

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**SOME OF NEW JERSEY'S CLAIMS FOR
PERSONAL CARE SERVICES DID NOT
COMPLY WITH FEDERAL AND STATE
REQUIREMENTS**

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Inspector General

August 2015
A-02-13-01022

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

New Jersey claimed at least \$32.2 million in unallowable Medicaid reimbursement for personal care services from August 1, 2008, through December 31, 2011.

WHY WE DID THIS REVIEW

During a prior review of New Jersey's personal care services program, 2004 through 2007, we identified a significant number of services improperly submitted for Federal Medicaid reimbursement. On the basis of these results, we decided that another review of this program was warranted.

The objective of this review was to determine whether the New Jersey Department of Human Services' (State agency) claims for Federal Medicaid reimbursement for personal care services complied with certain Federal and State requirements.

BACKGROUND

Personal care services provide assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they can remain in their homes and communities. These nonmedical services include activities related to daily living, such as bathing, dressing, light housework, medication management, meal preparation, and transportation.

Federal regulations require Medicaid personal care services to be authorized by a physician in accordance with a treatment plan. In New Jersey, the State agency administers the Medicaid program.

New Jersey regulations require personal care services providers (personal care agencies) to maintain a beneficiary's clinical records, including documentation of the personal care aide's activities. In addition, a physician must certify that a beneficiary needs personal care services. Further, a registered nurse must (1) prepare a plan of care in accordance with the physician's certification, (2) perform an initial assessment and reassessment of the beneficiary's need for personal care services every 6 months, and (3) provide direct supervision of the beneficiary's personal care aide at least every 60 days. Finally, personal care aides must receive 12 hours per year of in-service education from the provider.

HOW WE CONDUCTED THIS REVIEW

For August 1, 2008, through December 31, 2011, we limited our review to Medicaid costs claimed for personal care services. From a total of approximately \$787 million (\$393 million Federal share) that the State agency claimed for 18,204,489 personal care claim lines (referred to as "claims"), we reviewed a random sample of 100 claims.

WHAT WE FOUND

Some of the State agency's claims for Federal Medicaid reimbursement for personal care services did not comply with Federal and State requirements. Of the 100 claims in our random sample, 83 complied with Federal and State requirements, but 17 did not. Some of the deficiencies we found included: (1) nursing supervision requirements not met, (2) in-service training qualifications not met, (3) no physician's certification, and (4) no nursing assessment.

The deficiencies occurred because some personal care agencies did not comply with Federal and State requirements. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$32,236,308 in Federal Medicaid reimbursement for personal care services that did not meet Federal and State requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$32,236,308 to the Federal Government and
- issue guidance to providers regarding Federal and State requirements for claiming Medicaid reimbursement for personal care services.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency partially concurred with our first recommendation and described actions it had taken to address our second recommendation. Under separate cover, the State agency provided clinical documentation and correspondence with personal care providers meant to support six sampled claims related to nursing assessments and nursing supervision requirements. In addition, the State agency argued that we should exclude five claims from our sample because of "extraordinary circumstances." Specifically, for these claims, the State agency argued that providers were no longer in business, more than 5 years had passed since the service date, the service date was after our audit period, or the provider's records were damaged by a flood.

The State agency also disagreed with our sampling methodology. Specifically, it took issue with our using a simple random sample and argued that a possible systematic variation among personal care providers' compliance with Federal and State requirements may have been of such magnitude as to not be adequately addressed by our estimation policy.

After reviewing the State agency's comments and additional documentation, including its correspondence with providers, we revised our findings to allow one claim for which the associated records were reportedly damaged by a flood. We maintain that our remaining findings and recommendations are valid.

We found no reason to exclude any claims from our sample. State regulations require all Medicaid enrolled providers to retain all records for 5 years. The service dates associated with our sample claims were within the State agency's 5-year document retention period and the audit period.

Regarding our sampling methodology, we note that the legal standard for use of sampling and extrapolation is that they must be based on a statistically valid methodology, not on the most precise methodology. We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation. Further, the State agency's argument regarding our sampling methodology is unsupported. Specifically, its argument is based on assumptions about the characteristics of personal care providers throughout New Jersey and speculation about the magnitude of systematic variation that may have been introduced because of those assumptions.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objective	1
Background	1
Medicaid Program	1
New Jersey’s Medicaid Personal Care Services Program	1
Federal and State Requirements	1
How We Conducted This Review	2
FINDINGS	2
Nursing Supervision Requirements Not Documented or Not Met.....	3
In-Service Training Qualifications Not Documented or Not Met.....	3
No Physician’s Certification	4
No Nursing Assessment	4
No Clinical File	4
No Plan of Care	4
Services Not Documented	4
Services Not Provided	5
Conclusion.....	5
RECOMMENDATIONS	5
STATE AGENCY COMMENTS.....	5
OFFICE OF INSPECTOR GENERAL RESPONSE	6
APPENDIXES	
A: Audit Scope and Methodology	7
B: Statistical Sampling Methodology	9

C: Sample Results and Estimates.....10
D: State Agency Comments.....11

INTRODUCTION

WHY WE DID THIS REVIEW

During a prior review of New Jersey's personal care services program, 2004 through 2007, we identified a significant number of services improperly submitted for Federal Medicaid reimbursement.¹ On the basis of these results, we decided that another review of this program was warranted.

OBJECTIVE

Our objective was to determine whether the New Jersey Department of Human Services' (State agency) claims for Federal Medicaid reimbursement for personal care services complied with certain Federal and State requirements.

BACKGROUND

Medicaid Program

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

New Jersey's Medicaid Personal Care Services Program

In New Jersey, the State agency administers the Medicaid program. Under its personal care services program, the State agency provides personal care assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they can remain in their homes and communities. These services include activities related to daily living, such as bathing, dressing, light housework, medication management, meal preparation, and transportation.

Federal and State Requirements

Federal law requires Medicaid personal care services to be authorized by a physician and provided by a qualified individual in accordance with a treatment plan.²

¹ *Review of Medicaid Personal Care Claims Submitted by Providers in New Jersey*, (A-02-09-01002), issued December 29, 2011.

² Social Security Act § 1905(a)(24); 42 CFR § 440.167. These services must be provided by a qualified individual who is not a member of the beneficiary's family (42 CFR § 440.167).

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

New Jersey regulations require personal care services providers (personal care agencies) to maintain a beneficiary's clinical records, including a personal care aide activity assignment sheet (activity sheet). In addition, a physician must certify that a beneficiary needs personal care services. The regulations further require a registered nurse to (1) prepare a plan of care in accordance with the physician's certification, (2) perform an initial assessment and reassessment of the beneficiary's need for personal care services every 6 months, and (3) provide direct supervision of the beneficiary's personal care aide at least every 60 days. Finally, personal care aides must receive 12 hours per year of in-service education from the provider.³

HOW WE CONDUCTED THIS REVIEW

From August 1, 2008, through December 31, 2011 (the audit period), the State agency claimed Federal Medicaid reimbursement totaling approximately \$787 million (\$393 million Federal share) for 18,204,489 claims for personal care services. Of these claims, we reviewed a simple random sample of 100 claims. Specifically, we reviewed provider documentation to determine whether personal care services were provided in accordance with Federal and State requirements.

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

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

FINDINGS

Some of the State agency's claims for Federal Medicaid reimbursement for personal care services did not comply with Federal and State requirements. Of the 100 claims in our random sample, 83 complied with Federal and State requirements, but 17 did not. Of the 17 noncompliant claims, 3 contained more than 1 deficiency. Table 1 on the following page summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

³ State regulations on Medicaid provider responsibilities are found in Title 10 § 49-9 of the New Jersey Administrative Code (N.J.A.C.). State regulations on personal care services are found in N.J.A.C. 10:60.

Table 1: Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Noncompliant Claims⁴
Nursing supervision requirements not documented or not met	8
In-service training qualifications not documented or not met	4
No physician's certification	3
No nursing assessment	3
No clinical file	2
No plan of care	2
Services not documented	2
Services not provided	1

The deficiencies occurred because some personal care agencies did not comply with Federal and State requirements. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$32,236,308 in Federal Medicaid reimbursement for personal care services that did not meet Federal and State requirements.

NURSING SUPERVISION REQUIREMENTS NOT DOCUMENTED OR NOT MET

A registered nurse must provide direct supervision of the personal care aide in the beneficiary's residence within 48 hours of the start of personal care services and at least once every 60 days thereafter. Additional supervisory visits shall be made as the situation warrants, such as when a new personal care assistant starts work (N.J.A.C. 10:60-3.5(a)(2)).

For 8 of the 100 claims in our sample, direct supervision requirements were not met. Specifically, for six claims, direct supervision was either not provided within 60 days of the service date (three) or not provided for a new personal care assistant (three). For two other claims, there was no documentation to show that direct supervision of the personal care aide was ever provided.

IN-SERVICE TRAINING QUALIFICATIONS NOT DOCUMENTED OR NOT MET

Personal care services must be provided by a qualified individual.⁵ A qualified individual includes a personal care aide who has received 12 hours of in-service education per year (N.J.A.C. 10:60-1.2 (definition of "personal care assistant")).

For 4 of the 100 claims in our sample, the personal care aide's in-service training qualifications were not documented or not met. Specifically, for three claims, the personal care agency did not provide documentation of the personal care aide's in-service training for the applicable year, and

⁴ The total exceeds 17 because 3 claims contained more than 1 deficiency.

⁵ 42 CFR § 440.167(a)(2); N.J.A.C. 10:60-3.1(b)(4).

for one claim, the aide did not meet the required 12 hours of in-service training for the applicable year.

NO PHYSICIAN'S CERTIFICATION

To qualify for payment, a beneficiary's need for personal care services must be certified in writing by a physician (N.J.A.C. 10:60-3.4).

For 3 of the 100 claims in our sample, the personal care agency did not provide a physician's certification.

NO NURSING ASSESSMENT

Personal care agencies must perform an initial nursing assessment within 48 hours of the start of personal care services and at least once every 6 months thereafter (N.J.A.C. 10:60-3.5(a)(1)).

For 3 of the 100 claims in our sample, the personal care agency did not provide a nursing assessment for the applicable period.

NO CLINICAL FILE

Personal care agencies must maintain clinical records for each beneficiary for 5 years (N.J.A.C. 10:49-9.8 and N.J.A.C. 10:60-3.6(a)(1)).

For 2 of the 100 claims in our sample, we could not obtain a clinical record for the beneficiary. The claims were associated with two provider agencies that ceased operating after our audit period.

NO PLAN OF CARE

Personal care services must be provided in accordance with a plan of care (42 CFR § 440.167(a)(1); N.J.A.C. 10:60-3.5(a)(1)).

For 2 of the 100 claims in our sample, the personal care agency did not provide a plan of care.

SERVICES NOT DOCUMENTED

Medicaid providers must maintain records that are necessary to disclose fully the extent of services provided (N.J.A.C. 10:49-9.8). Further, personal care agencies must document the personal care aide's activities as part of each beneficiary's clinical record (N.J.A.C. 10:60-3.6(a)(2)).

For 2 of the 100 claims in our sample, the personal care aide's activities were not documented in the beneficiary's clinical record.

SERVICES NOT PROVIDED

Medicaid providers must certify that services billed on any claim were provided (N.J.A.C. 10:49-9.8(a)).

For 1 of the 100 claims in our sample, personal care services were not provided. According to the personal care agency's records associated with the claim, the beneficiary was not at home when the personal care aide attempted to provide services.

CONCLUSION

These deficiencies occurred because some personal care agencies did not comply with Federal and State requirements. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$32,236,308 in Federal Medicaid reimbursement for personal care services that did not comply with Federal and State requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$32,236,308 to the Federal Government and
- issue guidance to providers regarding Federal and State requirements for claiming Medicaid reimbursement for personal care services.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency partially concurred with our first recommendation and described actions it had taken to address our second recommendation. Under separate cover, the State agency provided clinical documentation and correspondence with personal care providers meant to support six sampled claims related to nursing assessments and nursing supervision requirements. In addition, the State agency argued that we should exclude five claims from our sample because of "extraordinary circumstances." Specifically, for these claims, the State agency argued that providers were no longer in business, more than 5 years had passed since the service date, the service date was after our audit period, or the provider's records were damaged by a flood.

The State agency also disagreed with our sampling methodology. Specifically, it took issue with our using a simple random sample and argued that a possible systematic variation among personal care providers' compliance with Federal and State requirements may have been of such magnitude as to not be adequately addressed by our estimation policy.

The State agency's comments, excluding the information provided under separate cover, are included as Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments and additional documentation, including its correspondence with providers, we revised our findings to allow one claim for which the associated records were reportedly damaged by a flood. We maintain that our remaining findings and recommendations are valid.

We found no reason to exclude any claims from our sample. State regulations (N.J.A.C. 10:49-9.8(b)) require all Medicaid-enrolled providers to retain all records for 5 years in accordance with N.J. Stat. Ann. § 30:4D-12(d). The service dates associated with our sample claims were within the State agency's 5-year document retention period and the audit period.⁶

Regarding our sampling methodology, we note that the legal standard for use of sampling and extrapolation is that they must be based on a statistically valid methodology, not on the most precise methodology.⁷ We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation. Further, the State agency's argument regarding our sampling methodology is unsupported. Specifically, its argument is based on assumptions about the characteristics of personal care providers throughout New Jersey and speculation about the magnitude of systematic variation that may have been introduced because of those assumptions.

⁶ For claim number 90, we maintain that the State agency's statement that the date of service was nearly 2 years after our audit period is incorrect. The State agency asserted that the claim had dates of service of November 9 to 13, 2013. The actual dates of service were November 9 to 13, 2009, which was within our audit period. For claim number 97, the State agency's statement that the provider was not expected to maintain clinical records because of the age of the claim is incorrect. The date of service associated with the claim was in August 2009. In May 2013, within the State agency's 5-year record-retention requirement, we informed the State agency of the personal care providers that we planned to visit and, in June 2013, contacted the provider regarding the claim. For claim numbers 10 and 92, the regular record retention policy still applies.

⁷ See *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Transyd Enter., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 18,204,489 personal care claim lines, totaling \$786,850,076 (\$393,474,570 Federal share), submitted by 266 personal care agencies in New Jersey from August 1, 2008, through December 31, 2011. (In this report, we refer to these lines as claims.) Our audit population did not include claims previously audited, personal care agencies that were under criminal or civil investigation, and other miscellaneous claims.⁸

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

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

We performed fieldwork at the State agency's offices in Trenton, New Jersey, and at personal care agencies throughout New Jersey from April through November 2013.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with State agency officials to gain an understanding of the State's personal care services program;
- obtained an electronic file of Medicaid personal care services claims submitted by 266 personal care agencies in New Jersey during our audit period from the State agency's MMIS;
- reconciled the personal care services claimed for Federal reimbursement by the State agency on Forms CMS-64 for our audit period with the data obtained from the MMIS file;

⁸ We eliminated 500,613 claims that we audited as part of a separate review (*Medicaid Personal Care Claims Made by Bayada Nurses, Inc.* (A-02-10-01001), issued September 24, 2012). In addition, we eliminated 1,157,368 claims associated with 5 providers under criminal or civil investigation by State or Federal agencies and 598,328 claims with (1) service dates older than 5 years, (2) procedure codes for registered nurse and cash and counseling services, or (3) service codes associated with a Medicaid waiver program for developmentally disabled beneficiaries.

- ran computer programming applications that identified a sampling frame of 18,204,489 claims, totaling \$786,850,076 (\$393,474,570 Federal share);
- selected a simple random sample of 100 claims from the 18,204,489 claims to determine if claims complied with Federal and State requirements, and for each of the 100 claims:
 - obtained and reviewed beneficiary clinical records, if available, and
 - obtained and reviewed personal care aide personnel records, if available;
- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 18,204,489 claims; and
- discussed our results with State agency officials.

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

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of personal care service claims submitted by personal care agencies in New Jersey during our August 1, 2008, through December 31, 2011, audit period that the State agency claimed for Federal Medicaid reimbursement.

SAMPLING FRAME

The sampling frame was a computer file containing 18,204,489 detailed claims for personal care services submitted by 266 personal care agencies in New Jersey during our audit period. The total Medicaid reimbursement for the 18,204,489 claims was \$786,850,076 (\$393,474,570 Federal Share). The Medicaid claims were extracted by our advanced audit techniques staff from the State agency's Medicaid payment files provided to us by staff of the State agency's MMIS fiscal agent.

SAMPLE UNIT

The sample unit was an individual Federal Medicaid claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claims.

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

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

ESTIMATION METHODOLOGY

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

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Details and Results

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Number of Unallowable Claims	Value of Unallowable Claims (Federal Share)
18,204,489	\$393,474,570	100	\$1,871	17	\$391

Table 3: Estimated Unallowable Costs
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	71,177,732
Lower limit	32,236,308
Upper limit	110,119,155

APPENDIX D: STATE AGENCY COMMENTS



State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

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April 13, 2015

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Audit Report Number: A-02-13-01022

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Department of Health and Human Services
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Dear Mr. Edert:

This is in response to your letter dated February 10, 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 Personal Care Services Did Not Comply with Federal and State Requirements.*" 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 personal care services did not comply with federal and State requirements. Of the 100 claims out of 18M claims during the audit period in the auditor's random sample, 82 claims complied with these requirements, but 18 claims did not. According to the audit report, the deficiencies occurred because some personal care agencies did not comply with federal and State requirements.

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

Recommendation 1:

The OIG recommends that DMAHS refund \$37,204,835 to the Federal Government:

The State concurs with some but not all of the findings concerning claims for personal care services. The State respectfully requests 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. The supporting information for the following cases is included with this response:

New Jersey Is An Equal Opportunity Employer

<u>Claim #</u>	<u>Name</u>
#18	[REDACTED]
#36	[REDACTED]
#49	[REDACTED]
#50	[REDACTED]
#89	[REDACTED]
#100	[REDACTED]

DMAHS expects to receive additional supporting documentation from agencies involved in the audit. As DMAHS receives additional supporting documentation, it will be forwarded to the OIG auditor.

Furthermore, DMAHS believes the following cases should be excluded from the sample because of extraordinary circumstances that would unfairly influence the extrapolation methodology:

- #10 [REDACTED]:
Services of Monmouth County, requested termination of its Medicaid provider eligibility status in August 27, 2013.
- #46 [REDACTED]:
Cumberland County Homemaker/Home Health went out of business in 2012; the files in long-term storage were damaged by a flood.
- #90 [REDACTED]:
This claim covers service dates November 9, 2013 to November 13, 2013 and should be excluded from the sample as it falls outside the audit period.
- #92 [REDACTED]:
Executive Care LLC (Advantage) went out of business for the last time in 2013 after changing names several times. It is impossible to either find the records and or attribute blame for the loss given the number of ownership groups.
- #97 [REDACTED]:
Personal care agencies must maintain clinical records for each beneficiary for a period of five years (N.J.A.C. 10:49-9.8 & N.J.A.C. 10:60-3.6 (a) (1)). Pursuant to regulation there is no expectation that the agency would have the record because of its age, therefore it should be excluded from the sample.

In addition to the analysis outlined below which was included in a previous response to an OIG draft report, we also disagree with the OIG's sampling methodology and the extrapolation of results across the entire universe of providing agencies. OIG auditors took a sample of claims from 48 agencies and extrapolated across the entire universe of 266 agencies that provide personal care services. The choice of a simple random sample would be appropriate if there were no systematic variations in the sample that would bias the estimates. However, the variability within New Jersey over time suggests the potential for systematic variation and the

Office of Inspector General Note—We redacted the names of Medicaid beneficiaries because they are personally identifiable information.

need for stratified sampling and weighting, particularly with regard to agencies that have dissolved and may be overrepresented in the sample, since one potential explanation for business failure can be a failure to institute proper internal controls and record-keeping. Under such circumstances, a lower limit may not adequately address the magnitude of error.

We can already see some evidence for variability among claims sampled during the audit period in terms of dissolution. We therefore believe that either stratification with weighting or a larger sample should have been drawn, particularly given the large number of agencies delivering personal care services and the enormous variability in error estimates over time and across agencies.

Analysis of OIG Sampling Methodology (from a previous response to a draft OIG audit report):

To select a probability sample of a population in order to accurately estimate some characteristic of the total population, it is necessary to define the population.¹ This definition of a population for a particular study is called the sampling frame. Individual elements and units within the sampling frame are selected for a study using various kinds of sampling procedures.

The selection of random samples is the preferred method for studies in which population characteristics are estimated based on a sample because random sampling leads to extremely accurate estimates when the sampling procedures are appropriate for what we know (or can assume) about the characteristics of the total population. Random samples can be selected by simple random sampling or by stratified random sampling. Simple random sampling leads to accurate results if we know or can assume that the population is relatively homogenous with respect to the questions of interest. For instance, a sample of student-months representing the rate of non-compliance of all Medicaid school-based health claims submitted for one type of service for individuals within one type of disability category selected by simple random sampling may be extremely accurate for estimating the overall rate of non-compliance.

If known or assumed, however, that the population is heterogeneous with respect to the questions of interest so that the findings are likely to differ substantially within subgroups of the population, the validity of the estimates of population characteristics is greatly improved by stratified random sampling. Stratified random sampling ensures that the proportion of individual units within each subgroup of the sample matches the proportion of individual units within each subgroup of the total population and thus the combined estimates derived from subgroups within the sample represent the characteristics of the total population accurately.

Recommendation 2:

OIG Recommends DMAHS Issue Guidance to the Provider Community Regarding Federal and State Requirements for Claiming Medicaid Reimbursement for Personal Care Services:

Since the audit period, the PCA program has been redesigned, the most significant change being the "carve-in" of the PCA program into Medicaid Managed Care Organizations (MCO). The MCOs are now responsible for the administration and over-sight of their providers who

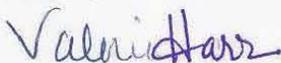
¹ McBurney, D. H., & White, T. L. (2007). Research Methods. Thomson Wadsworth, Belmont, CA.

James P. Edert
April 13, 2015
Page 4

provide personal care services to their members. The NJ Division of Disability Services (DDS) continues to provide oversight of personal care providers who provide services to their fee-for-service (FFS) beneficiaries although the majority of Medicaid personal care beneficiaries are now in MCOs. DDS has issued several guidance memos informing PCA agencies of the changes in the program and is a resource to both the MCO and FFS providers while these changes have been taking place.

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 Hurd at 609-588-2550.

Sincerely,



Valerie Harr
Director

VH:H

c: Elizabeth Connolly, Acting Commissioner
Richard Hurd, DMAHS Chief of Staff