DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

March 7, 2012

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

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

SUBJECT: Review of Medicaid Administrative Costs Claimed by New Jersey for State Fiscal Years 2005 and 2006 (A-02-08-01009)

Attached, for your information, is an advance copy of our final report on Medicaid administrative costs claimed by New Jersey for State fiscal years 2005 and 2006. We will issue this report to the New Jersey Department of Human Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Services Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through email at James.Edert@oig.hhs.gov. Please refer to report number A-02-08-01009.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION II
JACOB K. JAVITS FEDERAL BUILDING
26 FEDERAL PLAZA, ROOM 3900
NEW YORK, NY 10278

March 8, 2012

Report Number: A-02-08-01009

Jennifer Velez, Esq.
Commissioner
New Jersey Department of Human Services
222 South Warren Street
P.O. Box 700
Trenton, NJ 08625-0700

Dear Ms. Velez:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Administrative Costs Claimed by New Jersey for State Fiscal Years 2005 and 2006.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact John J. Madigan, Audit Manager, at (518) 437-9390, extension 224, or through email at John.Madigan@oig.hhs.gov. Please refer to report number A-02-08-01009 in all correspondence.

Sincerely,

/James P. Edert/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID ADMINISTRATIVE COSTS CLAIMED BY NEW JERSEY FOR STATE FISCAL YEARS 2005 AND 2006

Daniel R. Levinson
Inspector General

March 2012
A-02-08-01009

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

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

In New Jersey, the Department of Human Services (State agency) administers the Medicaid program. The State agency contracts with community-based mental health providers to provide Medicaid-related mental health and related services. Section 1903(a)(7) of the Act permits States to claim Federal reimbursement for 50 percent of the costs of administrative activities that are necessary for the proper and efficient administration of the State Medicaid plan (Medicaid administration). States submit expenditures for Medicaid administration activities for reimbursement on Form CMS-64, the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64). New Jersey computes the cost of Medicaid administration activities performed by staff of contracted mental health providers using a process that results in New Jersey's Medicaid Administrative Claim (MAC). To compute the MAC for State fiscal years (FY) 2005 and 2006, the State agency entered into a contingency fee contract with Maximus, Inc. (Maximus), which developed a four-step methodology that included a random moment timestudy (RMTS) to identify the Medicaid administration activities of staff in contracted mental health providers.

For State FYs 2005 and 2006, the State agency claimed Federal Medicaid reimbursement totaling $44,962,841 ($22,481,421 Federal share) for the cost of Medicaid administration activities performed by staff of contracted community mental health providers on the Form CMS-64.

OBJECTIVE

Our objective was to determine whether the State agency's MAC for FYs 2005 and 2006 complied with Federal requirements for claiming costs associated with the administration of the State Medicaid plan.

SUMMARY OF FINDINGS

The State agency's MAC did not comply with Federal requirements for claiming costs associated with the administration of the State Medicaid plan. Specifically, Maximus included unallowable salaries and operating costs in the cost pool used to compute the MAC, resulting in a claim for $22,223,499 ($11,111,750 Federal share) in excess Medicaid administrative costs. In addition, as part of the allocation method used to identify salary costs to be included in the payment rate, Maximus assigned Medicaid-reimbursable RMTS codes to workers' activities that were not allowable costs related to Medicaid administration or could not be documented as related to

Medicaid and performed an RMTS that deviated from acceptable statistical sampling practices. Finally, in calculating the MAC payment rate, the State agency used Medicaid eligibility rates that could not be documented. Therefore, the remaining $22,739,432 ($11,369,671 Federal share) of administrative costs claimed was unallowable. These errors occurred because the State agency did not establish adequate policies and procedures to ensure that its MAC complied with Federal requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund $22,481,421 to the Federal Government,
- maintain supporting documentation for Medicaid-reimbursable activities,
- establish policies and procedures to ensure that future MAC calculations follow acceptable cost principles and CMS requirements, and
- maintain supporting documentation for Medicaid eligibility rates used in computing the MAC.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not agree with our findings and recommendations related to its inclusion of unallowable administrative costs in its Medicaid administrative cost pool, its assignment of Medicaid-reimbursable RMTS codes for unallowable and undocumented activities, and its deviation in the RMTS from acceptable statistical sampling practices. The State agency agreed with our recommendation to maintain supporting documentation for Medicaid eligibility rates and described steps that it has taken to address our finding.

After reviewing the State agency comments, we maintain that our findings and recommendations are valid. The State agency's comments appear in their entirety as Appendix B.

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INTRODUCTION

BACKGROUND

Medicaid Program

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

Section 1903(a)(7) of the Act permits States to claim Federal reimbursement for 50 percent of the costs of administrative activities that are necessary for the proper and efficient administration of the State Medicaid plan (Medicaid administration). States submit expenditures for Medicaid administration for reimbursement on Form CMS-64, the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64).

Medicaid Administration Costs

To clarify activities that are "necessary for proper and efficient administration of the State [Medicaid] plan," CMS provided guidance in a State Medicaid Director letter issued on December 20, 1994. The letter stated that allowable claims must be directly related to Medicaid State plan or waiver services and may not include the overhead costs of a provider facility or the operating costs of an agency whose purpose is other than the administration of the Medicaid program. The letter provides that States should ensure that their methodologies for distinguishing administrative activities eligible for Federal financial participation conform to the guidelines in the letter and are included in the State's cost allocation plan.

Federal regulations (45 CFR § 95.507(a)(2)) require that cost allocation plans conform to the accounting principles and standards in Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments* (2 CFR pt. 225), and other pertinent regulations and instructions, including:

- Program costs must be reasonable and necessary and allocated in accordance with the benefits received by the program (OMB Circular A-87, Att. A, §§ C.1.a and C.3.a.

- Random moment sampling may be used to allocate salaries and wages to a Federal award, but such systems must "meet acceptable statistical sampling standards" (OMB Circular A-87, Att. B, § 8.h.6).

- Costs must be adequately documented (OMB Circular A-87, Att. A, § C.1.j).

New **Jersey's Community Mental Health Services Medicaid Administrative Claim**

In New Jersey, the Department of Human Services (State agency) administers the Medicaid program. The State agency contracts with community-based mental health providers to provide Medicaid-covered mental health and related services.[1] Mental health provider staff also perform certain activities in support of the State's administration of the State Medicaid plan.

For FYs 2005 and 2006, the State agency claimed Federal Medicaid reimbursement on the Form CMS-64 totaling $44,962,841 ($22,481,421 Federal share) for Medicaid administration activities performed by mental health providers.[2] The payment rate for these services was computed using a process that resulted in the State's MAC. To develop the MAC, the State agency entered into a contingency fee contract with Maximus, Inc. (Maximus), which designed a four-step method to identify the costs of Medicaid administration activities performed by staff of contracted mental health providers:[3]

1. Maximus first calculated the MAC cost pool, which included the salaries and other operating costs contained in annual operating budgets for the mental health providers.[4]

2. To estimate the percentage of time and related costs spent by mental health provider staff on Medicaid administration efforts, Maximus performed an RMTS of the activities of sampled employees of sampled mental health providers.[5]

3. To determine the Medicaid-related percentage of the employees' administration efforts, Maximus applied the applicable Medicaid eligibility rates—the providers' number of Medicaid patients divided by total patients.

4. Finally, Maximus applied the estimated percentage of the employees' efforts applicable to Medicaid administration to the MAC cost pool.

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[1] The State contracted with 55 community-based mental health providers in State fiscal year (FY) 2005 and 59 in State FY 2006. The mental health providers are managed by nonprofit organizations and county governments. The mental health providers' services include Medicaid and non-Medicaid psychiatric treatment, community residences (e.g., group homes), case management, and job placement.

[2] In another audit (A-02-07-01050), we reviewed whether the State agency's Medicaid Administrative Claim (MAC) for FY 2007 complied with Federal requirements for claiming costs associated with administration of the State Medicaid plan. Because of the volume of random moment timestudy (RMTS) observations (3,168) used to determine the State agency's MAC for FY 2007, we did not analyze each observation. However, our review of selected observations found a high number of errors in properly assigning activities to Medicaid-reimbursable codes. For our current audit period (FYs 2005 and 2006), the State agency used 750 observations to determine its MAC. Therefore, we were able to analyze all of the individual observations.

[3] The contingency fee contract was valued at 4.75 percent of new Federal funds generated by Maximus' efforts. The State agency did not claim the contingency fee for Federal reimbursement.

[4] Maximus utilized FY 2005 operating budgets for FYs 2005 and 2006 in the MAC cost pool.

[5] On the selected date and time, Maximus contacted a sample of employees and recorded an activity code for each reported activity. Maximus calculated the percentage of responses related to various activities.

The resulting MAC was calculated using an estimate that 34 percent of employees' staff time across all mental health agencies was used to perform activities that directly support administration of the State Medicaid plan.[6]

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's MAC for FYs 2005 and 2006 complied with Federal requirements for claiming costs associated with the administration of the State Medicaid plan.

Scope

We reviewed the $44,962,841 ($22,481,421 Federal share) that the State agency claimed on its Forms CMS-64 for FYs 2005 and 2006 related to administrative costs applicable to the mental health providers.

Our objective did not require an understanding or assessment of the State agency's internal control structure. We limited our review to internal controls related to the State agency's and Maximus' calculation of the MAC payment rate.

We performed our fieldwork at the State agency's offices in Trenton, New Jersey, and at 37 mental health providers throughout New Jersey whose costs were used to calculate the MAC.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- reviewed the State agency's contingency fee contract with Maximus;
- held discussions with the State agency, Maximus, U.S. Department of Health and Human Services (HHS) Division of Cost Allocation, and CMS officials to gain an understanding of the process for calculating the MAC;
- reconciled the quarterly administrative costs claims developed by Maximus to the costs submitted by the State agency on the Forms CMS-64;

[6] Based on the RMTS, 14 percent of employees' activities were allocated to direct Medicaid reimbursable codes. However, consistent with CMS guidelines for school-based settings, the State agency redistributed the general administrative activities of the sampled employees across all codes, resulting in an additional 20 percent of activities being allocated to Medicaid.

- reviewed the budgeted costs included in the Medicaid administration cost pool for the mental health providers;

- reviewed the 750 RMTS observations, taken between February 15 and April 15, 2005, that Maximus used to allocate employee time and costs to the Medicaid program;

- analyzed the activity descriptions for 107 observations coded as Medicaid-reimbursable and 643 observations coded as non-Medicaid-reimbursable to determine whether the observations were correctly coded;

- reviewed documentation to support the statewide Medicaid eligibility rates; and

- visited 37 mental health providers to review documentation supporting each provider's Medicaid eligibility rates.

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

FINDINGS AND RECOMMENDATIONS

The State agency's MAC did not comply with Federal requirements for claiming costs associated with the administration of the State Medicaid plan. Specifically, Maximus included unallowable salaries and operating costs in the cost pool used to compute the MAC, resulting in a claim for $22,223,499 ($11,111,750 Federal share) in excess Medicaid administration costs. In addition, Maximus assigned Medicaid-reimbursable RMTS codes to workers' activities that were not allowable costs of Medicaid administration or could not be documented as related to Medicaid and performed an RMTS that deviated from acceptable statistical sampling practices. Finally, in calculating the MAC payment rate, the State agency used Medicaid eligibility rates that could not be documented. Therefore, the remaining $22,739,432 ($11,369,671 Federal share) of administrative costs claimed was unallowable. These errors occurred because the State agency did not establish adequate policies and procedures to ensure that its MAC complied with Federal requirements.

UNALLOWABLE ADMINISTRATIVE COSTS INCLUDED IN MEDICAID ADMINISTRATION COST POOL

Federal Requirements

Section 1903(a)(7) of the Act permits States to claim Federal reimbursement for 50 percent of the costs of administrative activities that are "found necessary by the Secretary for the proper and efficient administration of the State [Medicaid] plan."

On December 20, 1994, CMS issued a State Medicaid Director Letter reiterating its "long-standing policy" on Federal financial participation for costs "found necessary by the Secretary for the proper and efficient administration of the State [Medicaid] plan." The letter stated that allowable administrative costs must be "directly related to Medicaid State plan or waiver services" and may not include the overhead costs of "operating a provider facility" or "the operating costs of an agency whose purpose is other than the administration of the Medicaid program." The letter also stated that allowable administrative costs do not include gaining access to or coordinating non-Medicaid services, even if such services are health related and do not include administrative costs that are part of a direct service. Medicaid pays for administrative costs related to a direct service as part of the payment made for the medical or remedial service. The activities may not be claimed as a separate Medicaid administration cost.

To be allowable under a Federal award, OMB Circular A-87, Att. A, § C.1.a, states that costs must be necessary and reasonable for the proper and efficient performance and administration of the award. Further, costs must be allocable and chargeable in accordance with the relative benefits received. Under OMB A-87, Att. B, § 8.h.6, the sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results.

Unallowable Overhead Costs

Maximus improperly included overhead costs of the mental health providers in the MAC cost pool. The costs consisted of operating costs (e.g., indirect salaries and wages,[7] rent, utilities, and depreciation) that were not directly related to Medicaid administration and were overhead costs of the provider facilities or operating costs of agencies whose purposes were not related to the administration of the Medicaid program. As a result, the State agency claimed excess Medicaid administration costs totaling $13,559,408 ($6,779,704 Federal share).

Unallowable Salaries and Wages

Maximus improperly included unallowable salaries and wages in the MAC cost pool related to employees at 15 mental health providers that provided few or no services covered under the Medicaid program. CMS's 1994 State Medicaid Director Letter states that an allowable Medicaid administration cost must be "directly related to Medicaid State Plan or waiver services." Specifically, the mental health providers furnished primarily mental health-related social, family, legal, and housing services that were not reimbursable by Medicaid. The State agency did not document that activities performed by employees at these agencies, and coded as Medicaid reimbursable in the RMTS, were directly related to the Medicaid program or were separate from activities that were, or should have been, reimbursed as part of the direct services furnished by the agency. As a result, the State agency claimed excess Medicaid administration costs totaling

[7] The unallowable salaries and wages were related to the mental health providers' general and administrative employees who were not included in the RMTS roster. The State agency instructed contract agencies that participated in the RMTS to include on the RMTS roster all employees who perform reimbursable MAC activities and notified the agencies that they could only claim MAC reimbursement for staff included in the RMTS. Maximus also included unallowable salaries and wages for general and administrative staff who did participate in the RMTS, but we were unable to determine the monetary effect of this.

$3,852,000 ($1,926,000 Federal share). Appendix A details the non-Medicaid services provided at the 15 providers.

In addition, Maximus improperly included unallowable direct salaries and wages in the MAC cost pool related to contracted mental health employees who were properly excluded from Maximus' RMTS sample universe. As a result, the State agency claimed excess Medicaid administrative costs totaling $4,812,091 ($2,406,045 Federal share).

RANDOM MOMENT TIMESTUDY OBSERVATIONS IMPROPERLY CODED AS MEDICAID-REIMBURSABLE

Federal Requirements

In the December 20, 1994, State Medicaid Director Letter, CMS provided specific guidance on allowable Medicaid administration activities. The letter, quoted in relevant part below, stated that an allowable administrative cost:

- must be directly related to Medicaid State plan or waiver services. Allowable administrative costs do not include gaining access to or coordinating non-Medicaid services even if such services are health-related. Also, allowable administrative costs do not include gaining access to or coordinating social, educational, vocational, legal or other non-Medicaid services.

- cannot reflect the cost of providing a direct medical or remedial service.

- cannot be an integral part or extension of a direct medical or remedial service, such as patient follow-up, patient assessment, patient counseling, or other physician-extender activities. Such services are properly paid for as part of the payment made for the medical or remedial service.

- may not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns, unless the campaign is explicitly directed at assisting Medicaid eligible individuals to access the Medicaid program.

- may not include the overhead costs of operating a provider facility.

- may not include the operating costs of an agency whose purpose is other than the administration of the Medicaid program.

- must be included in a cost allocation plan that is approved by [CMS] and supported by a system which has the capability to isolate the

costs which are directly related to the support of the Medicaid program from all other costs incurred by the agency.

Random Moment Timestudy Codes Incorrectly Assigned or Insufficiently Documented

For the random moments that Maximus sampled in the RMTS, we found that Medicaid-reimbursable codes were incorrectly assigned to non-Medicaid activities or that activities were not sufficiently documented to show that they were related to Medicaid. For example:

- Work related to a Medicaid beneficiary's treatment plan was coded as "Medicaid administration for referral, coordination and monitoring of medical services." However, under CMS's guidance, preparation of a treatment plan would be reimbursed by Medicaid as part of payment for the associated medical service and should not be assigned to a Medicaid administration code.

- A mental health worker's meeting to discuss the results of an evaluation of a client of the State Division of Youth and Family Services was coded as "Medicaid administration for program planning." However, to be allowable as Medicaid administration, the program planning activity must be directly related to Medicaid services and should relate to planning for improved delivery of Medicaid services to the population served.[8] Under CMS's policies, individual client follow-up would be reimbursed as part of the direct service furnished by the agency. The State agency provided no documentation that the activity was related to developing plans or strategies to improve delivery of Medicaid services to the population served.

- A mental health employee's time spent answering a crisis hotline was coded as "Medicaid referral, coordination and monitoring of medical services." However, the crisis line was established for use by the general public and was not targeted to Medicaid-eligible individuals. Further, the hotline was funded as part of an emergency services program that assisted individuals with accessing non-Medicaid social and other services. Under CMS's policies, costs of general public health initiatives, not explicitly directed to assisting Medicaid eligible individuals to access Medicaid services, are not allowable Medicaid administration costs.

The State agency was unable to document or otherwise support that activities coded as Medicaid-reimbursable were directly related to the Medicaid State plan; were separate from activities that were, or should have been, reimbursed by Medicaid as part of a medical or remedial service; or were otherwise reimbursable as Medicaid administration. As a result, the State agency's remaining claim of $22,739,342 ($11,369,671 Federal share) of administrative costs was unallowable.

[8] CMS issued additional guidance on administrative claiming specifically for school-based settings in its 2003 *Medicaid School-Based Administrative Claiming Guide* (*Claiming Guide*). Although the *Claiming Guide* would not apply directly to payment methods for mental health agencies, it provides additional clarification of types of activities that CMS would consider to be properly coded as Medicaid administration for purposes of conducting an RMTS. The State agency reported that it used the *Claiming Guide* in developing its RMTS codes.

RANDOM MOMENT TIMESTUDY DEVIATED FROM ACCEPTABLE STATISTICAL SAMPLING PRACTICES

Federal Requirements

OMB Circular A-87, Att. B, § 8.h.6 (2 CFR 225 App. B. § 8.h.6), states that random moment sampling may be used to allocate salaries and wages to a Federal award. Further, "… systems which use sampling methods … must meet acceptable statistical sampling standards including: (i) The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results [with certain approved exceptions]; (ii) The entire time period involved must be covered by the sample; and (iii) The results must be statistically valid and applied to the period being sampled."

HHS's *A Guide for State, Local, and Indian Tribal Governments: Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements With the Federal Government* (Reference No. ASMB C-10, pt. 3.4 § 3-23) states that the results of an acceptable statistical sampling method covering one period of time cannot be applied to a different period.

Random Moment Timestudy Used To Allocate Salaries of Employees Not in the Sampling Universe

Salaries of employees that contracted mental health providers did not include on the RMTS roster as performing reimbursable MAC activities were included by the State agency in the cost pool that was allocated using the results of the RMTS.

Random Moment Timestudy Did Not Cover Period to Which It Was Applied

The State agency applied the results of the RMTS to a period that was not covered by the RMTS. Maximus performed the RMTS for the period February 15 through April 15, 2005, but the State agency applied the RMTS results to administrative costs for the period October 1, 2004, through June 30, 2006.

Random Moment Timestudy Did Not Reduce the Potential for Bias

Acceptable statistical sampling practices reduce the potential for bias by ensuring that (1) study participants do not have access to potentially biasing information and (2) selected employees are not notified in advance. Specifically, Maximus' RMTS methodology contained the following departures from acceptable practices to reduce bias:

- Instructional materials that the State agency provided to the mental health providers contained potentially biasing statements that compliance with the RMTS would help generate additional funds for New Jersey and the providers.[9]

- Before Maximus conducted the RMTS, the State agency gave the mental health providers the names and contact times of employees who would be surveyed, thus potentially influencing the employees' assigned duties at the time they were polled.

MEDICAID ELIGIBILITY RATES NOT DOCUMENTED

Pursuant to OMB Circular A-87, Att. A, § C.1.j (2 CFR 225 App. A § C.1.j), allowable costs must be adequately documented.

The State agency did not maintain documents to support the eligibility rates used to determine the percentage of certain employee efforts applicable to the Medicaid program. In computing the MAC, the State agency gave each health center the option to develop its own Medicaid eligibility rate—the center's number of Medicaid patients divided by total patients—or to use a statewide rate. Mental health providers used both options during our audit period; however, the mental health providers and the State agency did not maintain documentation to support the Medicaid eligibility rates that were reported by the providers and used to compute the MAC.

RECOMMENDATIONS

We recommend that the State agency:

- refund $22,481,421 to the Federal Government,

- maintain supporting documentation for Medicaid-reimbursable activities,

- establish policies and procedures to ensure that future MAC calculations follow acceptable cost principles and CMS requirements, and

- maintain supporting documentation for Medicaid eligibility rates used in computing the MAC.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not concur with our findings and recommendations related to its inclusion of unallowable administrative costs in its Medicaid administrative cost pool, its assignment of Medicaid-reimbursable RMTS codes for unallowable and undocumented activities, and its deviation in the RMTS from acceptable statistical sampling

[9] By letter dated January 10, 2005, Maximus informed contracted agencies of the amounts the State agency could expect to recover for each participating staff member and urged "participation in this annual revenue recovery process." The letter offered to share a percentage of Federal revenues recovered with participating agencies and indicated that contracted providers "are encouraged to participate and begin recovering new Federal revenues."

practices. The State agency agreed with our recommendation to maintain supporting documentation for Medicaid eligibility rates and described steps that it has taken to address our finding. State agency's comments appear in their entirety as Appendix B.

Unallowable Administrative Costs Included in Medicaid Administrative Cost Pool

Applicability of Federal Criteria

State Agency Comments

The State agency stated that the OMB Circular A-87 requirement that costs must be "necessary and reasonable" applies to its development of its MAC. However, the State agency argued that "A-87 is only applicable to these provider costs in that the costs paid by the State for the administrative functions performed by the provider agencies must be reasonable, since they are contracted provider payments—not costs of the state agency staff directly performing these activities."

Office of Inspector General Response

The Federal cost principles set forth in OMB Circular A-87 are applicable to all costs incurred by the State under its Federal award. To be allowable to Medicaid under OMB Circular A-87, costs must be both necessary and reasonable and also allocable to Medicaid in accordance with the benefits received by Medicaid. The State may not develop a Medicaid payment rate based on costs that are not allowable. CMS's policy guidance on Medicaid administrative claiming is consistent with OMB Circular A-87. The December 20, 1994, State Medicaid Director Letter provides that allowable Medicaid administration costs must be included in a cost allocation plan approved by CMS. Pursuant to 45 CFR § 95.507, cost allocation plans must conform to OMB Circular A-87 cost principles. In addition, CMS's guidance to school-based programs applies OMB Circular A-87 guidance, particularly with respect to use of an RMTS. Accordingly, the OMB Circular A-87 cost allocation principles apply to the costs used to develop the State agency's MAC payment rate.

Unallowable Overhead Costs

State Agency Comments

The State agency stated that, because contractors perform activities that would otherwise be performed directly by the State agency, the overhead cost of operating contractor facilities may be included in calculating the rate paid for Medicaid administration. The State agency said that it modeled its development of the MAC rates on the approach in the CMS *Claiming Guide*. The State agency also stated that, "[b]ecause regulations do not contain a prohibition on the inclusion of 'overhead costs of operating a provider facility' as being part of allowable and claimable administrative costs … overhead costs were properly included in the claim."

Office of Inspector General Response

CMS's longstanding policy on administrative claiming, set forth in its 1994 State Medicaid Director letter, prohibits including costs that are not directly related to Medicaid and, specifically, the overhead cost of operating a provider agency. Further, the *Claiming Guide* was issued specifically for school settings and may not be applicable to the activities of contracted mental health providers.[10]

In developing its RMTS roster, the State agency instructed mental health providers to include all employees who performed MAC-reimbursable activities. The salaries included in our finding were related to employees that the State agency excluded from its roster of RMTS participants. Salaries of individuals who did not perform Medicaid activities (i.e., employees who were not on the RMTS roster) were not directly related to Medicaid. Further, OMB Circular A-87 requires that the sampling universe for the RMTS include all employees whose salaries and wages are to be allocated based on the sample results. Nevertheless, the State agency included nonroster salaries in the MAC cost pool. Accordingly, overhead costs associated with operating a provider agency and the salaries of employees who did not perform Medicaid activities and were not included on the RMTS roster should not have been included in the MAC cost pool.

We continue to recommend that the State agency refund $6,779,704 to the Federal Government.

Unallowable Salaries and Wages

State Agency Comments

The State agency stated that the salaries and wages related to the 15 contracted mental health providers were properly included in the MAC cost pool because some of the mental health providers' employees performed activities that related to the administration of Medicaid. Citing the December 20, 1994, State Medicaid Director Letter, the State agency argued that operating costs (including salaries) may be included in MAC cost pool if the State agency can identify the fraction of effort devoted exclusively to a Medicaid-claimable activity. The State agency further stated that its RMTS identified this fraction of claimable activity.

Office of Inspector General Response

We reviewed the documentation for the random moments sampled from the 15 mental health providers' employees. These employees reported a total of 13 Medicaid-reimbursable moments out of a total of 750 moments sampled. Of the 13 moments, we found that none of the activities were documented as Medicaid-related. Consequently, the questioned costs cannot be shown to be reasonable Medicaid costs. Further, using the statewide RMTS results to allocate a portion of the salary costs of these 15 mental health providers to Medicaid, when none of their activities can be documented as Medicaid-reimbursable, is contrary to both the OMB Circular A-87's

[10] The *Claiming Guide* was developed to help schools and school districts prepare appropriate claims for administrative costs under Medicaid and to ensure that Medicaid pays for only appropriate school-based administrative activities (*Claiming Guide*, page 1). Schools have a unique role in assuring that Medicaid-required services to children are provided and that eligible children are enrolled in Medicaid.

"necessary and reasonable" standard and CMS's guidance under § 1903 (a) of the Act that costs allowable to Medicaid administration must be necessary for the proper and efficient administration of the State plan. Therefore, the salary costs of these employees should not have been included in the cost pool apportioned to Medicaid on the basis of the statewide RMTS.

We continue to recommend that the State agency refund $1,926,000 to the Federal Government.

Random Moment Timestudy Observations Improperly Coded as Medicaid-Reimbursable

State Agency Comments

The State agency stated that it properly coded and documented its reimbursable costs and modeled its development of the MAC rates on the process described in the *Claiming Guide*. The State agency also indicated that State agency officials met with and emailed CMS representatives in 2004 to provide CMS with an overview of the State agency's MAC methodology and that CMS raised no issues or concerns regarding the State agency's proposed RMTS. In addition, the State agency stated that it disagreed with what it said was our determination that any work performed with existing Medicaid clients should be considered part of a direct medical service and thus included in the direct service rate. Rather, the State agency indicated that other activities with existing clients (e.g., "referral, coordination, and monitoring of medical services") were placed in reimbursable codes in accordance with the *Claiming Guide*.

Office of Inspector General Response

The *Claiming Guide* was issued specifically for school settings and may not be applicable to the activities of contracted mental health providers. However, we reviewed CMS's *Claiming Guide* for guidance on activities that would be properly coded as Medicaid administration under the MAC activity codes used by the State. According to the *Claiming Guide*, the RMTS code for "referral, coordination and monitoring of Medicaid services" should not be used for activities "that are an integral part of or an extension of a medical service (e.g. patient follow-up, patient assessment, patient counseling, patient education, patient consultation, billing activities)." The *Claiming Guide* directs that those activities should be coded and paid for as direct Medicaid services, not as Medicaid administration. The *Claiming Guide* recognizes that in some cases a referral to a Medicaid-covered service (e.g., family planning or medical or physical examinations) could be separate from a direct service furnished by the school. However, such activities must be documented as separate referrals to Medicaid-covered services. The State did not provide the necessary documentation that mental health providers were referring their clients to separate, Medicaid-covered services.

In addition, even though the State agency submitted its cost allocation plan to CMS with an overview and details related to the RMTS, the State agency did not provide documentation that CMS actually reviewed and approved the State agency's RMTS methodology and time codes. Under the *Claiming Guide* (p. 19) and CMS's State Medicaid Director Letter, time coding systems should be approved by CMS before implementation.

The December 20, 1994, State Medicaid Director Letter states that Medicaid pays for administrative costs related to direct services as part of the payment made for medical or remedial services. We reviewed the 107 Medicaid-reimbursable moments and found that the activities coded as "referral, coordination, and monitoring of medical services" appeared to be patient follow-up, patient assessment, patient counseling, or other physician-extender activities related to direct services furnished by the mental health providers. These activities should have been included in the direct service Medicaid rate paid to those providers and not claimed as Medicaid administration activities. Further, the State agency could not document that the coded activities were directly related to Medicaid-covered services; were separate from activities that were, or should have been, reimbursed by Medicaid as part of a medical or remedial service; or were otherwise reimbursable as Medicaid administration.

We continue to recommend that the State agency refund remaining claim of $11,369,671 to the Federal Government.

Random Moment Timestudy Deviated From Acceptable Statistical Sampling Practices

State Agency Comments

The State contends that salaries of employees who are not expected to perform Medicaid administration activities, and who were therefore not included on the RMTS roster, should still be allocated to Medicaid through the RMTS because they perform general and administrative activities for the providers. The State believes this approach is consistent with the *Claiming Guide*. The State disagreed that the results of the RMTS should only be applied to the period covered by the RMTS, as required by OMB Circular A-87. The State agency indicated that "there is no regulation or citation that precluded the results of the study from being employed to calculate the State's contract payments in a subsequent period." The State agency also objected to our finding that the State agency did not reduce the potential for bias. Nevertheless, the State agency indicated that it hired a new contractor to develop the State agency's MAC and that the new contractor had refined and changed its procedures related to the RMTS to address some of our concerns.

Office of Inspector General Response

Federal cost principles set forth in OMB Circular A-87 are applicable to costs incurred by the State under its Federal award, including certain "acceptable statistical sampling standards" for random moment sampling. OMB Circular A-87 requires that the sampling universe include all employees whose salaries and wages are to be allocated based on the RMTS sampling results. Accordingly, salaries of employees who did not perform MAC activities and were not included on the RMTS roster should not have been included in the costs allocated by the RMTS results. In addition, contrary to OMB Circular A-87, the State agency applied RMTS results to time periods not covered by the sample. We also found that the State agency did not adequately reduce the potential for bias in conducting its RMTS.

We continue to recommend that the State agency refund $2,406,045 to the Federal Government.

Medicaid Eligibility Rates Not Documented

State Agency Comments

The State agency indicated that the statewide Medicaid eligibility rate was supported by records that did not exactly match the rate used for FYs 2005 and 2006. According to the State agency, the underlying database is dynamic and corrections are made on an ongoing basis. As a result, the records queried at the time of our audit yielded a slightly different result. In addition, the State agency agreed that it did not require mental health providers to submit supporting documentation for their Medicaid eligibility rates. The State agency stated that it relied on mental health providers to maintain this documentation. The State agency indicated that it has adjusted its procedures to ensure these providers maintain documentation to support their Medicaid eligibility rate.

Office of Inspector General Response

The State agency acknowledged that records used to support the statewide Medicaid eligibility rate were not consistent with the rate actually used; therefore, we continue to recommend that it maintain supporting documentation for Medicaid eligibility rates used in computing the MAC.

APPENDIXES

APPENDIX A: COMMUNITY-BASED MENTAL HEALTH PROVIDERS THAT DID NOT PROVIDE SERVICES COVERED BY MEDICAID

Health Center	Non-Medicaid Services Provided
Advance Housing, Inc.	Housing services
Alternatives, Inc.	Housing services
Health Services, County of Bergen	Legal services
Bridgeway Rehabilitation Services, Inc.	Housing services
Career Opportunity Development, Inc.	Housing services
Central Jersey Legal Services	Legal services
Dept. of Social Services, City of Asbury Park	Legal services
Collaborative Support Programs of NJ, Inc.	Legal and housing services
Community Health Law Project	Legal services
Legal Services of Northwest Jersey	Legal services
Mental Health Association in New Jersey, Inc.	Legal, employment, family, and other services
Mental Health Association of Monmouth County	Housing and family services
Mental Health Association in Passaic County	Legal, family, and other services
Resources for Human Development	Housing services
United Family and Children's Society	Legal services

Note: Advance Housing, Inc.; Bridgeway Rehabilitation Services; Career Opportunity Development; and Alternatives, Inc., had additional fully reimbursed Medicaid and/or Division of Development Disability programs that were properly excluded from the Medicaid Administrative Claim cost pool.

APPENDIX B: STATE AGENCY COMMENTS

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
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November 7, 2011

James P. Edert
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Office of Inspector General
Office of Audit Services Region II
Jacob K. Javits Federal Building
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Report Number: A-02-08-01009

Dear Mr. Edert:

This is in response to your letter dated September 7, 2011 concerning the Department of Health and Human Services, Office of the Inspector General's (OIG) draft report entitled *"Review of Medicaid Administrative Costs Claimed by New Jersey for State Fiscal Years 2005 and 2006"* Your letter provides the opportunity to comment on this draft report.

The objective of this review was to determine whether the New Jersey Department of Human Services' Division Medical Assistance and Health Services's (DMAHS) Medicaid Administrative Claiming (MAC) for fiscal years 2005 and 2006 complied with Federal requirements for claiming costs associated with administration of the State Medicaid plan. Specifically, the State contracts with community-based mental health centers to provide Medicaid-related mental health and related services. Title XIX of the Social Security Act permits states to claim Federal reimbursement for 50 percent of the costs of administrative activities that are necessary for the proper and efficient administration of the State Medicaid plan. The review focused on the MAC claiming for these mental health centers.

The draft audit report concluded that New Jersey's MAC claiming did not comply with Federal requirements for claiming costs associated with the administration of the State Medicaid plan. Specifically, Maximus, DMAHS's contractor who developed the claiming methodology, included unallowable salaries and operating costs in the cost pool used to compute the MAC, resulting in a claim for $22,223,499 ($11,111,750 Federal share) in

excess Medicaid administrative costs. In addition, as part of the allocation method used to identify salary costs to be included in the payment rate, Maximus assigned Medicaid-reimbursable RMTS codes to workers' activities that were not allowable costs related to Medicaid administration, or could not be documented as related to Medicaid, and performed an RMTS that deviated from acceptable statistical sampling practices. Finally, in calculating the MAC payment rate, DMAHS used Medicaid eligibility rates that could not be documented. Therefore, the remaining $22,739,432 ($11,369,671 Federal share) of administrative costs claimed was deemed unallowable. The draft audit report stated that these errors occurred because DMAHS did not establish adequate policies and procedures to ensure that its MAC complied with Federal requirements.

We appreciate the opportunity to provide this response to the draft OIG audit report. Following are the auditors recommendations and DMAHS's responses:

Recommendation 1:

The OIG recommends that New Jersey should refund $22,481,421 to the Federal Government:

The State does not concur with this recommendation. Several of the issues addressed later in this letter derive in part from the auditors' assertion that the Federal Office of Management and Budget (OMB) Circular A-87 applies to the detailed method the State used to calculate the payment which contracted community providers are paid to provide Medicaid Administrative Services. In other words, the auditors' argue that the cost allocation methods used in the provider rate development process must map to those outlined in A-87, which establishes cost principles for state, local, or Indian tribal governments. The auditors' contend that because the costs were claimed by a state agency, A-87 must apply to the calculation of those costs, and thus to the rate development.

Applicability of A-87:

The State believes that this position is flawed because it fails to distinguish between the costs for which the State is seeking reimbursement and the costs to which Section 8.h.(6) of Attachment B of A-87 applies. The State's administrative claim consists of a contractually required payment to be made by the State to provider agencies that represents a reasonable estimation of the costs to be incurred by such agencies in performing allowable Medicaid administrative activities. It is not a claim for the costs of activities performed by State agency personnel. Since Section 8.h(6) relates solely to compensation for personal services of State agency personnel, it is totally unrelated to the contractually required payment that the State is claiming. Thus, while we agree that the general principles contained in Attachment A of A-87 apply to the claiming of the payments themselves in that the costs must be reasonable, we disagree that Attachment B, Section 8 applies to the specific method used to calculate provider rates. OMB Circular A-87, which contains the cost principles for State, Local and Indian Tribal governments for the administration of federal awards, states that, "Governmental units

are responsible for the efficient and effective administration of federal awards." Under these provisions, costs must be reasonable and necessary for the operation of the governmental unit or the performance of the federal award. OMB Circular A-87 goes on to state "Reasonable Costs - A cost is reasonable if, in its nature and amount, it does not exceed that which would be incurred by a prudent person under the circumstances prevailing at the time the decision was made to incur the cost..." and "In determining reasonableness of a given cost, consideration shall be given to:

A. Whether the cost is of a type generally recognized as ordinary and necessary for the operation of the governmental unit or the performance of the Federal award.
B. The restraints or requirements imposed by such factors as: sound business practices; arms length bargaining; Federal, State and other laws and regulations; and, terms and conditions of the Federal award.
C. Market prices for comparable goods or services.
D. Whether the individuals concerned acted with prudence in the circumstances considering their responsibilities to the governmental unit, its employees, the public at large, and the Federal Government."

The State argues that A-87 is only applicable to these provider costs in that the cost paid by the State for the administrative functions performed by the provider agencies must be reasonable, since they are contracted provider payments – not costs of the state agency staff directly performing these activities. The State has established what it contends is a reasonable method for establishing a rate paid to the providers for the purchase of Medicaid administrative services. Providers are paid pursuant to their contract at this rate, and once the payments are made, the State claims these payments. The payment must be claimed consistent with the principles contained in Attachment A of A-87, and the rate must be "reasonable", however the specific method for calculating the rate is not defined by A-87.

As a parallel example, in a foster care setting the state Title IV-E agency pays foster homes (providers) for the room, board, and supervision of the child via a monthly foster home payment (rate), which can be claimed to the Title IV-E program. States do not develop these rates by applying the same A-87 cost allocation principles that they would apply to developing claims for their own state agency staff costs. Rather, a reasonable method is used for establishing rates for various levels of care, this rate is paid to the provider, and payment made is the agency costs, assuming the child is Title IV-E eligible.

Unallowable Administrative Costs Included In Medicaid Administrative Cost Pool:

Unallowable Overhead Costs:

Finding:

The auditors' draft audit report contends that overhead costs of the mental health providers were improperly included in the MAC cost pool. The costs consisted of

operating costs that were not directly related to the administration of the Medicaid program and were operating costs of an agency whose purpose is other than administration of the Medicaid program. As a result, DMAHS claimed excess Medicaid administration costs of $6,779,704.

Response:

The State disagrees with the auditors' assertion that overhead costs were ***improperly*** included in the claim. We believe that such costs are properly includable as a component of the rates paid. The auditors cite a December 20, 1994 CMS State Medicaid Director Letter regarding administrative case management. The report includes a bullet from page 5 of the December letter indicating that an allowable administrative cost... "may not include the overhead costs of operating a provider facility such as the supervision and training of providers."

In developing the rates paid to the non-profit behavioral health service providers for administrative activities, the State modeled its approach on the School-Based Administrative Claiming Guide (School MAC Guide) issued by the Centers for Medicaid and Medicare Services (CMS). This is the only resource we have found which speaks directly to a method for calculating Medicaid Administration in a non-state agency setting. Schools play a similar role to Division of Mental Health Services (DMHS) community based agencies in terms of Medicaid administration. Schools perform Medicaid Administration on behalf of a state under an interagency agreement between the local education agency and the State. DMHS providers perform Medicaid Administration on behalf of the State of New Jersey pursuant to a contract between DMHS and the provider. In both cases the entity is serving individuals who have a likelihood of being Medicaid eligible, and in both cases the purpose of the entity is not exclusively provision of Medicaid services or Medicaid Administration. Both school staff and community mental health providers play an important role on behalf of the state in ensuring and promoting that the vulnerable populations get access to needed Medicaid services. Given all of these similarities, and the fact that this is published guidance from the federal cognizant agency (CMS), New Jersey concluded that it was reasonable to model a rate development process on this guide.

The School MAC Guide served as the basis for New Jersey's approach to developing compensation rates. These rates are paid to entities to perform activities that are necessary for the proper and efficient administration of the State Medicaid program that would otherwise have been performed directly by the State itself.

As such the State contends that the overhead costs included in our claim are allowable and are the same as those claimed in school-based settings nationwide, as well as in community settings in other states such as Indiana. As an example, the Departmental Appeals Board (DAB) made a decision related to Medicaid Administration in Texas DAB 2187 (2008). In addressing a particular questioned cost under dispute, the decision described that Texas included costs above and beyond those of the direct service staff

salaries and benefits as Medicaid administrative costs – and neither CMS nor the DAB questioned the appropriateness of including such costs, nor were they included via application of an indirect cost rate. Texas' claimed costs included "direct support staff" of time study participants, "materials, supplies, travel, and other operating costs for staff in the time study and their support staff. While the auditors question the inclusion of such costs in our rate development in New Jersey, these costs were not questioned by CMS or the DAB in Texas. Rather, CMS and the Board were focused on one particular item included within these "operating costs" which they determined to be educational in nature, not a general operating cost. Only this specific "educational" cost was disallowed.

The State further disputes the auditors' assertion because the State questions the applicability and enforceability of the statement contained in the bullet from page 5 of the December 20, 1994 CMS State Medicaid Director Letter. On page 7 of the letter, the Health Care Financing Administration (the prior name for CMS) indicated that "(W)e plan to issue an expanded list of policy interpretations to guide States' decision making regarding allowable costs for Medicaid administrative match for ACM [administrative case management] and other functions performed by state or local governments in a SMM [State Medicaid Manual] issuance. We also intend to incorporate these interpretations in regulations." By this statement, HCFA tacitly admitted that, in order for the policies contained in the letter to be given force, its contents must be included in either an official document, such as the SMM, or codified as official policy in the Code of Federal Regulations. To our knowledge, neither of these actions was ever taken. Because the regulations do not contain a prohibition on the inclusion of "overhead costs of operating a provider facility" as being a part of allowable and claimable administrative costs, as is the case with respect to 75% FFP for the costs of Skilled Professional Medical Personnel, we maintain that overhead costs were properly included in the claim.

Unallowable Salaries and Wages:

Finding:

The auditors contend that unallowable salaries and wages were improperly included in the MAC cost pool related to employees at 15 mental health providers that provided few or no services covered under the Medicaid program. As a result, DMAHS claimed excess Medicaid administration costs of $1,926,000.

Response:

The auditors' position is that because for some of these providers, their primary mission is providing "related social, family, legal, or housing" services, they could not be performing activities which directly benefit the Medicaid program. As authority for its position, they cite a bullet on page 6 of the December 20, 1994 CMS State Medicaid Director Letter indicating that allowable administrative costs... "may not include the operating costs of an agency whose purpose is other than the administration of the

Medicaid program, such as the operation of a probation department." The State strongly disagrees that this prohibition is applicable with respect to the 15 provider agencies referenced in the OIG draft report.

Unlike a probation department, that performs functions totally distinct from that of Medicaid type providers, the Division of Mental Health Services (DMHS) providers serve clients with mental illness, which is a vulnerable population for whom the provision of regular care is particularly critical. A crucial role that all providers play – even those such as the 15 providers referenced in the OIG draft report, that they themselves are not providing direct Medicaid services – is assuring that these clients obtain and maintain regular access to Medicaid covered behavioral health and medical care. Thus, similar to schools in the School-Based MAC program, whose primary purpose is to provide services that are not Medicaid eligible or directly related to the Medicaid State Plan, staff within these 15 mental health providers do perform activities which directly relate to the administration of the Medicaid program and should therefore be allowable under the MAC claim. The State contends that the nature of the activity rather than the nature of the entity is what should govern the claimability.

Furthermore 7 of the providers at issue are providing community support services for individuals in supportive housing settings, which is a coverable Medicaid service. The audit characterizes these as housing services. NJ received CMS approval of a SPA to cover community support services effective 10/1/11. The fact that this service was not a covered service at the time of audit is irrelevant as the service is in fact coverable and NJ has an approved SPA to provide this service. Again we would argue that the focus must be upon the nature of the administrative activities being performed, not the nature of the entity.

As the above paragraphs indicate, the 15 cited provider agencies do perform necessary and allowable Medicaid administrative tasks. As a consequence, their activities and costs fall under another statement contained in the December 1994 CMS Letter that was not cited in the OIG draft audit report. As a caveat to the prohibition cited in the OIG draft report, and placed immediately after it, the Letter states:

However, to the degree that a governmental agency directs some fraction of its efforts exclusively to Medicaid claimable administrative services, and can accurately identify that fraction, it may claim an appropriate portion of its operating costs to support that function if all other criteria for administrative claiming is satisfied (e.g., direct relationship to the State plan, health-related, etc.)

As permitted by the above paragraph, the State's methodology, through use of the Random Moment Time Study (RMTS), accurately identified the "fraction" of the efforts expended exclusively to Medicaid claimable administrative activities by staff at the 15 cited provider agencies and included only the appropriate portion of the provider agencies' operating costs related to such Medicaid claimable administrative activities in determining the amount of the contract payment to be made by the State to the agencies. Thus, contrary to the auditors' position, the inclusion of 15 questioned

provider agencies in the sample and the designation of a portion of their costs as representing allowable Medicaid administrative expenditures are appropriate and allowable.

Random Moment Time Study Observations Improperly Coded As Medicaid Reimbursable:

Random Moment Time study Codes Incorrectly Assigned or Insufficiently Documented:

Finding:

The audit report indicates that for the moments sampled, Medicaid reimbursable codes were incorrectly assigned to non-Medicaid activities or that activities were not sufficiently documented to show that they were related to Medicaid. The audit report states that the State Agency was unable to document or otherwise support that activities coded as Medicaid-reimbursable were directly related to the Medicaid State Plan; were separate from activities that were, or should have been, reimbursed by Medicaid as part of a medical or remedial service; or were otherwise reimbursable as Medicaid administration. As a result, DMAHS' remaining claim of $11,369,671 of administrative costs was unallowable.

Response:

The State disagrees with the audit report and believes that allowable Medicaid-reimbursable costs were properly coded and documented. As previously mentioned throughout this response letter, New Jersey Division of Mental Health modeled its Medicaid Administrative Claiming/Random Moment Time Study process to the School MAC Guide issued by CMS. The School MAC Guide provides a suggested coding structure for time studies used for Medicaid administration. On May 27, 2004, New Jersey Division of Mental Health Services staff met with CMS representatives and provided an overview of the Medicaid Administrative Claiming for Community Mental Health Center Contracted Services as described in a Division of Mental Health Services' staff email dated May 27, 2004. On November 19, 2004 Division of Mental Health Services staff provided through email to regional CMS representatives details regarding the program, including the fact that a time study would be utilized in development of the rate, and definitions of the time study codes. There were many examples listed for each of the time study codes. Providing crisis or hot-line phone services for health/mental health care services was one of the examples listed for the Referral, Coordination and Monitoring of Medical Services (not TCM) code and pertains to clients that we serve and not a general crisis hotline. CMS raised no issues or concerns pertaining to any of the time study code definitions prior to the approval of the cost allocation plan.

In regard to allowable Medicaid administration activities and costs, according to the Medicaid statute at section 1903(a)(7) of the Act and the implementing regulations at 42

CFR 430.1 and 42 CFR 431.15, for the cost of any activities to be allowable and reimbursable under Medicaid, the activities must be "found necessary by the Secretary for the proper and efficient administration of the plan" (referring to the Medicaid state plan).

Medicaid Administrative Claiming has been approved by the Center for Medicare and Medicaid Services. The State Medicaid Manual (SMM) Section 4302 identifies certain activities that may be properly claimed as administrative case management. An allowable administrative cost must be directly related to a Medicaid state plan or waiver service, and be necessary for the "proper and efficient administration of the state plan." Some examples of administrative case management services addressed at SMM Section 4302.2 (G)(2), are:

- Medicaid eligibility determinations and redeterminations;
- Medicaid intake processing;
- Medicaid preadmission screening for inpatient care;
- Prior authorization for Medicaid services;
- Utilization review; and
- Medicaid outreach

In the State Medicaid Director Letter (SMD) December 20, 1994, the Health Care Financing Administration (now CMS) provides a similar list of administrative activities, but indicates that this list from the SMM "was not intended to be all-inclusive".

The auditors' took issue with the coding of moments in the 2005-2006 fiscal year time studies and indicated that any work with an existing client should be considered part of the direct medical service, and thus included in the rate for direct medical services. We disagree with this finding and interpretation of the December 20, 1994, State Medicaid Director Letter. The time study responses for certain activities with existing clients such as the patient follow-up, patient assessment, patient education, counseling activities were placed in non-reimbursable activity codes. Other activities with existing clients such as referral, coordination and monitoring of medical services were placed in reimbursable codes. Again as expressed throughout this response the State's guide has been the MAC School guide.

Additionally the providers and programs included in the MAC program do not have rates established which include Medicaid administration and administrative case management. DMHS does have several programs which utilize "fully loaded" rates (such as Integrated Case Management, PACT, Partial Care, and Residential Services) which include Medicaid administration as part of the rate, however:

- Provider liaisons were instructed to exclude staff from the time study that were 100% assigned to these programs
- For staff who were partially assigned to these programs, if working on these programs when sampled, the time spent to these programs was assigned to a non-allowable code

- During the rate development, costs associated with these programs were excluded from the cost pool.

Other services reimbursed through a Medicaid rate include Individual Psychotherapy, Group Psychotherapy, Family Therapy, Medication Monitoring, Intake Evaluation, Psychological Testing and Family Conference. Some of these rates have not been updated since the late 1980's and/or mid 1990's and are not considered to be fully loaded rates (i.e. do not include reimbursement of Medicaid administrative costs).

The School MAC Guide provides suggested coding structure for time studies used for Medicaid administration, a structure upon which New Jersey based its MAC time study. This coding structure provides for seven allowable administrative activities, as demonstrated in the table below, in addition to allowing for a reallocated portion of general administrative activities to be attributed to Medicaid administration.

	SCHOOL MAC GUIDE CODE	REIMBURSABLE STATUS
	CODE 1.b. Medicaid Outreach	Total Medicaid – 100% Medicaid activity
	CODE 2.b. Facilitating Medicaid Eligibility Determination	Total Medicaid
	CODE 5.b. Transportation Related Activities in Support of Medicaid Covered Services	Partial Medicaid – Medicaid when performed for Medicaid eligible client, or when Medicaid Eligibility Rate is applied
	CODE 6.b. Translation Related to Medicaid Services	Partial Medicaid
	CODE 7.b. Program Planning, Policy Development, and Interagency Coordination Related to Medical Services	Partial Medicaid
	CODE 8.b. Medical/Medicaid Related Training	Partial Medicaid
	CODE 9.b. Referral, Coordination, and Monitoring of Medicaid Services	Partial Medicaid

The most common allowable activity performed by DMHS contracted community providers is "Referral, Coordination and Monitoring of Medicaid Services", which the

School MAC Guide defines as "making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services." The guide clearly anticipates and distinguishes these activities from activities which are "an integral part or extension of a medical service (e.g., patient follow-up, patient assessment, patient counseling, patient education, patient consultation, and billing activities)". This definition simply makes no sense if OIG is correct in their characterization that there is no Medicaid administration for existing clients that is not part of the direct service rate.

Random Moment Time Study Deviated From Acceptable Statistical Sampling Practices:

Random Moment Time Study Used To Allocate Salaries of Employees Not in the Sampling Universe:

Finding:

The auditors' report contends that the salaries of employees that contracted mental health providers did not include on the RMTS roster as performing reimbursable MAC activities were included by the State in the cost pool that was allocated using the results of the RMTS. As a result, DMAHS claimed excess Medicaid administrative costs of $2,406,045.

Response:

The State disagrees that such salaries should not have been included in the cost pool that was subsequently allocated using the results of the RMTS. Staff assigned to the General and Administrative Cost Column per the DMHS budget can be included in the RMTS if they perform Medicaid Administrative activities. If they do not perform Medicaid Administrative activities directly thus qualifying for participation in the RMTS, they are assigned to the G&A cost pool and subsequently allocated as G&A to benefiting program. As noted above the State contends that G&A costs are fully allowable costs.

As discussed previously, in developing the model for the MAC Program the State relied upon the CMS School MAC guide, the only detailed, operational document issued by CMS about claiming Medicaid administration. In discussing the type of staff that should be included in a MAC time study, CMS never excludes the type of administrative titles cited by the auditors. In fact, the guide provides two basic principles for the inclusion of staff:

- Staff whose salaries are 100% funded by non state/local funds should not be included, as a revenue offset would be required, effectively nullifying the addition of their costs in the cost pool. "For example, if federal funding sources or third party payers other than Medicaid meet 100 percent of the costs of social workers, then there would be no reason to include such workers in the time study and they must be excluded from participation."

- Only staff that perform Medicaid administrative activities should be included. "For example, medical staff hired by the schools as contractors and reimbursed on a fixed fee basis... and who do not perform any other administrative activities, should not be included in the time study."

CMS advocates in the School MAC guide examining the responsibilities of individual staff to determine if their job responsibilities include Medicaid administrative activities, such as reviewing position descriptions, to determine if a particular staff member is appropriate for inclusion.

Because of the large number of community providers participating in the program, the program includes agencies with widely varied organizational structures. In many of the smaller agencies, staff commonly serve multiple functions, and their official title may not be indicative of the types of activities the person actually performs. As a result of this variety, DMHS could not have created a list of "acceptable" ***titles*** for inclusion in the study. Instead, the State determined that the community providers themselves would be in the best position to determine which staff would be appropriate for inclusion in the study. Providers in the MAC program were asked to establish a program liaison that was responsible for preparing and submitting an agency roster of staff for participation in the time study. Staff were to be included on the roster based upon a number of rules, including the following principles:

Staff are expected to perform Medicaid administrative activities
Staff are paid staff
Staff are not 100% federally funded
Staff are not funded under one of several New Jersey programs which have fully loaded rates (including Medicaid administration)
Staff are not classified as 100% indirect

Agencies were provided an opportunity on a quarterly basis to update their staff rosters. The instructions for these updates, repeated the guidelines for what types of staff should be included in the study.

While some program liaisons may have made errors in the application of these guidelines, the general approach that the State implemented is consistent with the School MAC guide. It is not the title of the individual, but whether or not they are expected to perform MAC activities that is the determining factor of whether or not the person is to be included.

Moreover, our position is further supported by Texas DAB 2187 (2008), in which the DAB found in favor of the state related to the inclusion of non-direct service staff in the time study. OIG argued that "school principals, their secretaries, school superintendents, and certain other categories of school personnel on the ground that these individuals did not perform activities related to Medicaid." Texas demonstrated via time study results that these types of staff did perform Medicaid administrative activities, "CMS disavowed the original basis for the disallowance", and the DAB

reversed the disallowance. Additionally, this decision includes discussion of contractor costs, including some contractors that did not provide direct services. Again, the conclusion was that even though these contractors did not provide direct services, they still could be included in the time study.

Random Moment Time Study Did Not Cover Period to Which It Was Applied:

Finding:

The auditors question the propriety of the State's claim because the State applied the results of the RMTS to a period that was not covered by the time study. The RMTS was performed for the period February 15, 2005 through April 15, 2005, whereas the results were applied to the administrative costs for the period October 1, 2004 through June 30, 2006. In doing so, the OIG cites OMB Circular A-87, Attachment B, Section 8.h.(6)(a)(ii), which states that "the entire time period involved must be covered by the sample, as justification for its action.

Response:

The State disagrees with the auditors' position and believes that it is flawed because it fails to distinguish between the costs for which the State is seeking reimbursement and the costs to which Section 8.h.(6)(a)(ii) of Attachment B of A-87 applies.

The State's administrative claim consists of a contractually required payment to be made by the State to provider agencies that represents a reasonable estimation of the costs to be incurred by such agencies in performing allowable Medicaid administrative activities. As such, it does not represent a claim for the costs of activities performed by State agency personnel. Consequently, Section 8.h.(6)(a)(ii) is simply not applicable in this matter because it pertains solely to the calculation of compensation for personal services of State agency personnel and therefore is totally unrelated to the contractually required payment that the State is claiming. Thus, the auditor is incorrect in citing this section of A-87 as a basis of questioning the State's claim.

In order to determine an appropriate amount of the State's contract payment that meets the "reasonableness" standard contained in Circular A-87, the State is required to employ a valid methodology designed to accurately determine the portion of total provider agency time and effort expended on allowable and reimbursable Medicaid administrative activities. The method chosen to do so is the RMTS. In the current dispute, a RMTS was performed during the period February 15, 2005 through April 15, 2005 and the resulting percentage rate of time spent on allowable provider agency Medicaid administrative activities was employed to determine the amount of the State's total contractual payments to be made to the provider agencies .for the period October 1, 2004 through June 30, 2006. Since, in the State's claiming process, the RMTS serves solely as the mechanism to accurately determine the portion of total provider agency time and effort expended on allowable and reimbursable Medicaid administrative activities, there is no regulation or citation that precludes the results of

the study from being employed to calculate the State's contract payments in a different period.

Random Moment Time Study Did Not Reduce the Potential for Bias:

Finding:

The auditors contend that the RMTS deviated from acceptable statistical sampling practices because it did not reduce the potential for bias by ensuring that (1) study participants did not have access to potentially biasing information, and (2) selected employees were not notified in advance. Specifically, the RMTS methodology contained the following deviations from acceptable statistical sampling practices to reduce bias:

1. Instructional materials provided to the mental health providers contained potentially biasing statements that compliance with the RMTS would help generate additional funds for New Jersey and the mental health providers.

2. DMHS gave the mental health providers the names and contact times of employees prior to conducting the RMTS thereby potentially influencing the employees' assigned duties at the time they were polled.

Response:

The State's position on each of the above is as follows:

1. While it is true that time study information forms and liaison instructions indicated that participation in the program could generate additional funds for both the state and the community providers, the State disagrees that these statements are biasing. These materials were created to inform potential participants of the reasons why a time study was being implemented and imposed upon them, a common sense necessity in order to obtain worker cooperation, that they might be contacted, and to emphasize the importance of responding to time study phone pollers. Given the busy schedules of the community agency staff, this information was provided to encourage their cooperation, thereby allowing for a more accurate time study result. Contrary to the implication in the auditors' draft report's conclusion, staff were not informed or "coached" as to which response would result in additional funding – but instead, were only requested to provide information on the activity they were performing in sufficient detail in order to allow the phone poller to assign a code to their activity.

   Moreover, it is not unusual to inform staff that a function they are performing (responding to the time study) other than the actual direct service, is important for agency funding. As an example, clinicians may be asked to complete special forms, documentation, or coding following an office visit to allow for billing to Medicaid or third party insurance.

2. The School MAC guide says "All staff in the sample universe should be adequately trained before the sampling begins. Training should cover all aspects of the sampling process." The State chose to accomplish this via distribution of a time study training information form to be given to time study participants. In an effort to ensure that all staff that were to participate in the time study each quarter had been furnished with this information form, each community agency's liaison was provided with a "control list" of sampled employees for the quarter. The purpose of this list was not as the auditor's draft report implies, to notify the sampled individuals in advance of the day or time of their moment, but instead to ensure that all individuals had received training materials consistent with the School MAC guide. At no time did the state request the provider liaisons to advise employees when they would be contacted. Given the large number of participants statewide, this approach was used to assure that when an individual was sampled, they would be conscious of the program and be in a position to participate according to the established guidelines.

   As the program moved forward, the state moved to providing a control list which included individual names, but not dates or times to avoid any possibility of advance notice; finally the use of a control list was abandoned and liaisons were asked to provide the training materials to every rostered staff member, since all had a chance of being sampled, rather than just to those staff who were selected for the study.

   The auditors contend that any party in a community agency knowing who might participate in the study introduces unacceptable bias. The State disagrees with this position. Many states utilize paper time studies or "observer" time studies for allocation of costs in one or more public assistance programs. In both of these cases, someone within the agency must know ahead of time who will be sampled when, to ensure that the sampled individual is either provided the paper time study form, or that the observer visits the sampled individual to observe their activities. Although the procedures for the program were changed over time, we still contend that the notification to an agency liaison of the sampled individuals and the sampled moments was acceptable.

Medicaid Eligibility Rates (MER) Not Documented:

Finding:

The auditors contend that the State did not maintain documents to support the MER used to determine the percentage of employee efforts applicable to the Medicaid program and further that the providers did not maintain such documentation.

Response:

The State required providers to develop and submit their MER. For providers that failed to do so the State developed a statewide MER rate that was used in the absence of a

provider specific MER rate. The State concurs that we did not specifically require providers to submit the underlying documentation for the development of their MER and instead relied on providers to maintain such documentation.

The underlying database for the calculation of the statewide MER is dynamic and corrections are made on an ongoing basis from time-to-time after the period at issue. As a result, querying the records currently in the database for SFY 2005 and SFY 2006 yielded a result slightly different than that from the original query. The originally query used for the claim yielded a statewide MER of 35.8% and the current query of the applicable period yielded 31.1%.

Recommendation 2:

The OIG Recommends that DMAHS maintain Supporting Documentation for Medicaid Reimbursable Activities:

Response:

As detailed above, the State believes that the RMTS coding was appropriate and that the documentation maintained did clearly support the allowability of the activities. Prospectively the State is considering amending the State Plan to request permission for the entity administering the RMTS to use an email response system to provide further documentation trail regarding the exact nature of the activities being performed. The concerns raised through this audit have been communicated to the administering entity so that staff administering the RMTS can reinforce efforts to obtain clear comprehensive evidence of the activities to assure proper coding.

Recommendation 3:

The OIG Recommends that DMAHS Establish Policies and Procedures to Ensure that Future RMTS results Used to Allocate Costs to Medicaid Follow Acceptable Sampling Practices:
Response:

While the State believes that the RMTS used during this audit period to allocate costs to Medicaid were acceptable, the State has replaced Maximus and retained Public Consulting Group (PCG) to develop MAC claims for subsequent years. PCG also uses a RMTS to identify the Medicaid administration activities of staff in the contracted mental health centers. Public Consulting Group has refined and changed the RMTS procedures to address some of the concerns expressed by the auditors.

Recommendation 4:

The OIG Recommends that DMAHS Maintain Supporting Documentation for Medicaid Eligibility Rates Used in Computing the MAC:

Response:

The State has adjusted its procedures to assure prospectively that providers submit an attestation with their MER data regarding maintenance of underlying documentation. This documentation will be available for a review by an auditor.

If you have any questions or require additional information, please contact me or Richard Hurd at (609) 588-2550. I would like to thank the OIG audit team for their professionalism throughout the audit and our review of their findings and recommendations.

Sincerely,

Valerie Harr
Director

VH:H
c: Jennifer Velez
Richard Hurd