Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SOME OF NEW JERSEY'S CLAIMS FOR MEDICAID GLOBAL OPTIONS FOR LONG-TERM CARE WAIVER SERVICES WERE UNALLOWABLE

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EXECUTIVE SUMMARY

New Jersey claimed at least $47.3 million in Federal Medicaid reimbursement over 4 years for Global Options for Long-Term Care waiver services that were unallowable.

WHY WE DID THIS REVIEW

This audit is part of a series of reviews of New Jersey's Medicaid waiver programs. During prior reviews, we determined that the New Jersey Department of Human Services (State agency) claimed Federal Medicaid reimbursement for home and community-based services (HCBS) that did not comply with Federal requirements under a Medicaid waiver program.

The objective of this review was to determine whether the State agency's claims for Medicaid reimbursement for Global Options for Long-Term Care (GO-LTC) waiver services complied with certain Federal and State requirements.

BACKGROUND

In New Jersey, the State agency's Division of Medical Assistance and Health Services administers the Medicaid program and is responsible for the State's Medicaid waiver programs. Until the Medicaid GO-LTC waiver program transitioned to a managed care program in July 2014, the program was operated by the State agency's Division of Aging Services. GO-LTC enabled Medicaid beneficiaries assessed as needing nursing facility level of care and who met financial requirements to remain in the community or return from institutional care to the community.

Federal regulations require the State agency to conduct initial evaluations and annual reevaluations of Medicaid beneficiaries' level-of-care needs. Further, services must be furnished under a completed and approved plan of care (care plan). In addition, providers must maintain State licenses to perform services, as well as maintain complete and accurate records to support services billed. Federal regulations also require providers to ensure the personnel performing services are qualified and all services provided are appropriately billed to the waiver. The State agency is also required to claim reimbursement at the appropriate Federal medical assistance percentage (FMAP).

HOW WE CONDUCTED THIS REVIEW

From July 1, 2009, through June 30, 2013, we limited our review to Medicaid costs claimed for GO-LTC waiver services greater than $100 for a beneficiary-month of service. From a total of approximately $668 million ($335 million Federal share) that the State agency claimed during 427,223 beneficiary-months, we reviewed a random sample of 131 beneficiary-months. A beneficiary-month includes all GO-LTC waiver services for a beneficiary for 1 month.

WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for some GO-LTC waiver services that did not comply with certain Federal and State requirements. Of the 131 beneficiary-months in our sample, the State agency properly claimed Medicaid reimbursement for all GO-LTC waiver services during 69 beneficiary-months. However, the State agency claimed Medicaid reimbursement for unallowable GO-LTC waiver services during the remaining 62 beneficiary-months. Of the 62 beneficiary-months with services for which the State agency improperly claimed Federal Medicaid reimbursement, 29 contained more than 1 deficiency.

The State agency made claims for unallowable services because it lacked clear guidance on claiming and documenting Medicaid services for beneficiaries enrolled in the GO-LTC waiver program and providers did not ensure that: (1) services claimed were adequately documented, (2) services were provided only to beneficiaries with completed and approved care plans, (3) provider qualifications were documented, (4) beneficiaries' level-of-care evaluations were documented, (5) providers maintained State licenses authorizing them to provide services, (6) services were appropriately billed to the waiver, and (7) services were billed at the appropriate FMAP. On the basis of our sample results, we estimated that the State agency improperly claimed at least $47,355,736 in Federal Medicaid reimbursement for unallowable GO-LTC waiver services.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $47,355,736 to the Federal Government and

- reinforce guidance to the provider community on Federal and State requirements for claiming and documenting Medicaid services for beneficiaries.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency did not concur with our first recommendation and generally concurred with our second recommendation. Specifically, the State agency stated that it had provided supporting documentation that would eliminate or substantially reduce our recommended recovery amount. The State agency also stated that, although the GO-LTC waiver program transitioned to managed care organizations (MCOs) after the end of our audit period, it will provide periodic external quality reviews of these MCOs to ensure compliance with Federal and State regulations.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. We reviewed the additional documentation provided by the State agency before issuing our draft report and reduced our preliminary recommended disallowance accordingly. However, we determined that the remaining claims for Federal Medicaid reimbursement for GO-LTC waiver services still did not comply with certain Federal and State requirements.

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WHY WE DID THIS REVIEW

This audit is part of a series of reviews of New Jersey's Medicaid waiver programs. During prior reviews, we determined that the New Jersey Department of Human Services (State agency) claimed Federal Medicaid reimbursement for home and community-based services (HCBS) that did not comply with Federal requirements under a Medicaid waiver program. For a list of related Office of Inspector General reports, see Appendix A.

OBJECTIVE

Our objective was to determine whether the State agency's claims for Medicaid reimbursement for Global Options for Long-Term Care (GO-LTC) waiver services complied with certain Federal and State requirements.

BACKGROUND

The 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 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 Federal requirements.

Home and Community-Based Services Waivers Under the Medicaid Program

Section 1915(c) of the Social Security Act (the Act) authorizes Medicaid home and community-based services (HCBS) waiver programs.[1] HCBS may be provided only to beneficiaries who a State agency determines would, in the absence of such services, require the Medicaid-covered level of care provided in a hospital, nursing facility, or intermediate care facility for persons with intellectual disabilities.[2]

To be eligible for Federal Medicaid reimbursement, HCBS must be furnished under a written plan of care (care plan) and, on at least an annual basis, beneficiaries receiving HCBS must be reevaluated. To be eligible for HCBS, a beneficiary's care plan must include an assessment of the services needed to prevent the beneficiary from requiring institutionalization. The care plan must specify the medical and other services to be provided and their frequency.

[1] A State's HCBS waiver program must be approved by CMS and allows a State to claim Federal reimbursement for services not usually covered by Medicaid. HCBS are generally provided to Medicaid-eligible beneficiaries in the community rather than in an institutional setting.

[2] Changes in terminology are based on Rosa's Law (P.L. No. 111-256). For more information, see CMS Final Rule, 77 Fed. Reg. 29002, 29021 & 29028 (May 16, 2012).

Global Options for Long-Term Care Waiver Services in New Jersey

In New Jersey, the State agency's Division of Medical Assistance and Health Services administers the Medicaid program and is responsible for the State's Medicaid waiver programs. Until the Medicaid GO-LTC waiver program transitioned to a managed care program in July 2014, the program was operated by the State agency's Division of Aging Services. GO-LTC enabled Medicaid beneficiaries assessed as needing nursing facility level of care and who met financial requirements to remain in the community or return from institutional care to the community.

For details on Federal and State requirements related to the State agency's GO-LTC waiver program, see Appendix B.

HOW WE CONDUCTED THIS REVIEW

From July 1, 2009, through June 30, 2013, we limited our review to Medicaid costs claimed for GO-LTC waiver services greater than $100 for a beneficiary-month of service. From a total of approximately $668 million ($335 million Federal share) that the State agency claimed during 427,223 beneficiary-months, we reviewed a random sample of 131 beneficiary-months.[3]

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

Appendix C 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

The State agency claimed Federal Medicaid reimbursement for some GO-LTC waiver services that did not comply with certain Federal and State requirements. Of the 131 beneficiary-months in our sample, the State agency properly claimed Medicaid reimbursement for all GO-LTC waiver services during 69 beneficiary-months. However, the State agency claimed Medicaid reimbursement for unallowable GO-LTC waiver services during the remaining 62 beneficiary-months. Of the 62 beneficiary-months with services for which the State agency improperly claimed Federal Medicaid reimbursement, 29 contained more than 1 deficiency. Table 1 on the next page summarizes the deficiencies noted and the number of beneficiary-months that contained each type of deficiency.

[3] A beneficiary-month includes all GO-LTC waiver services for a beneficiary for 1 month.

Table 1: Summary of Deficiencies in Sampled Beneficiary-Months

Type of Deficiency	Beneficiary-Months With Unallowable Claims[a]
Services not documented	43
Services not provided in accordance with approved care plan	28
Provider qualifications not documented	10
Level-of-care assessment not documented	9
State license not documented	3
Services inappropriately billed to waiver	2
Services claimed at inappropriate rate	1

[a] The total exceeds 62 because 29 beneficiary-months contained more than 1 deficiency.

Appendix F contains a summary of deficiencies, if any, identified for each sampled beneficiary-month.

On the basis of our sample results, we estimated that the State agency improperly claimed at least $47,355,736 in Federal Medicaid reimbursement for unallowable GO-LTC waiver services.[4]

SERVICES NOT DOCUMENTED

States must have agreements with Medicaid providers under which providers agree to keep such records as necessary to fully disclose the extent of the services provided to individuals receiving assistance under a State plan (section 1902(a)(27) of the Act). In addition, Federal cost principles require providers to maintain documentation of services provided.[5]

During 43 beneficiary-months, the State agency claimed reimbursement for services that were not adequately documented. Specifically:

- **Service notes not provided.** During 41 beneficiary-months, providers did not maintain any service notes to support some services provided.

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

[5] Specifically, costs must be adequately documented to be allowable under Federal awards (2 CFR § 225, App. A § C.1.j (Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Tribal Governments*)). After our audit period, OMB consolidated and streamlined its guidance regarding all entities that receive and administer Federal awards. The consolidated guidance is now located at 2 CFR part 200. Expenditures are allowable only to the extent that, when a claim is filed, there is adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met (section 2497.1 of CMS's *State Medicaid Manual*).

- **Units billed not supported.** During 2 beneficiary-months, the service notes did not support the number of units billed. For example, for 1 beneficiary-month, the service notes supported 163 hours of homemaker services; however, the provider claimed 165 hours of service. As a result, we determined that 2 hours of homemaker services were unallowable.

SERVICES NOT PROVIDED IN ACCORDANCE WITH APPROVED CARE PLAN

HCBS must be furnished under a written care plan subject to approval by the State agency (42 CFR § 441.301(b)(1)(i)). In addition, the State's waiver agreement with CMS stated that all waiver services would be furnished pursuant to a written care plan and that Federal Medicaid reimbursement would not be claimed for waiver services that were not included in a beneficiary's care plan. Each care plan must have specified the services to be provided, their frequency, and the type of provider (section 4442.6 of CMS's *State Medicaid Manual*). Further, the waiver agreement required the care plan to be signed by the beneficiary's care manager and the care manager's supervisor.

During 28 beneficiary-months, the State agency claimed reimbursement for some services that were not provided in accordance with an approved care plan.[6] Specifically:

- **Care plan missing or incomplete.** During 12 beneficiary-months, the State agency claimed reimbursement for services provided to beneficiaries whose care plans were missing or incomplete (e.g., missing relevant sections).

- **Services not included in care plan.** During 12 beneficiary-months, the State agency claimed reimbursement for some services not specified in the beneficiary's care plan.

- **Care plan not signed.** During 5 beneficiary-months, the State agency claimed reimbursement for services for beneficiaries whose care plans were not signed by either the care manager or the care manager supervisor.

- **Services exceeded maximum units allotted.** During 2 beneficiary-months, the State agency claimed reimbursement for some services that exceeded the maximum units allotted in the beneficiaries' care plan. For example, one beneficiary's care plan indicated that the beneficiary should receive a maximum of 6 hours of homemaker services each day; however, the provider billed for 8 hours of homemaker services.

[6] The total exceeds 28 because 2 beneficiary-months contained more than 1 reason for disallowance.

PROVIDER QUALIFICATIONS NOT DOCUMENTED

Home Health Aides

In order to be an HCBS, the service must meet the Federal standards concerning health and welfare assurance (42 CFR § 440.180(a)(2)). Those standards include assuring that the standards of any State licensure or certification requirements are met for individuals furnishing HCBS (42 CFR § 441.302(a)(2)). In New Jersey, home health aides must be certified by the State's Department of Law & Public Safety, Division of Consumer Affairs (N.J.A.C. § 10:60-1.2).

During 8 beneficiary-months, the State agency claimed reimbursement for some services performed by a home health aide whose certifications were not documented. Thus, without this certification, the Federal standards concerning health and welfare assurance were not met.

Social Workers

In order to be an HCBS, the service must meet the Federal standards concerning health and welfare assurance (42 CFR § 440.180(a)(2)). Those standards include assuring that adequate standards exist for all types of providers that provide services under the waiver (42 CFR § 441.302(a)(1)). The GO-LTC waiver requires that social workers be licensed, have a college degree or higher, or have relevant work experience.[7]

During 2 beneficiary-months, the State agency claimed reimbursement for some services performed where the social workers qualifications were not documented. Thus, without these qualification, the Federal standards concerning health and welfare assurance were not met.

LEVEL-OF-CARE ASSESSMENT NOT DOCUMENTED

To be eligible for HCBS, a beneficiary's care plan must include a level-of-care assessment approved by the care manager that includes the services needed to prevent the beneficiary from requiring institutionalization.[8] Each beneficiary receiving HCBS must also have periodic reevaluations, at least annually, to determine whether the beneficiary continues to need the level of care provided (42 CFR § 441.302(c)).

During 9 beneficiary-months, the State agency claimed reimbursement for some services when the level-of-care assessment was not documented in the beneficiary's case file.

[7] State's GO-LTC waiver agreement with CMS, Appendix C, C-1/C-3 Service Specification (Provider Qualifications of Care Management service).

[8] Section 1915(c) of the Act, 42 CFR § 441.301(b)(1)(iii), and the State's GO-LTC waiver agreement with CMS.

STATE LICENSE NOT DOCUMENTED

The specific waiver service must be provided by an approved home health agency or other individual.[9] Further, in order to be an HCBS, State Medicaid agencies are required to assure the standards of any State licensure or certification are met for individuals furnishing waiver services (42 CFR § 441.302(a)).

During 3 beneficiary-months, the State agency claimed reimbursement for some services when the GO-LTC provider's license authorizing them to perform services was not documented by provider or the State agency.

SERVICES INAPPROPRIATELY BILLED TO THE WAIVER

Federal financial participation cannot be claimed for services when another State program is legally liable and responsible for providing and paying for the services (42 CFR § 433, subpart D).

During 2 beneficiary-months, the State agency claimed reimbursement for services that should not have been provided under the waiver. Specifically, for 1 beneficiary month, the services should have been billed under a different State-funded program; for the remaining beneficiary-month, the beneficiary was removed from coverage under the waiver before the services were provided.

SERVICES CLAIMED AT AN INAPPROPRIATE RATE

Federal regulations state that the Federal medical assistance percentage (FMAP) is determined by the formula described in section 1905(b) of the Act. Under the formula, if a State's per capita income exceeds the national average, the Federal share is a statutory minimum of 50 percent (42 CFR § 433.10(b)). New Jersey's per capita income exceeds the national average. Therefore, CMS reimbursed GO-LTC waiver services at an FMAP of 50 percent.

During 1 beneficiary-month, the State agency claimed reimbursement for GO-LTC waiver services at an enhanced FMAP of 75 percent when it should have been reimbursed at an FMAP of 50 percent.

CONCLUSION

On the basis of our sample results, we estimated that the State agency improperly claimed at least $47,355,736 in Federal Medicaid reimbursement for GO-LTC waiver services that did not comply with certain Federal and State requirements.

The State agency made claims for unallowable services because it lacked clear guidance on claiming and documenting Medicaid services for beneficiaries enrolled in the GO-LTC waiver program and providers did not ensure that: (1) services claimed were adequately documented,

[9] State's GO-LTC waiver agreement with CMS, Appendix C, C-1/C-3 Service Specification (service definition of home-based supportive care).

(2) services were provided only to beneficiaries with completed and approved care plans, (3) provider qualifications were documented, (4) beneficiaries' level-of-care evaluations were documented, (5) providers maintained State licenses authorizing them to provide services, (6) services were appropriately billed to the waiver, and (7) services were billed at the appropriate FMAP.

RECOMMENDATIONS

We recommend that the State agency:

- refund $47,355,736 to the Federal Government, and

- reinforce guidance to the provider community on Federal and State requirements for claiming and documenting Medicaid services for beneficiaries.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our first recommendation and generally concurred with our second recommendation. Specifically, the State agency stated that it had provided supporting documentation that would eliminate or substantially reduce our recommended recovery amount. The State agency also stated that, although the GO-LTC waiver program transitioned to managed care organizations (MCOs) after the end of audit period, it will provide periodic external quality reviews of these MCOs to ensure compliance with Federal and State regulations.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. We reviewed the additional documentation provided by the State agency before issuing our draft report and reduced our preliminary recommended disallowance accordingly. However, we determined that the remaining claims for Federal Medicaid reimbursement for GO-LTC waiver services still did not comply with certain Federal and State requirements.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Most of New Jersey's Claims for Medicaid Supported Employment Services Were Unallowable	A-02-12-01009	12/14/13
Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver From January 1, 2005, Through December 31, 2007	A-02-10-10129	4/20/12
Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver by Bancroft NeuroHealth From January 1, 2005, Through December 31, 2007	A-02-09-01034	3/22/12
Review of Medicaid Payments for Services Provided Under New Jersey's Section 1915(c) Community Care Waiver by Elwyn New Jersey From January 1, 2005, Through December 31, 2007	A-02-09-01033	7/27/11

APPENDIX B: FEDERAL AND STATE REQUIREMENTS RELATED TO THE GLOBAL OPTIONS FOR LONG-TERM CARE WAIVER

FEDERAL REQUIREMENTS FOR DOCUMENTATION NEEDED TO SUPPORT SERVICES BILLED

Section 1902(a)(27) of the Act, 42 U.S.C. § 1396a(a)(27), mandates that States have agreements with Medicaid providers under which providers agree to keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under a State plan. The Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Tribal Governments,* Att. A, § C.1.j (2 CFR § 225, App. A § C.1.j), requires States to maintain documentation of services provided.

FEDERAL REQUIREMENTS FOR SERVICES BEING APPROPRIATELY BILLED TO THE WAIVER

Regulations at 42 CFR § 433 subpart D state that Federal financial participation cannot be claimed for services when another State program is legally liable and responsible for the provision and payment of the service.

FEDERAL AND STATE REQUIREMENTS FOR SERVICES BEING PROVIDED IN ACCORDANCE WITH AN APPROVED CARE PLAN

Section 1915(c) of the Act and Federal regulations (42 CFR § 441.301(b)(1)(iii)) provide that HCBS may be provided only to beneficiaries who have been determined would, in the absence of such services, require the Medicaid-covered level of care provided in a hospital, nursing facility, or intermediate care facility for persons with intellectual disabilities.

Section 4442.6 of CMS's *State Medicaid Manual* requires an assessment of the individual to determine the services needed to prevent institutionalization that must be included in the care plan. In addition, the care plan must specify the medical and other services to be provided, their frequency, and the type of provider. No Federal financial participation is available under a § 1915(c) waiver for HCBS furnished without a written care plan.

The State's waiver agreement with CMS requires that the care plan be signed by the beneficiary's care manager and the care manager's supervisor.

FEDERAL AND STATE REQUIREMENTS TO QUALIFY PROVIDERS

In order to be an HCBS, the service must meet the Federal standards concerning health and welfare assurance (42 CFR § 440.180(a)(2)). Those standards include assuring that the standards of any State licensure or certification requirements are met for individuals furnishing HCBS (42 CFR § 441.302(a)(2)).

In New Jersey, home health aides must be certified by the State's Department of Law & Public Safety, Division of Consumer Affairs (N.J.A.C. § 10:60-1.2). NJAC 10:60-1.2 defines a home health aide as a person who completes a training program in personal care assistant services and is certified by the New Jersey State Department of Law and Public Safety, Board of Nursing. A copy of the certificate should be retained in the provider's personnel profile. Homemaker-home health aides must successfully complete a minimum of 12 hours in-service education per year and be supervised by a registered professional nurse employed by the Division-approved home health agency provider. The GO-LTC waiver requires that social workers providing case management services be licensed, have a college degree or higher, or have relevant work experience.

FEDERAL AND STATE REQUIREMENTS FOR ELIGIBLITY TO RECEIVE SERVICES

Federal regulations (42 CFR § 441.302(c)) state that the State Medicaid agency must provide for an initial evaluation of the recipients needs for the level of care that would be provided in an institution unless the individual receives the home of community-based services. The regulations further require periodic revaluations, at least annually, of each recipient receiving HCBS to determine if the recipient continues to need the level of care provided and would, but for the provision of waiver services, be institutionalized.

The State's waiver agreement with CMS indicates that for a beneficiary to be eligible for HCBS, he or she must have a care plan that includes a level-of-care assessment approved by the care manager that includes the services needed to prevent the beneficiary from requiring institutionalization.

FEDERAL REQUIREMENTS TO ENSURE PROVIDERS MAINTAIN A STATE LICENSE

Regulations at 42 CFR § 441.302(a) require State Medicaid agencies to assure the standards of any State licensure or certification are met for individuals furnishing waiver services.

FEDERAL REQUIREMENTS FOR BILLING SERVICES UNDER THE APPROPRIATE FEDERAL MEDICAL ASSISTANCE PERCENTAGE

Regulations at 42 CFR § 433.10(b) state that the FMAP is determined by the formula described in section 1905(b) of the Act. Under the formula, if a State's capita income exceeds the national average, the Federal share is a statutory minimum of 50 percent. CMS reimburses GO-LTC waiver services provided in New Jersey at a FMAP of 50 percent.

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered beneficiary-months of service for which the State agency received Medicaid reimbursement for services performed under New Jersey's GO-LTC waiver program from July 1, 2009, through June 30, 2013. We limited our review to Medicaid costs claimed for services greater than $100 for a beneficiary-month of service. A beneficiary-month is defined as all services for one beneficiary for 1 month.

We limited our review of the State agency's internal controls over the waiver program to those applicable to the services reviewed because our objective did not require an understanding of all internal controls over the waiver program.

We performed our fieldwork at 109 providers' offices throughout New Jersey from March through May 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State Medicaid laws, regulations, and guidance;
- met with CMS financial and program management officials to gain an understanding of the waivers' approval, administration, and assessment processes;
- met with State agency officials to discuss the State's administration and monitoring of the waiver program;
- obtained from New Jersey's Medicaid Management Information System (MMIS) a sampling frame of 427,223 beneficiary-months greater than $100 for GO-LTC waiver services for which the State agency claimed reimbursement totaling approximately $668 million ($335 million Federal share) from July 1, 2009, through June 30, 2013; [10]
- reconciled the GO-LTC waiver services that the State agency claimed for Federal reimbursement on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, to the sampling frame of all payments for GO-LTC waiver services to providers statewide obtained from New Jersey's MMIS from July 1, 2009, through June 30, 2013;
- selected a stratified random sample of 131 beneficiary-months from the sampling frame and, for each beneficiary-month:

[10] Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the MMIS file for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims data in the MMIS to the State agency's claim for reimbursement on the Form CMS-64.

- determined if contracted providers maintained licenses to provide services,
- determined whether the beneficiary was assessed to be eligible for the GO-LTC waiver program,
- determined whether services were provided in accordance with an approved plan of care,
- determined whether personnel met qualifications to perform the services they provided,
- determined whether documentation supported services billed, and
- determined whether services were reimbursed at the appropriate FMAP;

- estimated the unallowable Federal Medicaid reimbursement paid in the total sampling frame of 427,223 beneficiary-months;[11] and

- discussed the results of our review with State agency officials.

See Appendix D for the details of our statistical sampling methodology, Appendix E for our sample results and estimates, and Appendix F for our summary of deficiencies for each sampled beneficiary-month.

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.

[11] For those beneficiary-months that included both allowable and unallowable services, we included only the portion of the Federal Medicaid reimbursement associated with the unallowable services in our estimate.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of beneficiary-months of service for which the State agency received Medicaid reimbursement greater than $100 for services performed under New Jersey's GO-LTC waiver program from July 1, 2009, through June 30, 2013. A beneficiary-month is defined as all services for one beneficiary for 1 month.

SAMPLING FRAME

The sampling frame was an Access file containing 427,223 beneficiary-months for services totaling $668,163,783 ($335,408,466 Federal share) for which the State agency received Medicaid reimbursement greater than $100 for services performed under New Jersey's GO-LTC waiver program from July 1, 2009, through June 30, 2013. We extracted the data for the beneficiary-months from the New Jersey MMIS.

SAMPLE UNIT

The sample unit was a beneficiary-month.

SAMPLE DESIGN

We used a stratified random sample to review Medicaid payments made to the State agency on behalf of beneficiaries receiving services who were enrolled in the New Jersey GO-LTC waiver program. To accomplish this, we separated the sampling frame into two strata as follows:

- Stratum 1: beneficiary-months with total payments greater than $100 and less than or equal to $5,000—427,192 beneficiary-months totaling $667,860,735 ($335,219,559 Federal share).

- Stratum 2: beneficiary-months with total payments greater than $5,000—31 beneficiary-months totaling $303,048 ($188,907 Federal share).

SAMPLE SIZE

We selected a sample of 131 beneficiary-months:

- 100 beneficiary-months from stratum 1 and

- 31 beneficiary-months from stratum 2.

SOURCE OF THE RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the beneficiary-months in the first strata. After generating 100 random numbers for the stratum, we selected the corresponding frame items for our sample. We selected for review all 31 beneficiary-months in stratum 2.

ESTIMATION METHODOLOGY

We used the OAS statistical software to calculate our estimates. We estimated the overpayment associated with the unallowable GO-LTC waiver services in the beneficiary-months at the lower limit of the 90-percent confidence interval.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Details and Results

Stratum	Beneficiary-Months in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	No. of Beneficiary-Months With Unallowable Services	Value of Unallowable Services (Federal Share)
1	427,192	$335,219,559	100	$79,536	32	$16,289
2	31	188,907	31	188,907	30	117,936
Total	**427,223**	**$335,408,466**	**131**	**$268,443**	**62**	**$134,225**

Table 3: Estimated Value of Unallowable Services (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$69,704,362
Lower limit	47,355,736
Upper limit	92,052,988

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

Legend

Deficiency	Description
1	Services not documented
2	Services not provided in accordance with approved care plan
3	Provider qualifications not documented
4	Level-of-care assessment not documented
5	State license not documented
6	Services inappropriately billed to waiver
7	Services not claimed at appropriate Federal medical assistance percentage

Table 4: Office of Inspector General Review Determinations for the 131 Sampled Beneficiary-Months

Sample Beneficiary -Month[12]	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	No. of Deficiencies
S1-1								0
S1-2	X	X		X				3
S1-3		X		X				2
S1-4	X							1
S1-5								0
S1-6								0
S1-7		X		X				2
S1-8	X	X	X					3
S1-9	X							1
S1-10								0
S1-11								0
S1-12								0
S1-13								0
S1-14								0
S1-15								0
S1-16								0
S1-17								0
S1-18	X		X		X			3

[12] S1 and S2 indicate stratum 1 and 2, respectively.

Sample Beneficiary -Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	Number of Deficiencies
S1-19		X						1
S1-20	X	X						2
S1-21	X		X					2
S1-22		X						1
S1-23								0
S1-24			X					1
S1-25								0
S1-26								0
S1-27								0
S1-28	X					X		2
S1-29	X		X					2
S1-30								0
S1-31								0
S1-32	X					X		2
S1-33								0
S1-34	X						X	2
S1-35								0
S1-36	X							1
S1-37	X							1
S1-38								0
S1-39								0
S1-40								0
S1-41								0
S1-42								0
S1-43								0
S1-44								0
S1-45								0
S1-46								0
S1-47								0
S1-48								0
S1-49	X		X					2
S1-50		X						1

Sample Beneficiary -Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	No. of Deficiencies
S1-51								0
S1-52								0
S1-53								0
S1-54								0
S1-55								0
S1-56	X							1
S1-57								0
S1-58								0
S1-59	X							1
S1-60								0
S1-61								0
S1-62								0
S1-63	X							1
S1-64								0
S1-65								0
S1-66								0
S1-67		X		X				2
S1-68								0
S1-69	X							1
S1-70								0
S1-71								0
S1-72				X				1
S1-73								0
S1-74		X		X				2
S1-75								0
S1-76								0
S1-77								0
S1-78								0
S1-79	X		X					2
S1-80								0
S1-81	X		X		X			3

Sample Beneficiary -Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	No. of Deficiencies
S1-82	X		X					2
S1-83								0
S1-84								0
S1-85		X						1
S1-86								0
S1-87			X					1
S1-88								0
S1-89								0
S1-90								0
S1-91								0
S1-92								0
S1-93								0
S1-94								0
S1-95								0
S1-96								0
S1-97								0
S1-98								0
S1-99								0
S1-100								0
S2-1								0
S2-2		X		X				2
S2-3				X				1
S2-4	X	X						2
S2-5		X						1
S2-6		X						1
S2-7		X						1
S2-8	X	X						2
S2-9	X	X						2
S2-10	X	X						2
S2-11	X							1
S2-12	X	X						2

Sample Beneficiary -Month	Deficiency 1	Deficiency 2	Deficiency 3	Deficiency 4	Deficiency 5	Deficiency 6	Deficiency 7	No. of Deficiencies
S2-13	X							1
S2-14		X						1
S2-15	X							1
S2-16	X	X						2
S2-17	X	X		X	X			4
S2-18		X						1
S2-19	X							1
S2-20	X	X						2
S2-21	X							1
S2-22	X							1
S2-23	X							1
S2-24	X							1
S2-25	X							1
S2-26	X	X						2
S2-27	X							1
S2-28	X	X						2
S2-29		X						1
S2-30	X							1
S2-31	X							1
Category Totals	**43**	**28**	**10**	**9**	**3**	**2**	**1**	**96**

62 Beneficiary-months in Error

APPENDIX G: 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

ELIZABETH CONNOLLY
Acting Commissioner

VALERIE HARR
Director

December 1, 2015

James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services Region II
Jacob K. Javits Federal Building
26 Federal Plaza – Room 3900
New York, NY 10278

Audit Report Number: A-02-14-01008

Dear Mr. Edert:

This is in response to your letter dated September 22, 2015, concerning the Department of Health and Human Services, Office of the Inspector General's (OIG) draft report entitled *"Some of New Jersey's Claims for Medicaid Global Options for Long-Term Care Waiver Services Were Unallowable"*. Your letter provides the opportunity to comment on this draft report.

The draft audit report concluded that some of the New Jersey Division of Medical Assistance & Health Services' (DMAHS) claims for Federal Medicaid reimbursement for some Global Options for Long-Term Care (Go-LTC) waiver services did not comply with Federal and State requirements. Of the 131 beneficiary-months claims out of 427,223 beneficiary-months claims during the audit period in the auditor's random sample, 69 beneficiary-months claims complied with these requirements, but 62 beneficiary-months did not. According to the audit report, the deficiencies occurred because Medicaid lacked clear guidance on claiming and documenting Medicaid services for beneficiaries enrolled in the GO-LTC waiver program.

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 DMAHS refund $47,355,736 to the Federal Government:

The State does not concur with the findings concerning claims for GO-LTC waiver services. Subsequent to the completion of the auditors field work, the State delivered to the auditor's office additional supporting documentation that would eliminate or substantially reduce the recommended refund. This additional documentation was not reflected in this draft audit report. We respectively request that the amount of the refund be recalculated based upon a review of the supporting documentation retrieved by Division staff subsequent to the OIG Exit Conference and if necessary meet with State staff to assist in the review of this additional documentation.

Recommendation 2:

OIG Recommends DMAHS Reinforce Guidance to the Provider Community on Federal and State Requirements for Claiming and Documenting Medicaid Services for Beneficiaries:

The Medicaid GO-LTC waiver program transitioned to managed care organizations in July 2014 so while the managed care organizations (MCO's) will, in most cases, conduct the evaluations for level of care, DMAHS's Office of Managed Health Care is responsible for monitoring the MCOs compliance with their contractual obligations, which include ensuring that all of their providers comply with State and Federal regulations including proper documentation to support their claims. Furthermore, DMAHS's External Quality Review Organization (EQRO) periodically visits MCO providers to audit their compliance with State and Federal regulations.

Thank you for providing DMAHS the opportunity to provide written comments to the recommendations included in the draft audit report. If you have any questions, please do not hesitate to contact me or Richard H. Hurd at (609) 588-2550.

Sincerely,

Valerie Harr
Director

VH/RH
c: Beth Connolly, Acting Commissioner
Richard Hurd, Chief of Staff