performed a cursory review of beneficiary case files. We found numerous examples in which the State agency incorrectly found PACT providers to be in compliance with Medicaid requirements.

After reviewing the State agency's comments and additional documentation, we revised our determinations for six claims³⁸ and adjusted our related recommendation accordingly. Contrary to the State agency's contention that we considered sample claims with documentation of more than 10 hours of face-to-face intervention to be unallowable, our error determinations included only sample claims with 2 hours or less of documented, Medicaid-allowable services directly related to the plan of care.

The State agency's comments are included in their entirety as Appendix F.³⁹

³⁶ In its comments dated September 13, 2019, the State agency indicated that documentation for certain claims was available upon request. We requested the information, which the State agency provided on September 30, 2019, along with explanations for why it believed these claims should be reconsidered.

³⁷ Our review focused on whether the State agency's claims for Federal Medicaid reimbursement of payments for PACT services complied with Medicaid requirements. We did not assess the State's general monitoring of providers' compliance with mental health services regulations.

³⁸ The State agency also provided adequate documentation related to three other claims; however, we did not reclassify these claims because they had other deficiencies.

³⁹ We did not include the State agency's explanations for certain claims (dated September 30, 2019) as part of the appendix because they contained personally identifiable information.

SERVICES DID NOT COMPLY WITH FEDERAL AND STATE REQUIREMENTS

Services Not Adequately Supported or Documented

State Agency Comments

The State agency disagreed with our determinations for 32 of the 42⁴⁰ sample claims identified in our draft report as not adequately supported or documented.

Regarding 30 sample claims for services that we did not find in the beneficiary's plan of care, the State agency contended that PACT services associated with these sample claims were consistent with its Medicaid State plan and sufficiently documented. For example, although the State agency noted that PACT providers are not allowed to bill for transportation or social events, it contended that interventions provided by treatment professionals may occur during these events and would comply with PACT requirements. These interventions could include motivational interviewing, establishing rapport, building trust, and measuring status. In addition, the State agency subsequently provided explanations for why certain claims should be reconsidered.

Regarding 21 sample claims for which the duration of services was unsupported, the State agency commented on a 60-minute claim for providing medication described in the report (page 6). The State agency contended that every medication delivery includes a welfare check and assessment, conversation, and observation, as evidenced in the standard progress notes.

Lastly, for 13 sample claims identified in our draft report as not including the required elements for supporting documentation (e.g., time and duration of services), the State agency noted that Medicaid regulations only require the length of time of face-to-face contacts to be documented, not the precise time of day. The State agency indicated that, "[i]deally, progress notes will reflect the time an intervention occurs, but the duration of services is the requirement for Medicaid billing."

Office of Inspector General Response

Based on the State agency's comments and additional documentation, we reclassified 6 of the 42 sample claims that we had identified in our draft report as unallowable. Specifically, the State agency provided sufficient support for five sample claims that we determined contained services not in the beneficiary's plan of care and one claim that was missing the required elements. We maintain that, for the remaining sample claims, the provider did not document how services related to the beneficiary's treatment regimen and plan of care, did not

⁴⁰ The State agency agreed with our determination that one sample claim was unsupported and did not dispute nine other sample claims associated with one PACT provider due to provider performance issues identified. However, the State agency indicated that it is closely monitoring the provider, is taking corrective action, and believes that our findings related to the provider are "an outlier and should not be extrapolated."

sufficiently document the duration of services, or did not maintain documentation that contained the required elements.

Regarding sample claims for which the PACT provider did not document how services related to the beneficiary's plan of care, the State agency provided insufficient explanations. For example, for one sample claim, the State agency contended that more than 10 hours of face-to-face intervention was provided to the beneficiary. The related plan of care objectives were "time management and job readiness, meeting court requirements, medication compliance, and staying out of jail." However, based on the treatment notes, there was minimal support for service time directly related to the individualized plan of care. The remainder of time was spent transporting the beneficiary to/from appointments, food shopping, restaurants, and other everyday errands.

Regarding sample claims that included transportation or social outings (including some for which PACT providers included the entire time that they spent with the beneficiary), the State agency did not provide sufficient documentation of the duration of the service or provide additional documentation to support services, such as motivational interviewing, establishing rapport, building trust, and measuring status, specific to the beneficiary. In addition, for the one claim that it commented on—a 60-minute claim for providing medication—the State agency did not provide documentation in the progress notes or otherwise that the claim also included a welfare check and assessment, conversation, and observation.

Regarding the State agency's assertion that PACT providers are not required to document the precise time of day as part of their service documentation, we note that, under NJAC 10:76-2.1 (New Jersey's Medicaid regulations), PACT services must meet the requirements of NJAC 10:37J (New Jersey's mental health regulations). NJAC 10:37J-2.6 (e)2., requires progress notes for PACT services to, at a minimum, address the "date, time, and location where the service was provided, the duration of the contact, and the names of staff who rendered the services" (emphasis added). Additionally, requiring PACT providers to document the precise time that services were provided serves as a control for limiting potentially inappropriate billing.

Plan of Care Requirements Not Met

State Agency Comments

The State agency concurred with our determinations for 5 of the 17 sample claims identified in our draft report as not meeting plan of care requirements and indicated that the majority of the remaining claims were associated with the PACT provider identified earlier in the State agency's comments as having performance issues. The State agency commented that additional documentation was available for OIG to review.

Office of Inspector General Response

We note that 11 of the 17 sample claims for which plan of care requirements were not met were associated with the PACT provider with performance issues. It is our practice not to ignore deficiencies related to a problematic provider and therefore continue to question claims associated with such a provider. The State agency did not provide any additional documentation related to the remaining sample claim.

Required Clinical Disciplines Not Included on PACT Team

State Agency Comments

The State agency disagreed with our determinations for six sample claims that did not include all the required clinical disciplines on the PACT team and indicated that two other sample claims were associated with the one provider with performance issues. The State agency provided additional documentation for four of the six claims for which it disagreed with our determination.

Office of Inspector General Response

After reviewing the additional documentation, we maintain that our findings are valid. For one of the sample claims, the State agency explicitly noted on documentation that an individual listed on the PACT team as a specialist had not passed a required State exam. In addition, per the documentation provided, the State agency informed the provider that the individual was not eligible to be designated as a substance abuse specialist. For three other sample claims, the State agency provided a revised PACT team list with the missing discipline now present. However, one employee was not properly credentialed, another was hired months after the associated date of service, and only a list was provided for the third claim. As noted earlier, it is our practice not to ignore deficiencies related to a problematic provider and therefore continue to question claims associated with such a provider.

Prior Authorization Requirements Not Met

State Agency Comments

The State agency contended that all but one sample claim identified in our draft report as not having prior authorizations were not required to have them because State regulations do not require a new authorization for a beneficiary who is in the program and transferred to a new provider or reactivated following a brief incarceration or hospitalization. Further, the State agency noted that beneficiaries are eligible to receive PACT services until such time as they maintain function for 6 continuous months (N.J.A.C. 10:37J-2.7(d)(2)). Subsequent to its response, the State agency provided prior authorizations for two sample claims and explanations for why three other sample claims should be allowable.

Office of Inspector General Response

Based on additional documentation the State agency provided, we agree that the prior authorization requirement for two claims was met.⁴¹ We maintain that the remaining five claims, including the three for which the State agency provided explanations, required prior authorizations. Specifically, Medicaid regulations⁴² state that payments for certain services (e.g., PACT services) require prior authorization except in an emergency and that it is the responsibility of the provider to obtain prior authorization before providing a service. Regarding the State agency's explanations, we note that one of these claims—for services provided in 2014—had a prior authorization dating back to 1998 from a different PACT provider. The two other claims related to beneficiaries who were discharged from the program and did not have authorizations for the new enrollment period.

No Documentation of Compliance With Boarding Home Requirements

State Agency Comments

The State agency acknowledged that for three of the five sample claims we identified as deficient, there was no documentation of compliance with boarding home requirements. The State agency disagreed with our determinations for the two other sample claims. For one of the two claims, the State agency indicated that the associated beneficiary objected to PACT employees speaking with boarding home staff. For the other claim, the State agency contended that boarding home staff was updated on the associated beneficiary's current status.

Office of Inspector General Response

After reviewing the additional documentation, we maintain that our findings are valid. The State agency did not provide information or documentation to change our determinations for the two sample claims. Regarding the first sample claim, the State agency did not provide any evidence that the associated beneficiary did not consent to PACT employees speaking with boarding home staff. Additionally, the plan of care specified that the PACT team would collaborate with boarding home staff related to the beneficiary's medication. For the other sample claim, the progress note referenced in the State agency's comments described an unrelated incident that was shared with the boarding home staff. The note did not include any evidence that the PACT team member met with boarding home staff and reviewed the associated beneficiary's medications, behaviors, and records during the entire sampled month, as required.

⁴¹ The State agency provided adequate documentation to change the deficiency; however, we did not reclassify these two claims as allowable because they had other deficiencies.

⁴² NJAC 10:49-6.1 (a), 10:76-2.5.

No Nursing Assessment

State Agency Comments

The State agency provided a nursing assessment for one of the two claims identified in our draft report as not containing a nursing assessment and indicated that the other claim was associated with the one provider with performance issues.

Office of Inspector General Response

Based on additional documentation the State agency provided, we agree that one sample claim had a nursing assessment.⁴³ As noted earlier, it is our practice not to ignore deficiencies related to a problematic provider.

STATE AGENCY DID NOT ENSURE QUALITY OF CARE

Psychiatrists Did Not Meet Minimum Hourly Requirements

The State agency did not indicate whether it agreed with our finding regarding psychiatrists who did not meet minimum hourly requirements. Rather, the State agency indicated that New Jersey is experiencing a shortage of psychiatrists and is working to address the challenge. Additionally, the State agency indicated that a new State law will allow PACT providers the ability to provide psychiatric services remotely.

Beneficiaries Were Not Reevaluated for Services

State Agency Comments

The State agency disagreed with our finding related to beneficiaries not reevaluated for services and stated that beneficiaries are subject to “ongoing assessments” by PACT teams and are reevaluated for services at least every 6 months in accordance with NJAC 10:37J-2.5-2.6. Additionally, the State agency described State regulations to support its contention.

Office of Inspector General Response

As we described in the draft report, although State regulations stipulate that a prior authorization should cover all dates of service, they do not specify a timeframe for which authorized services are eligible for Medicaid reimbursement. Essentially, this results in indefinite authorizations for PACT services for which providers are not required to reevaluate beneficiaries’ eligibility. In addition, we note that our recommended recovery excludes claims for which the beneficiary’s eligibility for services was not reevaluated.

⁴³ The State agency provided adequate documentation to change the deficiency; however, we did not reclassify the claim as allowable because it had other deficiencies.

During our fieldwork, we found that some providers did not prepare annual psychiatric assessments as required by the State agency, and many beneficiary case files did not contain evidence that an assessment had been performed in the last 10 years or more. In addition, some treatment plans and psychiatric assessments were prepared by an APN who performed the duties of a psychiatrist. Therefore, we continue to recommend that the State agency consider developing regulations for periodic reassessments to determine whether beneficiaries enrolled in PACT continue to require PACT services.

OTHER MATTERS: OTHER MENTAL HEALTH SERVICES

During our audit, we observed that two State regulations contradict each other as they relate to payment for PACT services provided during the month these services are initiated. Specifically, one regulation (NJAC 10:76-2.4) states that PACT services providers shall not seek Medicaid reimbursement for services during the same month in which a beneficiary receives other mental health services.⁴⁴ However, a second regulation (NJAC 10:76-2.6(b)) states that the providers shall seek full reimbursement for PACT services for the month services are initiated.

None of the claims in our sample were for months in which PACT services providers and other mental health services providers claimed Medicaid reimbursement for services provided to the same beneficiary. However, we identified four beneficiaries associated with our sample claims for which these two provider types claimed reimbursement for services provided during the same month, including two months in which PACT services were initiated.⁴⁵ Without clear guidance related to payments for PACT services, providers may be confused about whether they may bill for PACT services during a month in which a beneficiary received other mental health services, including the month PACT services are initiated. Therefore, if a PACT provider opts to bill for PACT services during the first month of service, the State agency would pay for duplicative mental health services.

⁴⁴ Other mental health services include mental health personal care services, partial care/partial hospitalization services, integrated case management services, and mental health rehabilitation services provided in/by a community residence.

⁴⁵ During our audit period, there were 387 claims for PACT services submitted for beneficiaries that had other mental health services reimbursed during the same month.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 49,944 PACT services claim lines, totaling \$69,288,164 (\$35,992,388 Federal share), submitted by 13 PACT providers in New Jersey during CYs 2013 through 2016. (In this report, we refer to these lines as claims.)

Our audit 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 claim data in the MMIS to the State agency's claim for reimbursement on the CMS-64, Quarterly Medicaid Statement of Expenditures for the Medicaid Program (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 PACT services providers throughout New Jersey.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with State agency officials to gain an understanding of New Jersey's PACT program and the State agency's procedures for monitoring PACT services providers;
- obtained a claim database from the State agency's MMIS that contained 49,944 Medicaid PACT services claims submitted by 13 providers in New Jersey during our audit period;
- reconciled the PACT 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;
- created a sampling frame of 49,944 claims, totaling \$69,288,164 (\$35,992,388 Federal share);
- selected a simple random sample of 100 claims from our sampling frame of 49,944 claims; and for each of the 100 claims, obtained and reviewed beneficiary clinical records to determine whether claims complied with Federal and State requirements;

- matched the claims database of 49,944 PACT services claims contained in our sampling frame with claims for clinical and outpatient mental health services and analyzed to identify whether any claims were for the same beneficiaries during the same month;
- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 49,944 claims; 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 B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>New Jersey Claimed Federal Medicaid Reimbursement for Children's Partial Hospitalization Services That Did Not Meet Federal and State Requirements</i>	<u>A-02-16-01008</u>	3/21/2018
<i>New Jersey Claimed Medicaid Reimbursement for Adult Partial Hospitalization Services That Did Not Comply with Federal and State Requirements</i>	<u>A-02-14-01015</u>	4/19/2017
<i>New Jersey Claimed Medicaid Adult Mental Health Partial Care Services That Were Not in Compliance with Federal and State Requirements</i>	<u>A-02-13-01029</u>	12/27/2016

APPENDIX C: FEDERAL AND STATE REQUIREMENTS RELATED TO PROGRAMS OF ASSERTIVE COMMUNITY TREATMENT SERVICES

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. This part 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.

Social Security Act § 1902(a)(27) provides for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request.

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) and 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) also requires providers to maintain any other information that the State agency may require by regulations in order to be reimbursed. Finally, SMM § 2497 states that Federal financial participation (FFP) is available only to the extent there is adequate supporting documentation to support the claim.

The SMM, § 4221, establishes guidelines for outpatient programs to ensure appropriate use of psychiatric treatment services, including the following:

- The provider develop an individualized plan of care that describes the treatment regimen and projected schedule for service delivery, including the frequency and duration.
- The provider prepare documentation in support of each medical or remedial therapy, service, activity, or session billed. For services not specifically in the beneficiary's treatment regimen, the provider must prepare a detailed explanation of how the services billed relate to the treatment regimen and objectives.
- The evaluation team periodically review the beneficiary's plan of care to determine the beneficiary's progress toward the treatment objectives, the appropriateness of the services being furnished, and the need for the beneficiary's continued participation.

NJAC 10:76-1.4 states that PACT providers shall, at a minimum, maintain the following data in support of all payment claims: (1) name of the beneficiary; (2) name of the provider agency; (3) name and title of the team member providing service; (4) date(s) of service; (5) length of time face-to-face contact was provided; (6) name of individual(s) with whom face-to-face contact was maintained on behalf of the beneficiary (If the person contacted refuses to give their name, the team member shall document that refusal in the record of the contact); and (7) summary of the services provided. Per NJAC 10:37J-2.6(e), providers must document each individual face-to-face contact in the beneficiary's progress notes.

NJAC 10:76-2.1(a) states that all PACT services shall meet the requirements of NJAC 10:37J.

The Medicaid State Plan (Addendum to Attachment 3.1-A pg. 13(d).5-13(d).5a) specifies that PACT services are subject to prior authorization. Further, State regulations (NJAC 10:76-2.5) specify PACT services not be provided to an eligible Medicaid beneficiary without prior authorization. For PACT services, the provider obtains prior authorization as follows: (1) they must complete and submit the "DMHS⁴⁶ PACT Referral and Intake Outcome" form to request authorization, (2) the Regional DMHS Program Analyst will evaluate the eligibility of the beneficiary in accordance with NJAC 10:37J-2.3(b), and (3) if approved for services, the provider shall meet with and enroll the beneficiary into PACT, and return the signed and dated form to the DMHS Regional Office, confirming the enrollment of the beneficiary.

NJAC 10:76-2.3 and NJAC 10:37J-2.3 require that PACT services be provided to eligible beneficiaries. To be eligible, beneficiaries must meet all of the following:

- Have a serious and persistent mental illness for at least 12 months in duration.
- Pose a high clinical risk of hospitalization, as evidenced by recent history.
- Have at least one of the following primary diagnoses: schizophrenia or other psychotic disorder, major depressive disorder, bipolar disorder, delusional disorder, schizoaffective disorder.
- Have impaired functioning with personal self-care, relationships, work, or housing on a continuing or intermittent basis for at least one year.
- Have demonstrated a lack of benefit or refusal to participate in other mental health services for at least 6 months.

The Medicaid State Plan (Addendum to Attachment 3.1-A pg. 13(d).5) requires PACT services to be delivered to eligible individuals in accordance with the beneficiary's plan of care. NJAC 10:37J-2.6(b) states that each clinical record shall contain an initial and comprehensive plan of

⁴⁶ Division of Mental Health Services.

care and plan of care revision. It also indicates that the comprehensive plan of care is based on the comprehensive assessment and shall include:

- Goals and specific objectives that are written in behavioral, measurable terms and include target dates.
- Specific treatment, rehabilitation, and support interventions (including staff responsible) that demonstrate consumer involvement and choice, and their frequency and duration.
- Key areas including symptom stability, symptom education and management, medication monitoring, substance abuse, medical and dental needs, housing, employment, and family and social relationships.
- The signatures of all participants involved in the development of the plan, including the psychiatrist.

State regulations (NJAC 10:76-2.2(e), NJAC 10:37J-2.6(b)(4)) specify that the comprehensive plan of care be reviewed and revised every 3 months during the beneficiary's first year of PACT enrollment, or sooner if there is a significant change in the beneficiary's condition or course of treatment. After the beneficiary's first year in the program, plan of care revisions may be done every 6 months, so long as the beneficiary's mental status is stable.

The Medicaid State Plan (Addendum to Attachment 3.1-A pg. 13(d).5-13(d).5a) and NJAC 10:76-2.2(a)) indicate services are to be provided in accordance with a beneficiary's plan of care by a mobile interdisciplinary professional team consisting of, at a minimum, individuals representing five separate clinical, therapeutic and rehabilitative disciplines: psychiatry, nursing, counseling, substance abuse, and mental health rehabilitation. NJAC 10:37J-2.8(d) requires each PACT team shall, at a minimum, consist of the following: a licensed psychiatrist; two registered nurses; a dual disorder (substance abuse) specialist; one rehabilitation, vocational, or occupational specialist; two mental health specialists; and two clinicians.

NJAC 10:37J-2.8(d)(1) requires the licensed psychiatrist provide a minimum of 10 hours of psychiatric time, face-to-face with beneficiaries and/or team members, each week for a caseload of 56 consumers, increased on a pro-rated basis for larger caseloads.

NJAC 10:37J-2.6(a)(2)(viii)(2) requires that during the first 30 days of a beneficiary's enrollment, a nursing assessment must be completed.

NJAC 10:37J-2.5(d)(5) requires that for PACT services provided to a Medicaid beneficiary residing in a State-licensed boarding home, a PACT team member must (1) ensure the beneficiary is receiving prescribed medications and discuss symptoms and behaviors with boarding home staff, (2) regularly review boarding home records, and (3) meet in person at least once per month with boarding home staff to discuss the status of the beneficiary.

The Medicaid State Plan (Attachment 4.19-B pg. 24.2) and State regulations (NJAC 10:76-2.1(c)(1), NJAC 10:76-2.6(b) and (c)) require PACT services to be reimbursed for each month that services are performed, with a minimum service level provided of at least 2 hours of face-to-face contact with the beneficiary or on behalf of the beneficiary. Providers cannot bill for services for any month during which the minimum service level has not been achieved. Full reimbursement is provided for PACT services the month services are initiated.

NJAC 10:76-2.4 states that PACT services providers shall not seek Medicaid reimbursement for services during the same month in which a beneficiary receives other mental health services.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of monthly PACT services claims submitted by providers in New Jersey during CYs 2013 through 2016 that the State agency claimed for Federal Medicaid reimbursement.

SAMPLING FRAME

The sampling frame was an Access file containing 49,944 monthly PACT services claims submitted by 13 providers in New Jersey during our audit period. The total Medicaid reimbursement for the 49,944 claims was \$69,288,164 (\$35,992,388 Federal share). We extracted the Medicaid claims 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 a monthly PACT services 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 OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We 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 estimate the overpayment associated with the unallowable claims at the lower limit of the two-sided 90-percent confidence interval. We also used the software to calculate the corresponding point estimate and upper limit of the 90-percent confidence interval.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Details and Results

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Claims	Value of Unallowable Claims (Federal Share)
49,944	\$35,992,388	100	\$70,726	50	\$36,024

Table 4: Estimated Unallowable Costs (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$17,991,637
Lower limit	14,888,980
Upper limit	21,094,293

APPENDIX F: STATE AGENCY COMMENTS



State of New Jersey Department of Human Services

P.O. BOX 700
TRENTON NJ 08625-0700

PHILIP D. MURPHY
Governor

Carole Johnson
Commissioner

Sheila Y. Oliver
Lt. Governor

September 13, 2019

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

Dear Ms. Tierney:

The Department of Human Services (the Department) is in receipt of the draft audit report issued by the Office of Inspector General (OIG) entitled *"Nearly One-Half of New Jersey's Federal Medicaid Reimbursement for Providing Community-Based Treatment Services was Unallowable"* for the period of calendar years 2013 through 2016. Thank you for the opportunity to respond to the draft report.

First, the Department disagrees with OIG's assessment that "New Jersey did not inform PACT providers of all Federal and State requirements for providing PACT services and did not adequately monitor or have procedures in place to ensure that providers claimed PACT services in accordance with these requirements." The Department is unclear how OIG arrived at this finding without meeting with the Department's Division of Mental Health and Addiction Services (DMHAS), which is the Single State Authority (SSA) for substance use disorder services and the State Mental Health Authority (SMHA) that manages the State's publicly-funded mental health treatment, prevention, and recovery service system. DMHAS is responsible for educating PACT providers and monitoring the PACT program.

The State provides notice to PACT providers of all regulations governing PACT services. When regulations are updated, amended or revised, the State provides electronic notice to all PACT program directors. Every PACT agency has advance notice of and access to the procedures and practice requirements for the program.

PACT providers acknowledge notice and confirm understanding of these regulations and program standards in their contracts with DMHAS. Through these contracts, providers agree to comply with all applicable federal and State laws and regulations. State Medicaid Provider Agreements contain similar references to applicable regulations. State Medicaid regulations also

require Medicaid providers to comply with the provisions of N.J.A.C. 10:76-1.1 et. seq., and N.J.A.C. 10:37J-1.1 et. seq.

Further, N.J.A.C. 10:37J-2.9 requires providers to develop and implement an individualized training plan for each PACT staff member. DMHAS provides a mandatory PACT Training and Technical Assistance Initiative, a five-day training class for all new PACT employees. The training covers every program element and regulation to ensure that each staff member is informed and prepared to provide appropriate and effective treatment in strict keeping with the PACT fidelity model. After the initial training, individual agencies are obligated to provide continued training and attend any additional conferences and technical assistance activities offered by DMHAS.

In addition to the various regulatory and contractual notices and training requirements, DMHAS requires providers to incorporate PACT program regulations into written agency policies. N.J.A.C. 10:37J-2.1(a)(1) requires every PACT agency to “develop and implement written policies and procedures to... [e]nsure that the services provided comply with the rules of [PACT].” State Medicaid regulations contain this same agency requirement. N.J.A.C. 10:76-1.3(a). Prior to its issuance of a license to a PACT provider, the Department of Health’s Office of Licensing (OOL) requires the production of all written policies and procedures mandated by regulation to verify that the provider has procedures in place to ensure regulatory compliance, including all forms used in the clinical record to meet the documentation requirements.

The State conducts robust monitoring of the PACT program. Three separate State entities monitor PACT providers to ensure program compliance: DMHAS conducts extensive and ongoing monitoring; OOL engages in extensive audits to evaluate every PACT agency and team for compliance; and, program support specialists and regional staff nurses from the regional Medical Assistance Customer Centers (MACC) conduct annual State Medicaid audits.

DMHAS requires every PACT team to submit a quarterly contract monitoring report (QCMR). The QCMR monitors new enrollment, program transfers, discharges, face-to-face service delivery, group contact modality, individual contact modality, consumer outcomes (including, but not limited to, incarceration, in-patient psychiatric treatment, homelessness, education, and employment), staff fill rates, and psychiatric hours provided. If this data shows a deviation from standard performance measures, DMHAS conducts an unannounced site visit or takes other appropriate monitoring action, issues a formal report of findings, and requires a plan of correction from the provider. DMHAS conducts follow-up visits to ensure continued compliance. Failure to sustain plans of corrective action can result in the early termination of contract.

PACT providers are subject to periodic audits conducted by DMHAS, averaging at least once every eighteen months. Every regulatory requirement is reviewed and enforced. DMHAS attends daily treatment team meetings, interviews the PACT program director and team leaders, observes the provision of services at the agency and in the community, reviews individual case files, and reviews program records. In addition, the State also requires PACT providers to submit Unusual Incident Reports (UIRs). The Department’s Critical Incident Management Unit tracks all UIRs to ensure proper response. OOL also audits each provider every three years to determine whether they are complying with PACT licensing requirements. OOL’s licensure and

monitoring ensure that programs for mental health services meet the standards set by the Department, are safe for participants, protect consumers' rights, and have staff who meet minimum educational and experience qualifications. N.J.A.C. 10:190-1.7(a).

In addition, State Medicaid audits are conducted by program support specialists and regional staff nurses from the MACC. Every PACT team is audited at least once a year. The audits focus on clinical supervision, face-to-face contacts, service planning, team composition, medication monitoring, clinical status review, clinical needs review, proper documentation of services, and the medical necessity of services.

Finally, each of the various governmental agencies shares its findings with the others so every entity may respond appropriately. In sum, the draft report's finding related to program requirements and monitoring fails to recognize the extensive provider education and intensive monitoring efforts of DMHAS.

Accordingly, the Department requests that OIG revisit this draft finding.

Please accept the following responses to OIG's specific findings and recommendations:

OIG Finding

Services not adequately supported or documented.

Response

The Department disagrees with this finding. OIG found that 42 claims had insufficient documentation. OIG suggests three distinct "documentation" deficiencies: services not included in the plan of care, duration of the services was not supported, and document elements were missing (time/duration of services or team member's name were incomplete).

OIG identified 30 claims for which it believes services were not included in the plan of care. The Department does not dispute this finding for nine claims which related to a particular provider.¹ However, the remaining claims were consistent the Department's State Plan Amendment (SPA) and sufficiently documented.

PACT provides "comprehensive, integrated, rehabilitation, treatment and support services to individuals most challenged by the need to cope with serious and persistent mental illness."² A PACT recipient may receive a wide range of rehabilitative services under an individualized treatment plan. For the purposes of monitoring whether the provision of a service is consistent with the treatment plan, the State requires progress notes demonstrating, among other things, who provided the service and of what the service consisted. PACT providers may bill a monthly

¹ The Department did not examine these claims because of performance issues with this provider. As further explained below, DMHAS has been closely monitoring this provider and is taking corrective action as necessary. The Department believes the audit findings related to this provider are an outlier and should not be extrapolated.

² Medicaid State Plan Addendum to Attachment 3.1-A p.13(d).5.

rate so long as they meet a minimum service requirement of at least two hours of face-to-face contact with or on behalf of a beneficiary. However, providers generally exceed this monthly minimum and receive the same rate regardless.

The State does not allow providers to bill for transportation or “socials at a local restaurant.” Yet interventions authorized by a plan of care and consistent with the SPA may occur during transport or a group event. Indeed, social events, at which interventions are provided by treatment professionals, are an important part of PACT. The SPA authorizes such treatment modalities as counseling and support to enhance social living skills and psychiatric rehabilitative services. According to guidance issued by the U.S. Department of Health and Human Services, rehabilitative services include psychosocial services that “facilitate the development of social networks, increase environmental adaptability, and ultimately strengthen an individual’s ability to live independently. These services employ recreational activities that focus on reducing isolation and withdrawal...”³ Under the rehabilitative option, the goal of the treatment must be considered. Agencies are not required to establish immediate success to receive reimbursement; they need to support a nexus between a stated goal and the intervention.

OIG deemed invalid interventions that occurred during vehicle transportation or involved mental health groups or social events. However, in these circumstances, the plans of care authorized the intervention provided, and the progress notes documented the service and who provided it. Moreover, the underlying services were consistent with the SPA. The fact that these interventions were provided during transport or in group settings does not render them invalid. The Department recognizes and enforces that transportation alone is not a covered service, however professionals are not prohibited from conducting interventions during transport. In fact, travel time can be an opportunity to engage the consumer – the provider can engage beneficiaries in difficult conversations in a fixed setting over a fixed period of time. Documentation can demonstrate the use of motivational interviewing, establishing rapport, building trust and measuring status. These interventions relate to socialization, health maintenance, symptom management and other goals stated in plans of care, and are consistent with the SPA.

The draft report also included 21 claims for which OIG believed the progress notes were too short for the duration of service recorded. For example, OIG notes a 60-minute claim for medication delivery. As the SPA authorizes medication administration and monitoring, every medication delivery involves a general welfare check and assessment (as to appearance, affect, mood and surroundings), conversation, observation of side effects and general adherence to prescription medications, as evidenced in the assessment section of standard progress notes.

OIG noted 13 claims it believed lack adequate support because the progress note did not include the duration of services/time of day or team member’s name. However, while State Medicaid regulations require agencies to document the “length of time face-to-face contact was provided,” they do not require agencies to document the precise time of day. N.J.A.C. 10:76-1.40. Ideally, progress notes will reflect the time an intervention occurs, but the duration of services is the requirement for Medicaid billing.

³ U.S. DHHS, Office of Asst. Sec. Planning and Eval., Using Medicaid to Support Working Age Adults with SMI in the Community, A Handbook, Jan. 2005 at 80.

OIG Finding

Plan of Care Requirements Not Met.

Response

OIG reports 17 claims without plan of care documentation. DMHAS requested additional documentation from the PACT providers, which was not reviewed the OIG auditors.⁴ In some instances, signatures were not maintained electronically so the agency had to access and verify signatures on hard copies that were warehoused off-site. In other instances, agencies located signed and updated plans of care.

As a general matter, it will sometimes take a psychiatrist several days to execute a plan. The plan, however, must be carried out so a beneficiary is not unjustifiably denied services pending signatures.

The State concurs with 5 disallowances (claims no. 15, 45, 68, 70 and 89) and notes that the majority of the remaining claims are from one outlier provider that the agency already has on a corrective action plan and is closely monitoring performance.

OIG Finding

Required Clinical Disciplines Not Included on PACT Team.

Response

The Department disagrees with this finding. OIG identified eight claims where it believes the PACT team did not include members from the five required disciplines (psychiatry, nursing, counseling, substance use disorder/co-occurring/dual disorder, and mental health rehabilitation or vocational/occupational services).⁵ DMHAS requested additional documentation, not reviewed by the OIG auditors, from providers. In response, agencies provided documentation with evidence of staffing for each of the required disciplines, which is available for review by OIG.

OIG Finding

Prior Authorization Requirements Not Met.

Response

The Department does not concur with this finding. OIG identified seven claims that did not have adequate prior authorizations. However, in all but one of these claims, the beneficiary was not a

⁴ Documentation for the claims is available upon request.

⁵ Two of the eight disallowed claims for clinical discipline deficiencies were from the outlier provider.

new enrollee and was transferred after a move or reactivated following a brief incarceration or hospitalization. State regulations do not require readmission to PACT or new authorization every time a beneficiary moves to a new apartment or suffers a set-back.

While OIG believes that claims should be disallowed because providers “may not have been able to obtain prior authorizations for these beneficiaries if the beneficiaries’ conditions had improved,” beneficiaries are eligible to receive PACT services until such time as they maintain function (in areas of self-care, socialization, and work, without requiring assistance) for six continuous months. N.J.A.C. 10:37J-2.7(d)(2).

OIG Finding

No Documentation of Compliance with Boarding Home Requirements.

Response

OIG identified five claims it believes are invalid for failure to comply with the boarding home requirements at N.J.A.C. 10:37J-2.5(d)(5). OIG invalidated one such claim despite a progress note documenting that PACT staff updated the boarding home staff on the beneficiary's current status. Documentation for another claim demonstrated that the beneficiary objected to the PACT provider communicating with boarding home staff. Consent of the beneficiary is a precondition to the provider collaborating with boarding home staff. N.J.A.C. 10:37J-2.5(d)(5).

The Department acknowledges that documentation for the three remaining claims did not show that the PACT provider communicated with boarding home staff or sought the beneficiary's consent to do so. The Department's technical assistance going forward will include educating providers about the importance of more completely capturing these updates in the note. However, documentation for all five claims cited by OIG demonstrated the provision of the minimum two hours of face to face intervention. The lack of face-to-face collateral contact with boarding home staff does not negate the full monthly bundled rate when all other interventions were provided to the beneficiary.

OIG Finding

Documentation Did Not Support 2 Hours of Face-to-Face Contact.

Response

The State acknowledges that two claims did not include documentation for 2 hours of face-to-face contact, but notes that one of these claims relates to the outlier provider discussed above.

OIG Finding

No Nursing Assessment.

Response

OIG disallowed two claims for the failure to complete a nursing assessment. One claim is from the outlier provider and is not disputed. The other provider produced the required nursing assessment for the second claim to DMHAS, which is available for review by OIG.

OIG Finding

Psychiatrists Did Not Meet Minimum Hourly Requirements.

Response

As is the case nationally, the State is experiencing a shortage of psychiatrists and is working, along with its contracted agencies, to address this challenge.

The national shortage of psychiatrists is well established. Recently, the federal government acknowledged the extreme shortage in New Jersey when the Health Resources and Services Administration designated certain of the State's psychiatric hospitals as "Mental Health Professional Shortage Areas." The recent designation will provide opportunities needed to help bring additional psychiatrists to the State, which may offer opportunities to better address this issue.

In addition, the State's telehealth law allows the use of psychiatric telemedicine where the provider is able to meet the same standard of care as if provided in-person. The law gives PACT agencies the ability to access psychiatric services remotely. The State's professional licensing boards are charged with setting certain minimum criteria. PACT agencies await receipt of the minimum standards to proceed under the law.

OIG Finding

Beneficiaries were not reevaluated for services.

Response

The Department disagrees with this finding. Beneficiaries are subject to ongoing assessments by the PACT team and are reevaluated for services at least every three months in the first year and at least every six months thereafter in accordance with N.J.A.C. 10:37J-2.5-2.6. The assessments determine beneficiaries' current functioning, verify continuing improvement and reassess the need for continued treatment.

PACT regulations require an ongoing and multi-disciplinary assessment process. N.J.A.C. 10:37J-1.2 defines "assessment" as "the ongoing process of identifying and reviewing a consumer's strengths, needs, and consumer-defined goals, based upon input from the consumer, significant others, family members and health professionals. The assessment process continues throughout the entire length of service." N.J.A.C. 10:37J-2.5(b) requires PACT teams to conduct an "ongoing assessment of the consumer's mental illness symptoms, behaviors, and concerns

(that is, the consumer's unique experience with the mental illness)" and an "ongoing assessment of the consumer's response to treatment, including the team's strategies for engaging the consumer in PACT services." Information resulting from the ongoing assessment process can be documented in daily progress notes, annual discipline-specific assessments, recovery plans, annual psychiatric assessments, or any other component of the clinical file. N.J.A.C. 10:37J-2.6(d).

Accordingly, PACT team members must conduct an ongoing assessment of eligibility, need for particular PACT services, accomplishment of goals, need for updated treatment plans, and readiness for discharge. State regulations ensure that ongoing assessments include daily updates, long and short-term treatment planning, clinical supervision and team collaboration. The State mandates daily treatment team meetings, tri-monthly and bi-annual treatment plan updates, and monthly clinical case reviews. PACT teams create a comprehensive recovery plan within 30 days of a consumer's admission to the program, and this plan is reviewed and revised on an ongoing basis. N.J.A.C. 10:37J-2.6(b).

PACT teams are also required to seek (with DMHAS approval) to discharge beneficiaries from the PACT program when appropriate. N.J.A.C. 10:37J-2.7. Discharge may occur for several reasons, including whenever the beneficiary "demonstrates an ability as determined collaboratively to function in areas of self-care, socialization, and work, without requiring assistance from the PACT program for up to six months," as determined collaboratively by the consumer and the PACT team. N.J.A.C. 10:37J-2.7(d)(2). The requirements for six-month success and collaboration are well-established principles of the federal fidelity Assertive Community Treatment (ACT) model. ACT is designed specifically for beneficiaries who are prone to relapse. The team approach helps to ensure that beneficiaries' specific and changing needs are addressed immediately and continually. Notably, NJ PACT teams graduate consumers at an approximate rate of 5% annually, which is well in keeping with PACT fidelity standards.⁶

Consistent with the State Plan Amendment, State regulations define the recovery planning process as "the process of organizing the outcomes of the assessment in collaboration with the consumer... The plan addresses the consumer's goals, services/interventions that will be employed to achieve these goals, and strategies/supports that will be utilized to engage and motivate the consumer. The recovery planning process continues throughout the consumer's receipt of PACT services." N.J.A.C. 10:37J-1.2. The team psychiatrist must sign all service plans (initial, comprehensive and revised) and the team participants must sign the treatment plan. N.J.A.C. 10:76-2.2(e); N.J.A.C. 10:37J-2.6(b)(2)(iv).

State regulations require continuing review of service eligibility and level of care. PACT providers must determine beneficiaries' current functioning, verify continuing improvement, continually reassess the need for treatment in strict accordance with PACT program standards, and discharge the beneficiary only when clinically appropriate. State regulations satisfy 42 C.F.R. §440.130(d) criteria and are consistent with the federal fidelity model.

⁶ Substance Abuse and Mental Health Services Administration, *Assertive Community Treatment: Evaluating Your Program*. DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008 at 34.

OIG Recommendation

Refund \$16,986,173 to the Federal Government.

Response

The Department disagrees. As demonstrated above, the vast majority of claims cited by OIG comply with federal and State requirements. Moreover, OIG is proposing to improperly invalidate the entire monthly bundled rate in instances where documentation is available for more than 10 hours of face-to-face intervention provided to individuals with serious mental illness (when only a minimum of two hours are necessary to bill the monthly bundled rate).

While the State does not dispute factual findings related to the 15 sampled claims for the outlier provider, this provider does not fairly represent the PACT program. DMHAS has already taken well-documented and measured steps to identify and address deficiencies in this organization.⁷ Accordingly, this provider's deficiencies should not be extrapolated across the program.

OIG Recommendation

Reinforce guidance to the provider community regarding Federal and State requirements for claiming Medicaid reimbursement for PACT services.

Response

The Department will reinforce guidance to the provider community regarding PACT requirements. The State will continue to reinforce this guidance and conduct thorough monitoring and oversight.

OIG Recommendation

Improve its procedures for monitoring PACT services providers, including implementing procedures to identify deficiencies similar to those identified in this report.

Response

While the State's monitoring of PACT providers is robust, it recognizes that it does not have controls in place to verify that agencies completed prior authorizations. Currently, DMHAS reviews and executes the beneficiary enrollment form, which serves as an indication of prior authorization for services. The agency maintains a copy of the form in the consumer record and DMHAS enters the PACT beneficiary into a computerized consumer tracking system. As a

⁷ Following intense monitoring, technical assistance, and numerous plans of corrective action, DMHAS reduced the outlier provider from four to two PACT teams and its term of contract from twelve months to six months. DMHAS continues to monitor the outlier provider's contract performance and will take all necessary corrective action.

corrective action, DMHAS will ensure that it has "read only" access to verify prior authorization of PACT services for eligible beneficiaries.

OIG Recommendation

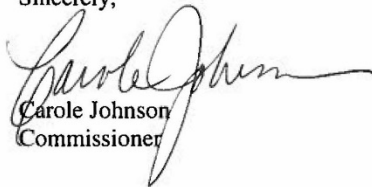
Consider developing regulations for periodic reassessments to determine whether beneficiaries enrolled in PACT continue to require PACT services.

Response

The State disagrees with this recommendation, as regulations requiring periodic and ongoing assessments already exist.

Thank you for the opportunity to review and respond to the OIG's draft audit report. The Department remains committed to providing beneficiaries with severe mental illness with rehabilitative treatment so that they can live their lives fully integrated in the community of their choice.

Sincerely,



Carole Johnson
Commissioner

c: Valerie Mielke, Assistant Commissioner