DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

December 28, 2011

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

FROM: /Daniel R. Levinson/
Inspector General

SUBJECT: Review of Medicaid Personal Care Claims Submitted by Providers in New Jersey (A-02-09-01002)

Attached, for your information, is an advance copy of our final report on Medicaid personal care claims submitted by providers in New Jersey. 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 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-02-09-01002.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region II
Jacob Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

December 29, 2011

Report Number: A-02-09-01002

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 Personal Care Claims Submitted by Providers in New Jersey*. 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 Kevin W. Smith, Audit Manager, at (518) 437-9390, extension 232, or through email at Kevin.Smith@oig.hhs.gov. Please refer to report number A-02-09-01002 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 PERSONAL CARE CLAIMS SUBMITTED BY PROVIDERS IN NEW JERSEY

Daniel R. Levinson
Inspector General

December 2011
A-02-09-01002

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

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.

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 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 State), the Department of Human Services (DHS) is the State agency responsible for operating the Medicaid program. Within DHS, the Division of Medical Assistance and Health Services administers the Medicaid program. DHS's Division of Disability Services (DDS) oversees the State's personal care services program.

Pursuant to 42 CFR § 440.167, personal care services are generally furnished to individuals residing in their homes and not residing in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or institutions for mental diseases. Medicaid beneficiaries are authorized for personal care services by a physician in accordance with a plan of treatment or with a service plan approved by each State. Pursuant to the State's regulations: (1) a physician must certify the beneficiary's need for personal care services; (2) a registered nurse must perform an initial assessment and a reassessment of the beneficiary's need for such services at least once every 6 months and prepare a plan of care for the personal care assistant to implement; (3) the provider must notify DHS of the initial assessment or reassessment, and DDS must provide prior authorization to claim Medicaid reimbursement for personal care services; (4) a registered nurse must provide direct supervision of the personal care assistant at least once every 60 days or more often, as required; (5) personal care assistants must be certified by the New Jersey Board of Nursing and receive inservice education from the provider; and (6) providers must document the time spent providing personal care services. Examples of personal care services include cleaning, shopping, grooming, and bathing.

OBJECTIVE

The objective of our review was to determine whether the State claimed Federal Medicaid reimbursement for personal care services claims submitted by providers in accordance with Federal and State requirements.

SUMMARY OF FINDINGS

The State did not claim Federal Medicaid reimbursement for some personal care services claims submitted by providers in accordance with all Federal and State requirements. Of the 100 claims in our random sample, 64 complied with Federal and State requirements, but 36 did not.

Of the 36 noncompliant claims, 14 contained more than 1 deficiency:

- For 17 claims, DDS did not issue a prior authorization.
- For 13 claims, the personal care assistant did not receive inservice education.
- For eight claims, there was no nursing supervision.
- For seven claims, there was no documentation of services.
- For five claims, there was no nursing assessment.
- For two claims, the personal care assistant was not certified by the New Jersey Board of Nursing.
- For one claim, there was no plan of care.
- For one claim, there was no physician's authorization.

These deficiencies occurred because the State did not effectively monitor the personal care services program for compliance with certain Federal and State requirements.

Based on our sample results, we estimated that the State improperly claimed $145,405,192 in Federal Medicaid reimbursement during our January 1, 2004, through December 31, 2007, audit period.

RECOMMENDATIONS

We recommend that the State agency:

- refund $145,405,192 to the Federal Government and
- improve its monitoring of the personal care services program to help ensure compliance with Federal and State requirements.

DEPARTMENT OF HUMAN SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, DHS generally disagreed with our recommendations. In addition, DHS stated that the sample claims associated with one provider should be excluded from our sample frame because the provider was an outlier that did not represent the work done by other providers. DHS also provided 41 pages of additional documentation for 8 sample claims under separate cover. We maintain that our statistically valid statewide random sample fairly represented personal care services claims submitted by DHS, including those submitted on behalf of the outlier provider and, therefore, we did not change our original determination for the 8 sampled claims. After reviewing DHS's comments and additional documentation, we revised

our findings and modified our statistical estimates accordingly. DHS's comments appear in their entirety as Appendix D.

TABLE OF CONTENTS

Page

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 Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

New Jersey's Medicaid Program

In New Jersey (the State), the Department of Human Services (DHS), is the State agency responsible for operating the Medicaid program. Within DHS, the Division of Medical Assistance and Health Services administers the Medicaid program. DHS employees work at Medical Assistance Customer Centers (MACC) throughout the State to assist Medicaid beneficiaries. DHS uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims, including personal care services claims. The Federal Government's share of costs is known as the Federal medical assistance percentage (FMAP). From January 1, 2004, to June 30, 2004, the FMAP in New Jersey was 52.95 percent and from July 1, 2004, through December 31, 2007, the FMAP was 50 percent.

New Jersey's Personal Care Services Program

The State's personal care services program is operated by DHS's Division of Disability Services (DDS). The purpose of the State's personal care services program is to accommodate beneficiaries' need for long-term chronic or maintenance health care, as opposed to their need for short-term skilled care required for some acute illnesses. Pursuant to New Jersey Administrative Code (NJAC) 10:60-3.1, personal care services "include personal care, household duties and health related tasks performed by a qualified individual in a beneficiary's place of residence, under the supervision of a registered nurse, as certified by a physician in accordance with a written plan of care."

During our audit period, the State phased in guidance to providers requiring them to obtain prior authorization for personal care services through a State-mandated procedure. On a county-by-county basis, beginning in 1998, DHS required certain providers to obtain prior authorizations for personal care services. Effective July 3, 2006, the State amended its regulations to incorporate this requirement. Before issuing this guidance, the State required providers to submit, within 5 days of a provider's assessment or reassessment, a Form CMS-485, Home Health Certification and Plan of Care (CMS-485), to the MACC serving the county in which the beneficiary resided (NJAC 10:60-1.8(a)).

Under the State's mandated prior authorization procedures, a registered nurse must see the beneficiary face-to-face and complete an evaluation form that includes information on 10 elements used to measure the beneficiary's need for personal care services. The provider transmits the evaluation form with a prior authorization request to DDS, which determines the number of hours of personal care services authorized for the beneficiary (NJAC 10:60-3.9).

DDS requires all personal care providers to be accredited by one of four accrediting organizations. Beginning in 2005, DDS required the accrediting organizations to review providers' compliance with the State's regulations (NJAC 10:60-1.2; NJAC 10:60-3.1(a)).[1]

Federal and State Requirements Related to Personal Care Services

The State and providers must comply with certain Federal and State requirements in determining and redetermining whether beneficiaries are eligible for personal care services. Pursuant to section 1905(a)(24) of the Act and implementing Federal regulations (42 CFR § 440.167), personal care services must be: (1) authorized for an individual by a physician in a plan of treatment or in accordance with a service plan approved by the individual State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or, at the State's option, in another location.

Pursuant to Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, Att. A, § C.1.c (2 CFR, pt. 225, App. A, § C.1.c), to be allowable under a Federal award, costs must be authorized or not prohibited by State or local laws or regulations.

Chapter 60 of NJAC Title 10 establishes requirements for the State's personal care services program. These requirements include that a physician certify the need for personal care services, a registered nurse perform an initial assessment and a reassessment at least once every 6 months, and a registered nurse prepare a plan of care for the personal care assistant to implement. In addition, personal care assistants must be certified by the New Jersey Board of Nursing, be under the supervision of a registered nurse employed by a State agency-approved personal care provider, and receive a minimum of 12 hours of inservice education per year from the provider. Finally, providers must document the time spent providing personal care services. Appendix A contains the specific Federal and State requirements related to personal care services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our review was to determine whether the State claimed Federal Medicaid reimbursement for personal care services claims submitted by providers in accordance with Federal and State requirements.

[1] DDS enters into memorandums of understanding with the accrediting organizations that specify the standards to be applied in their reviews of providers.

Scope

Our review covered 19,554,975 claim lines totaling $1,058,406,073 ($533,133,954 Federal share) submitted by personal care providers from January 1, 2004, through December 31, 2007. (We refer to these lines in this report as "claims.")

During our audit, we did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we limited our internal control review to those controls related to the objective of our audit.

We conducted fieldwork at DHS's offices in Trenton, New Jersey, and at 48 personal care providers throughout the State.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State regulations and guidelines;
- held discussions with DHS officials to gain an understanding of the personal care services program;
- obtained a database from the MMIS fiscal agent of all Medicaid claims paid by the State for our audit period;
- ran computer programming applications that identified 19,554,975 personal care services claims, totaling more than $1 billion ($533 million Federal share);
- selected a simple random sample of 100 claims from the population of 19,554,975 claims (Appendix B) for each of which we:
    - reviewed the corresponding personal care provider's documentation supporting the claim, if available, and
    - visited the beneficiary or a member of the beneficiary's family associated with the claim, if available, to inquire about the personal care services received;[2] and
- estimated the unallowable Federal Medicaid reimbursement paid in the population of 19,554,975 claims.

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

[2] For various reasons (e.g., beneficiaries were deceased, had moved out of State), we were able to visit only 44 of the 100 beneficiaries.

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 did not claim Federal Medicaid reimbursement for some personal care services claims submitted by providers in accordance with all Federal and State requirements. Of the 100 claims in our random sample, 64 complied with Federal and State requirements, but 36 did not. Of the 36 noncompliant claims, 14 contained more than 1 deficiency. Table 1 summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

Table 1: Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Unallowable Claims[3]
No prior authorization	17
Inservice education requirement not met	13
No nursing supervision	8
No documentation	7
No nursing assessment	5
Personal care assistant not certified	2
No plan of care	1
No physician's authorization	1

These deficiencies occurred because the State agency did not effectively monitor the personal care services program for compliance with certain Federal and State requirements.

Based on our sample results, we estimated that the State agency improperly claimed $145,405,192 in Federal Medicaid reimbursement during our January 1, 2004, through December 31, 2007, audit period.

NO PRIOR AUTHORIZATION

Pursuant to NJAC 10:60-1.8(a), within 5 days of a provider's assessment or reassessment, the provider must submit a completed CMS-485 to the MACC that serves the county in which the beneficiary resides. In addition, pursuant to State procedures implemented between 1998 and 2006, to obtain prior authorization, a registered nurse must provide a face-to-face evaluation of the beneficiary and complete a form used to measure the beneficiary's need for personal care services.

Of the 100 claims in our sample, 17 were not preauthorized.[4]

[3] The total exceeds 36 because 14 claims contained more than 1 error.

[4] For claims submitted before the State codified NJAC 10:60-3.9 (July 3, 2006), we questioned the claim only if no CMS-485 was submitted and no prior authorization was obtained.

INSERVICE EDUCATION REQUIREMENT NOT MET

Pursuant to NJAC 10:60-1.2, personal care assistants must successfully complete a minimum of 12 hours of inservice education per year offered by the provider.

For 13 of the 100 claims in our sample, there was no evidence that the personal care assistant received the minimum required inservice education during the calendar year in which the service was provided or during the preceding 12 months.[5]

NO NURSING SUPERVISION

NJAC 10:60-3.5(a)(2) states:

> Direct supervision of the personal care assistant must be provided by a registered nurse at a minimum of one visit every 60 days, initiated within 48 hours of the start of service, at the beneficiary's place of residence during the personal care assistant's assigned time. The purpose of the supervision is to evaluate the personal care assistant's performance and to determine that the plan of care has been properly implemented.… Additional supervisory visits shall be made as the situation warrants, such as a new [personal care assistant] or in response to the physical or other needs of the beneficiary.

For 8 of the 100 claims in our sample, there was no evidence that a registered nurse (1) directly supervised the personal care assistant within 2 months before the sampled service, (2) directly supervised a new personal care assistant before the sampled service, or (3) supervised the personal care assistant at the beneficiary's residence.

SERVICES NOT SUPPORTED BY DOCUMENTATION

Pursuant to section 1902(a)(27) of the Act and NJAC 10: 49-9.8(b)(1), Medicaid services must be supported by documentation of the time spent providing the claimed service.

For 7 of the 100 claims in our sample, the provider did not document the amount and type of services performed or the documentation did not support the number of hours claimed.

NO NURSING ASSESSMENT

Pursuant to NJAC 10:60-3.5(a), a registered nurse must prepare an assessment within 48 hours after the start of service. The registered nurse also must perform a reassessment visit at least every 6 months, to reevaluate the beneficiary's need for continued care.

For 5 of the 100 claims in our sample, the provider did not produce the applicable assessment.

[5] We prorated the inservice education hours required for personal care assistants that were not employed by the beneficiary's provider for either the entire calendar year or the preceding 12 months.

PERSONAL CARE ASSISTANT NOT CERTIFIED

Pursuant to NJAC 10:60-1.2, a personal care assistant must be certified by the New Jersey Board of Nursing as a homemaker-home health aide.[6]

For 2 of the 100 claims in our sample, the personal care assistant was not certified on the date of the sampled service.

NO PLAN OF CARE

Pursuant to section 1905(a)(24)(A) of the Act and NJAC 10:60-3.1, personal care services must be provided in accordance with a plan of care. Pursuant to NJAC 10:60-3.5(a)(1), the plan of care must be prepared by a registered nurse.

For 1 of the 100 claims in our sample, the provider did not produce a plan of care.

NO PHYSICIAN'S AUTHORIZATION

Pursuant to 42 CFR § 440.167(a)(1) and NJAC 10:60-3.4, personal care services must be authorized by a physician.

For 1 of the 100 claims in our sample, the provider did not produce a physician's certification authorizing services.

CAUSES OF UNALLOWABLE CLAIMS

Contrary to State regulations, DHS did not require providers to submit CMS-485s for personal care services during our audit period. (Providers did not submit a CMS-485 for any of the 100 claims in our sample.) Rather, over a 7-year period, DHS implemented requirements for providers to obtain prior authorizations through a State-mandated procedure. DHS officials told us that, by 2006, all providers were subject to the State's mandated requirement. However, DHS did not fully implement its prior authorization control process before discontinuing its CMS-485 control process. The resulting gap in DHS's control process contributed to the submission of 17 improper claims for Federal Medical reimbursement for lack of proper authorization.

In addition, until 2005, DHS did not require the four organizations accrediting personal care service providers to review providers' compliance with State regulations. Further, the four accrediting organizations were not equally effective in ensuring compliance with State requirements. Specifically, for the 36 noncompliant claims, the 4 organizations' corresponding error rates (number of noncompliant claims divided by number of sample claims) ranged from 25 percent to 67 percent. As a result, during a portion of our audit period, the State's accreditation program did not effectively ensure that personal care providers complied with State requirements.

[6] The New Jersey Board of Nursing is administered by the New Jersey Department of Law and Public Safety, Division of Consumer Affairs.

ESTIMATE OF THE UNALLOWABLE AMOUNT

Of the 100 personal care services claims we sampled, 36 were not made in accordance with Federal and State requirements. Based on our sample results, we estimated that the State improperly claimed $145,405,192 in Federal Medicaid reimbursement from January 1, 2004, through December 31, 2007. The details of our sample results and estimates are shown in Appendix C.

RECOMMENDATIONS

We recommend that the State agency:

- refund $145,405,192 to the Federal Government and
- improve its monitoring of the personal care services program to help ensure compliance with Federal and State requirements.

DEPARTMENT OF HUMAN SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, DHS generally disagreed with our recommendations. In addition, DHS stated that the sample claims associated with one provider should be excluded from our sample frame because the provider was an outlier that did not represent the work done by other providers. DHS also provided 41 pages of additional documentation for 8 sample claims under separate cover.

After reviewing DHS's comments and additional documentation, we revised our findings and modified our statistical estimates accordingly. DHS's comments appear in their entirety as Appendix D.

No Prior Authorization

Department of Human Services Comments

DHS stated that it did not require prior authorization for all personal care services claims until 2005. DHS further stated that, since the service date for 15 sample claims occurred before the implementation of this policy, no authorization was required. However, DHS conceded that a CMS-485 or equivalent documentation should have been completed for the claims to comply with State regulations. In addition, DHS stated that two sample claims (numbers 55 and 95) related to a provider for whom we did not find similar errors during another review and that two other claims (numbers 26 and 93) related to a provider (now out of business) for which DHS was unable to review records.[7]

[7] In its comments, DHS also stated that two claims (numbers 26 and 57) should have received prior authorization before services were provided, but we did not question these claims for that reason.

Office of Inspector General Response

We agree that a CMS-485 or equivalent documentation should have been completed for these claims in accordance with State regulations. DHS's requirement for prior approval of personal care services was codified in the NJAC effective July 3, 2006. Based on the implementation of the requirement, we questioned a sample claim only if no CMS-485 or equivalent documentation was submitted and no prior authorization was obtained. Regarding claim numbers 95 and 55, the review cited by DHS covered a period after DHS had codified the prior approval process into State regulations. For claim numbers 26 and 93, case records were available for review during our visit to the provider.

Inservice Education Requirement Not Met

Department of Human Services Comments

DHS stated that it uncovered documentation related to four claims for which the individual providing personal care services met inservice education requirements. Specifically, for two claims, DHS stated that, since the New Jersey Department of Law and Public Safety, Division of Consumer Affairs, renewed the provider's credentials, it can be inferred that inservice training requirements had been met. For the remaining two claims, DHS stated that it had provided documentation that inservice training requirements were met. DHS also stated that it relies on the accrediting agencies to enforce its inservice training requirement and that it should not be penalized for deficiencies over which it has no control.

Office of Inspector General Response

DHS provided additional documentation for only one claim—number 91. However, the documentation did not adequately support DHS's statement that inservice training requirements were met. DHS provided no additional documentation for the remaining three claims. We cannot accept that inservice training requirements were met for any of the four claims. Certified homemaker-health care aides can renew their credentials online, a process that does not require the individuals to attest to having met inservice requirements.

No Nursing Supervision

Department of Human Services Comments

DHS stated that, under separate cover, it would provide documentation confirming that nursing supervision occurred for five claims. For one of the claims (number 19), DHS stated that the provider substituted a routine nursing supervision visit with a reassessment visit.

Office of Inspector General Response

DHS provided documentation for only four claims, and it was the same documentation that we reviewed at the personal care providers we visited. For all four claims, the materials did not document that a registered nurse (1) directly supervised the personal care assistant within

2 months before the sampled service, (2) directly supervised a new personal care assistant before the sampled service, or (3) supervised the personal care assistant at the beneficiary's residence.

Services Not Supported by Documentation

Department of Human Services Comments

DHS stated that, under separate cover, it would provide documentation for four sample claims. Additionally, for one claim (number 45), DHS stated that the service should be removed from our sample frame because the beneficiary's family was combative with provider staff and terminated the relationship with the provider, and only 1 hour was billed on the sampled occasion.

Office of Inspector General Response

DHS provided documentation for only one claim, and it was the same documentation that we reviewed at the personal care provider we visited. Regarding claim number 45, we disagree that we should remove it from our sample frame.

No Nursing Assessment

Department of Human Services Comments

DHS stated that, under separate cover, it would provide documentation for one sample claim (number 54). DHS also stated that it was unable to review three other claims related to one provider (Exclusive Care) because it was no longer in business and had destroyed all of its records.

Office of Inspector General Response

The documentation submitted for claim number 54 was the same documentation that we reviewed at the personal care provider we visited, and it did not demonstrate that a nursing assessment took place. Regarding the three claims associated with Exclusive Care, we noted that, during our onsite review, we found a case record for all 5 Exclusive Care claims included in our sample of 100 claims.

Personal Care Assistant Not Certified

Department of Human Services Comments

Under separate cover, DHS provided documentation for one sample claim (number 31). DHS indicated that the personal care assistant associated with the claim was certified by the New Jersey Department of Law and Public Safety, Division of Consumer Affairs, Board of Nursing, within the Board of Nursing's 30-day certification "grace period." Also, as part of its 41 pages of additional documentation, DHS provided documentation related to claim number 33.

Office of Inspector General Response

The documentation DHS submitted for claim number 31 was the same documentation that we reviewed at the personal care provider we visited and indicated that the personal care assistant was not certified on the date of the sample service, as required by NJAC 10:60-1.2. Regarding claim number 33, DHS's documentation did not relate to the aide associated with the claim.

Incorrect Reimbursement Rate

Department of Human Services Comments

DHS stated that the two sample claims (numbers 2 and 32) associated with beneficiaries with a mental health primary diagnosis should not have been paid at the lower, mental health personal care rate. DHS stated that although these beneficiaries each had a mental health diagnosis, they were not eligible for the mental health care program (NJAC 10:60-4.1 et seq.) but were eligible for the nonmental health personal care program (NJAC 10:60-3.1 et seq.).

Office of Inspector General Response

The records for claim numbers 2 and 32 indicated that the beneficiaries each have a mental health diagnosis, but both beneficiaries also had a coexisting physical condition. We accepted DHS's opinion on this issue and removed this finding. However, we continue to disallow claim number 2 for a lack of prior authorization and a lack of nursing supervision.

No Plan of Care

Department of Human Services Comments

DHS stated that it was unable to examine records for the one sample claim because the provider (in this case, Exclusive Care) was no longer in business and had destroyed all of its records.

Office of Inspector General Response

During our onsite review of documentation at Exclusive Care, we did not find any plan of care in the record for the beneficiary associated with the sample claim.

No Physician's Authorization

Department of Human Services Comments

DHS stated that it was unable to examine records for the one sample claim because the provider (in this case, Exclusive Care) was no longer in business and had destroyed all of its records.

Office of Inspector General Response

During our onsite review of documentation at Exclusive Care, we did not find any physician's authorization in the record for the beneficiary associated with the sample claim. We also contacted the beneficiary's physician, who stated that he could not locate a physician's authorization for the beneficiary.

Claims Related to One Provider

Department of Human Services Comments

DHS stated that claims associated with Exclusive Care should be excluded from our audit results because DHS's monitoring resulted in Exclusive Care's going out of business and paying a penalty. DHS stated that Exclusive Care settled a dispute with DHS over the use of personal care assistant pay rates for $85,000 rather than face a hearing board. DHS stated that Exclusive Care's owner declared bankruptcy after the settlement was reached. DHS further stated that Exclusive Care was an "outlier" and did not represent the work performed by other providers. DHS stated that the nine errors attributable to Exclusive Care significantly skew the results of our sample and unfairly penalize DHS. Finally, DHS stated that because Exclusive Care retained no billing and case records, it could not review Exclusive Care's records.

Office of Inspector General Response

Our statistically valid statewide random sample fairly represented personal care services claims submitted by DHS during our audit period, including those submitted on behalf of Exclusive Care. Therefore, we do not agree with DHS's position that claims submitted by Exclusive Care should be excluded from our audit results.[8] Also, Exclusive Care was taken over by Accredited Health Services in June 2008, and during a February 2009 site visit to Accredited Health Services, we reviewed all available supporting documentation for the five Exclusive Care claims.[9] Further, during the planning stage of our audit, DHS officials stated that our audit would not overlap with DHS's audits of providers' use of personal care assistant pay rates.

[8] We also note that DHS's sanctions against Exclusive Care related to whether the statutory increase in personal care assistant rates were used for staff salaries. The objective of our audit was to determine whether DHS claimed Medicaid reimbursement for personal care services claims submitted by providers in accordance with Federal and State requirements.

[9] During our site visit to Accredited Health Services, the former owner of Exclusive Care supplied documentation for these claims. Of the five claims, we found that claim number 84 contained no errors, claim number 89 contained an inservice education deficiency, and three other claims (numbers 23, 26, and 93) contained a nursing assessment deficiency.

Personal Care Services Program Monitoring

Department of Human Services Comments

DHS stated that "there is always room for improvement in monitoring its programs." However, DHS also stated that it believes that its monitoring of personal care service programs during the audit period was "very good" and pointed to its monitoring of Exclusive Care as proof of its monitoring efforts.

Office of Inspector General Response

We agree with DHS that its monitoring can always be improved. Even if we ignored those claims associated with Exclusive Care, we maintain that improved monitoring of DHS's personal care services program would help ensure that providers comply with Federal and State requirements.

OTHER MATTER: BENEFICIARY-IDENTIFIED PROBLEMS WITH PERSONAL CARE SERVICES

We interviewed 44 of the 100 sampled beneficiaries or their family members to determine whether quality-of-care issues existed, what service type and frequency were involved, and whether any service-related problems existed. We did not interview the remaining 56 sampled beneficiaries or their family members because the beneficiaries were deceased, had moved out of the State, declined to be interviewed, or could not be located. Of the 44 individuals interviewed, 20 said they had problems with a personal care assistant or a personal care services agency, including allegations that personal care assistants falsified timesheets, verbally abused beneficiaries, and stole property.[10] Table 2 summarizes the problems identified and the number of beneficiaries who encountered each type of problem.

[10] We were unable to determine whether any of the identified problems occurred on the specific service date drawn in our sample. For some beneficiaries, we were able to determine that the problems occurred during our audit period or that the aide on duty on the service date we reviewed was the cause of the beneficiary's problems. Not all of the problems occurred during our 4-year audit period.

Table 2: Problems Identified in Beneficiary Interviews

Type of Problem	Number of Beneficiaries[11]
Personal care assistant scheduling and turnover	7
Personal care assistant engaged in activities not related to care	7
Beneficiary did not receive a plan of care	6
Theft of property by the personal care assistant	4
Language barrier with the personal care assistant	3
Verbal abuse by the personal care assistant	2
Plan of care not followed by the personal care assistant	2
Other	3

Below are examples of some of the problems identified in our interviews.

PERSONAL CARE ASSISTANT ENGAGED IN ACTIVITIES NOT RELATED TO CARE

Of the 44 beneficiaries and family members we interviewed, 7 indicated that a personal care assistant engaged in activities not related to care. For example, it was alleged that, during duty hours, personal care assistants would sleep, talk on their cell phones, or arrive with their children. It was also alleged that personal care assistants did not work for the entire time recorded on their timesheets. Further, some alleged that personal care assistants arrived late, left early, forged the beneficiary's signature on the timesheet, and added an additional day worked to the timesheet.

THEFT OF PROPERTY

Of the 44 beneficiaries and family members we interviewed, 4 indicated that a personal care assistant stole property from them. Among items allegedly stolen were the beneficiary's medication, clothing, a purse with miscellaneous items, linens, a diamond ring valued at $5,000, and cash. One beneficiary's parents said that they filed a police report about the ring.[12] However, the parents said that they filed the police report only to claim the loss of the ring on their homeowners' insurance policy. In the police report, the parents did not implicate the personal care assistant in the alleged theft, nor did they notify the personal care provider.

LANGUAGE BARRIER WITH PERSONAL CARE ASSISTANT

Of the 44 beneficiaries and family members we interviewed, 3 indicated that a language barrier existed between them and the personal care assistant. Two beneficiaries said that they could not communicate with the personal care assistant because the aide did not speak English. The other beneficiary's daughter said that although her mother spoke only Spanish, the personal care provider sent only English-speaking aides.

[11] The total exceeds 20 because 9 beneficiaries identified more than 1 problem.

[12] The parents live with the beneficiary, who is incapable of fully communicating because of her physical condition.

VERBAL ABUSE BY PERSONAL CARE ASSISTANT

Of the 44 beneficiaries and family members we interviewed, 2 indicated that a personal care assistant verbally abused them. One beneficiary alleged that a personal care assistant yelled at her when she asked the aide to do the laundry. A second beneficiary alleged that two different personal care assistants verbally abused him. A family member witnessed both of these alleged incidents and notified the personal care provider.

APPENDIXES

APPENDIX A: FEDERAL AND STATE REQUIREMENTS RELATED TO PERSONAL CARE SERVICES

- Section 1905(a)(24) of the Social Security Act and implementing Federal regulations (42 CFR § 440.167) permit States to elect, as an optional Medicaid benefit, personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease. The statute specifies that personal care services must be: (1) authorized for an individual by a physician within a plan of treatment or in accordance with a service plan approved by a State, (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (3) furnished in a home or other location.

- Federal regulations (42 CFR § 440.167(a)(1)) and the New Jersey Administrative Code (NJAC) 10:60-3.4 specify that personal care services must be authorized by a physician.

- Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. Section C.1.c. of Attachment A provides that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.

- The beneficiary's need for services must be certified in writing to the provider by the attending physician (NJAC 10:60-3.4). The nurse must immediately record and sign a verbal order and obtain the physician's countersignature, in conformance with the provider's written policy.

- A registered nurse must perform an initial assessment within 48 hours of the start of service (NJAC 10:60-3.5(a)(1)). A reassessment visit must be performed at least once every 6 months, or more frequently if the beneficiary's condition warrants, to reevaluate the beneficiary's need for continued care (NJAC 10:60-3.5(a)(3)).

- Within 5 days of a provider's assessment or reassessment of a beneficiary, the provider must submit the Form CMS-485 (CMS-485) to the Medical Assistance Customer Center that serves the beneficiary's county (NJAC 10:60-1.8(a)). The CMS-485 collects information on the beneficiary's medical condition and treatment orders. Upon receipt of the CMS-485, Division of Disability Services (DDS) or Division of Medical Assistance and Health Services (DMAHS) staff must conduct concurrent quality assurance reviews on a selected number of cases. The reviews must include visits to the beneficiary's place of residence. DDS or DMAHS staff must also conduct random postpayment quality assurance reviews.

- All personal care services are required to have prior authorization by DDS, effective July 3, 2006 (NJAC 10:60-3.9(a)). To obtain prior authorization, a registered nurse must provide a face-to-face evaluation of the beneficiary and complete a form that includes information on 10 elements used to measure the beneficiary's need for personal care services (NJAC 10:60-3.9(b)). The provider transmits the evaluation form with a prior authorization request to

DDS, which determines the number of hours of personal care services authorized for the beneficiary.

- A registered nurse must prepare a plan of care for the personal care assistant to implement (NJAC 10:60-3.5(a)(1)). The plan of care must be prepared within 48 hours of the start of service. The plan of care must include the tasks assigned to meet the specific needs of the beneficiary.

- A registered nurse must provide direct supervision of a personal care assistant at a minimum of 1 visit every 60 days, initiated within 48 hours of the start of service, at the beneficiary's residence during the personal care assistant's assigned time (NJAC 10:60-3.5(a)(2)). The purpose of the supervision is to evaluate the personal care assistant's performance and to determine that the plan of care has been properly implemented. Additional supervisory visits must be made as the situation warrants, such as a new personal care assistant or in response to the physical or other needs of the beneficiary.

- The personal care assistant must be certified by the New Jersey Board of Nursing (NJAC 10:60-1.2).

- The personal care assistant must successfully complete a minimum of 12 hours inservice education per year offered by the personal care provider (NJAC 10:60-1.2).

- Providers are required to keep such records as are necessary to fully disclose the extent of services provided (NJAC 10:49-9.8(b)(1)). Where such records do not document the extent of services billed, payment adjustments are necessary (NJAC 10:49-9.8(b)(3)).

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was personal care services claim lines (claims) submitted by 258 providers in New Jersey (the State) during our January 1, 2004, through December 31, 2007, audit period that were claimed for Federal Medicaid reimbursement by the State.

SAMPLING FRAME

The sampling frame was a computer file containing 19,554,975 detailed paid claims for personal care services submitted by 258 providers in the State during our audit period. The total Medicaid reimbursement for the 19,554,975 claims was $1,058,406,073 ($533,133,954 Federal share). The Medicaid claims were extracted by our advanced audit techniques staff from the State's Medicaid payment files provided to us by staff of the State's Medicaid Management Information System fiscal agent.

SAMPLING UNIT

The sampling unit was an individual Federal Medicaid claim.

SAMPLE DESIGN

We used a simple random sample to evaluate the population of Federal Medicaid claims.

SAMPLE SIZE

We selected a sample of 100 claim lines.

SOURCE OF RANDOM NUMBERS

The source of the random numbers was the Office of Audit Services' statistical software, RAT-STATS. We used the random number generator for our sample.

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the 19,554,975 detailed claims. After generating 100 random numbers, we selected the corresponding frame items. We created a list of 100 sample items.

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate our estimates. We used the lower limit at the 90-percent confidence level to estimate the overpayment associated with the unallowable claims.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

Claims in Frame	Value of Frame (Federal Share)	Sample Size	Value of Sample (Federal Share)	Unallowable Claims	Value of Unallowable Claims (Federal Share)
19,554,975	$533,133,954	100	$2,854	36	$1,100

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

Point Estimate	$215,141,879
Lower Limit	$145,405,192
Upper Limit	$284,878,566

APPENDIX D: STATE AGENCY COMMENTS

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PO BOX 712
TRENTON, NJ 08625-0712

JENNIFER VELEZ
Commissioner

VALERIE HARR
Director

June 24, 2011

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

Report Number: A-02-09-01002

Dear Mr. Edert:

I am writing in response to your letter dated March 28, 2011 concerning the Department of Health and Human Services, Office of the Inspector General's (OIG) draft report entitled *"Review of Medicaid Personal Care Claims Submitted by Providers in New Jersey"*. Your letter provides the opportunity to comment on this draft report.

The objective of this review was to determine if the State claimed Medicaid reimbursement for personal care services claims submitted by providers in accordance with Federal and State requirements during the audit period of January 1, 2004 through December 31, 2007. Specifically, the purpose of the State's personal care service program which is operated by the New Jersey Department of Human Services' Division of Disability Services (DDS) is to accommodate beneficiaries' need for long-term chronic or maintenance health care, as opposed to their need for short-term care required for some acute illnesses. Personal care services include personal care, household duties and health related tasks performed by a qualified individual in a beneficiary's place of residence, under the supervision of a registered nurse, as certified by a physician in accordance with a written plan of care.

The draft audit report concluded that New Jersey's claims for reimbursement of Medicaid personal care services submitted by providers did not fully comply with Federal and State requirements. While 63 of the 100 claims in the random sample fully complied with all Federal and State requirements, the remaining 37 claims did not meet one or more of the applicable requirements. The report states that the deficiencies occurred because the State did not effectively monitor the personal care services program for compliance with

certain Federal and State requirements. Based upon the sample results, the auditor estimated that New Jersey was improperly reimbursed $145,805,934 in Federal Medicaid reimbursement during the January 1, 2004 through December 31, 2007 audit period.

We appreciate the opportunity to provide this response to the draft OIG audit report. Following are the auditors' recommendations and the Division of Medical Assistance & Health Services (DMAHS) responses:

Recommendation 1:

The OIG recommends that New Jersey refund $145,805,934 to the Federal Government:

The State does not concur with this recommendation. We have addressed each category of deficiencies below and in some cases additional documentation to support Sample Claims was located and forwarded directly to the auditor. Attached is a list of each Sample Claim with the issue(s) involved and documentation provided under separate cover. Furthermore, as outlined below, the State believes that the Sample Claims attributable to Exclusive Care should **not** have been included in the sampling frame.

I. **No Prior Authorization - 17 Claims:**

The Division did not begin prior authorization for 100 percent (from 1 hour) of claims until 2005. Given that 15 of the claims are for less then 25 hours of service, which were rendered prior to the date of mandatory authorization, DDS believes it had no obligation to authorize the claims in question since no authorization was required. The Division concedes that a CMS Form 485 should have been completed for these claims in compliance with *N.J.A.C. 10:140-1.8(a)*; however a section of the Medicare Program Integrity Manual, Transmittal Number 23, March 18, 2002 allows agencies an alternative to completing the Form #485. It states:

> Amendments to Chapter 6, Section 3.1 clarify that completion of a CMS Form 485 is not a CMS requirement; However, Home Health Agencies (HHAs) must have the plan of care elements available in a readily identifiable location within the medical record.

It does not appear that a Form 485 was meant for the purpose of authorizing a claim but was meant to be used for the purposes of notification and as tool for uniformity in recordkeeping. Further, the Section continues "that failure to complete the Form 485 does not necessarily justify the denial of a claim for services." Given that the claims were subsequently processed and paid without issue, it is the State's position that neither the vendor of the services nor DDS would have had cause to believe that there was an element of non-compliance.

In a review of these cases, the vendor of services (Bayada Nurses) for claim sample #95 and #55, notes that there were no discrepancies/issues found on this file during the 2009 audit. In an effort to resolve the issue, they have submitted documentation to support their compliance which has been sent to the auditor under separate cover.

DDS concurs that two of the sample claims (Sample #26 and #57) should have been prior authorized by DDS because the dates of service were after the date on which prior authorization was mandated and will take action to recoup any payments made in error.

Sample Claims #26 and #93 in this category were provided by Exclusive Care who went out of business after paying an $85,000 recoupment to DDS on another administrative matter. Immediately after making this payment, the owner declared bankruptcy and destroyed all records, making further recoupment or examination of records impossible. The issue concerning Exclusive Care is discussed below since several other Sample Claims relate to this provider.

II. **The Personal Care Assistant Did Not Receive In-Service Education – 13 Claims:**

The Division has uncovered documentation related to four claims which demonstrates that the individual PCA did, in fact, have the requisite in-service training. In two of the cases, the provider's credentials were renewed by the Division of Law and Public Safety for the same period and furnishing proof of in-service training would have been required as part of that process. One can then infer that in-service requirements were met given that the credential was renewed. In the third and fourth cases, a training record/verification has been provided under separate cover.

As detailed in the Audit Report, the Division is dependent on the four accreditation bodies to monitor the agency's compliance with this requirement. The accrediting bodies use a sampling method to determine compliance. Each agency is awarded a score, and agencies that attain a passing score are not reported to the DDS, despite the fact that there may be a few errors and exceptions. Furthermore, there is a dispute in the industry with regard to who "owns" an individual training record; the individual aide or the agency that provided and paid for the education. Individual aides often find it difficult or impossible to obtain in-service training records that were provided while they were employed by another agency, either because of animosity between the parties or where the agency may have ceased to exist.

DDS is working with the accrediting bodies to develop a standard regarding the transfer of an employee's training records when there is a separation from the

agency where the training was provided. However, DDS must rely upon the accrediting bodies to enforce this standard. It is the State's position that the State should not be penalized for deficiencies that in many cases it does not have control over.

III. <u>There Was No Nursing Supervision – 8 Claims:</u>

DDS is providing documentation under separate cover confirming that nursing supervision occurred as required during the time period in five of the cases noted in the claim sample. With regard to Sample Claim #19, the agency substituted a routine nursing supervision visit with a reassessment visit during which the client's status and level of care were re-determined. The HHA was also present at this meeting, and supervision also took place.

IV. <u>There Was No Documentation of Services Provided – 7 Claims:</u>

DDS is providing documentation under separate cover of billing records for four cases that detail the dates and times of services rendered, service codes, and hours billed. DDS believes that the supporting documentation meets the requirement. Additionally, Mercy Home Care has submitted a letter explaining that the family of Sample Claim #45 became combative with the agency staff regarding duties and refused to sign time records and allow supervisory staff into the house when they endeavored to mediate the situation. The family ultimately terminated service with the agency to seek services elsewhere. Given that only one hour was billed on one occasion, the error should be abated as an outlier caused by the family situation and not the agency or DDS. Consequently, the State does not believe this sample claim should be included in the sampling frame.

V. <u>There Was No Nursing Assessment – 5 Claims:</u>

DDS is providing documentation under separate cover that demonstrates that a nursing assessment took place for Sample Claim #54. Also, three claims in this category belong to Exclusive Care. DDS was unable to review any claims from Exclusive Care as previously detailed above. The issue concerning Exclusive Care is discussed below since several other Sample Claims relate to this provider.

VI. <u>The Personal Care Assistant Was Not Certified By The NJ Board of Nursing – 2 Claims:</u>

DDS is submitting documentation under separate cover regarding Sample Claim #31 that demonstrated that the aide was within a 30-day certification "grace period" granted by the NJ Board of Nursing when the services were rendered on December 16, 2003.

VII. The Provider Improperly Claimed A Higher Reimbursement Rate – 2 Claims:

The State does not agree with this audit finding. The draft audit report claims that in both cases the primary diagnosis of the service recipient was a mental health diagnosis, and therefore, they should have been serviced under *N.J.A.C. 10:60, Subchapter 4*, colloquially known as "Mental Health PCA.," The services under this subchapter are billable at a lower rate. A review of the subchapter and discussion with the Deputy Commissioner overseeing the Division of Mental Health Services confirms that this is a hybrid service to provide limited PCA benefits as part of a Community Rehabilitation package of services to those with mental illness. The services differ from those covered under *Subchapter 3* in that they are offered more as a tool for community integration then for ADL support and are provided to individuals on a short term basis, who may be transitioning to the community after residing in a clinical or acute care setting. Neither of the cases that were selected in the audit met these criteria. The service recipients did have mental health diagnoses but were not enrolled in/or eligible for any other community rehabilitation services. Each individual also had co-existing physical disabilities that warranted the need for PCA services under *Subchapter 3* that were provided and appropriately billed. Further, both of the vendors that provided the service were not providers for the mental health provider network, and therefore, are ineligible to provide services under *Subchapter 4*. The providers also would have had no knowledge of their client's interaction with the mental health system and the respective services each were receiving, if any.

DDS has also been advised that it is illegal to reimburse at a different rate for identical services, solely on the basis of the service recipient's diagnosis. These two Sample Claims should be categorized as complying with all Federal and State requirements.

VIII. There Was No Plan of Care On File – 1 Claim:

The single case in violation of this rule was serviced by Exclusive Care. As detailed above, DDS was unable to examine the records for this case or to contact anyone at the agency to resolve the matter or to provide an explanation. The issue concerning Exclusive Care is discussed below since several other Sample Claims relate to this provider.

IX. There Was No Physician's Authorization In Place – 1 Claim:

The single claim in violation of this rule was serviced by Exclusive Care. As detailed above, the Division was unable to examine the records for this case or to contact anyone at the agency to resolve the matter or to provide an explanation.

The issue concerning Exclusive Care is discussed below since several other Sample Claims relate to this provider.

X. Exclusive Care – 9 Deficiencies:

Exclusive Care was a problem agency within the PCA program. DDS has had many issues related to the monitoring of this agency. Most notably in 2006, DDS took the agency for a Fair Hearing to dispute their use of a statutory raise in the PCA rate that was used by the agency for administrative costs when it was mandated to be used for staff salaries. While preparing for the Fair Hearing, DDS noted several "red flags" related to the agencies shoddy business practices. The agency was advised that unless prompt remedial action was taken its provider status would be suspended. The Fair Hearing was resolved by an impromptu settlement in which DDS on behalf of DMAHS recouped $85,000. Almost immediately thereafter, the owner of Exclusive Care closed the doors of the agency, declared bankruptcy, and ceased contact with all parties. **No billing and case records were retained. This has made the review of the records in question within this audit impossible.**

Of the 56 deficiencies contained in the 37 Sample Claims that did not comply with Federal and State requirements, 9 deficiencies were attributable to Exclusive Care. Seven of the nine deficiencies were found in just 2 claims. The State believes that including any claims attributable to Exclusive Care significantly skews the sample data and, consequently, unfairly penalizes the State.

The Division believes that its diligent monitoring of this agency forced it out of business, fearing that we had uncovered only the "tip of the iceberg." We request that in light of the circumstances and the sampling error caused by these claims, they be removed from the error batch as outliers, since we believe they are not representative of the work done by other agencies or the oversight by the Division.

Recommendation 2:

The OIG recommends that DMAHS improve its monitoring of the personal care services program to ensure compliance with Federal and State requirements:

While the State agrees that there is always room for improvement in monitoring its programs, the State believes that its monitoring of personal care services programs during the audit period was very good as evidenced by its diligent monitoring of the Exclusive Care agency. The OIG uses the Exclusive Care errors as evidence of poor monitoring when in fact DDS's monitoring of this agency resulted in its removal for their program. The State believes this supports the position that DDS's monitoring of the personal care services program is very good.

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

Valerie Harr
Director

VH:H
c: Jennifer Velez
Richard Hurd

PCA AUDIT DOCUMENTATION

Sample No.	Provider	Client Name	Issue(s)	Documentation Provided
1	Accredited Health Services	[redacted]	No Prior Authorization	
2	Bayada Nurses, Union	[redacted]	No Prior Authorization No Nursing Supervision Incorrect Reimbursement Rate	Prior authorization was not required at date of service; see narrative.
3	Bayada Nurses, Linwood	[redacted]	No Prior Authorization No Documentation	Prior authorization was not required at date of service; see narrative. Hours Bill Report; HHA Time & Activity Record
4	Accredited Health Services	[redacted]	NO ERRORS	
5	Nursefinders, Edison	[redacted]	No Prior Authorization	Prior authorization was not required at date of service; see narrative.
6	Loving Care Agency, Clifton	[redacted]	Inservice Ed. Requirement Not Met	None-waiting for agency to forward documentation
7	People Choice Home Care	[redacted]	NO ERRORS	
8	Priority Nursing Services	[redacted]	No Prior Authorization	Prior authorization was not required at date of service; see narrative.
9	Loving Care Agency, Perth Amboy	[redacted]	NO ERRORS	
10	Northeastern Prof Nurses	[redacted]	No Documentation	HHA/Personal Care Worker Services Form
11	Loving Care Agency, Hackensack	[redacted]	NO ERRORS	
12	Confident Care	[redacted]	NO ERRORS	
13	Nursefinders, Hackensack	[redacted]	No Prior Authorization	Prior authorization was not required at date of service; see narrative.
14	Carefinders, Hackensack	[redacted]	NO ERRORS	
15	Maxim Healthcare Services	[redacted]	Inservice Ed. Requirement Not Met	None-waiting for agency to forward documentation

Office of Inspector General Note: We have redacted portions of the DHS's comments that contain personally identifiable information.

PCA AUDIT DOCUMENTATION

16	Loving Care Agency, Springfield	[redacted]	NO ERRORS	
17	Home Care Options	[redacted]	NO ERRORS	
18	Interim Healthcare	[redacted]	NO ERRORS	
19	Bayada Nurses, Union	[redacted]	No Nursing Supervision	Nursing Assessment
20	Maxim Healthcare Services	[redacted]	NO ERRORS	
21	Personalized Homecare	[redacted]	NO ERRORS	
22	Loving Care Agency, Camden	[redacted]	NO ERRORS	
23	Exclusive Care	[redacted]	No Nursing Assessment	None-invalid phone number
24	Bayada Nurses, Millville	[redacted]	NO ERRORS	
25	Confident Care	[redacted]	NO ERRORS	
26	Exclusive Care	[redacted]	No Physician Authorization No Nursing Assessment NO POC	None-invalid phone number
27	National Staffing Association	[redacted]	NO ERRORS	
28	Confident Care	[redacted]	NO ERRORS	
29	Be Kind Healthcare	[redacted]	Inservice Ed. Requirement Not Met	None-invalid phone number
30	Loving Care Agency, Springfield	[redacted]	No Documentation	None-waiting for agency to forward documentation

PCA AUDIT DOCUMENTATION

31	Bayada, Clifton	[redacted]	No Prior Authorization PCA Not Certified	Prior authorization was not required at date of service; see narrative. Aide's certification expired on 11/30/03; however it was confirmed with the NJ BON that aides are given a 30-day grace period to renew their certification which means aide was still certified on services were provided. IT had been dettermined tha the aide did not renew her certification until 1/27/04; therefore a repayment for the services she provided during the 27 days she wsa not certiifed will be made in the amount of $418.50
32	All Metro Health Care	[redacted]	Incorrect Reimbursement Rate	None-invalid phone number
33	Bayada Nurses, Cherry Hill	[redacted]	PCA Not Certified Inservice Ed. Requirement Not Met	Timesheets; Licensee Verification Letter from Div. of Consumer Affairs
34	Loving Care Agency, Camden	[redacted]	NO ERRORS	
35	Confident Care	[redacted]	NO ERRORS	
36	Home Care Options	[redacted]	NO ERRORS	
37	Wanda Best Health Care	[redacted]	No Prior Authorization	Prior authorization was not required at date of service; see narrative.
38	Accredited Health Services	[redacted]	NO ERRORS	
39	Loving Care Agency, Hackensack	[redacted]	NO ERRORS	
40	SJ Nurses, Inc.	[redacted]	NO ERRORS	
41	Care at Home	[redacted]	Inservice Ed. Requirement Not Met	None-Agency no longer exists
42	Loving Care, Springfield	[redacted]	Inservice Ed. Requirement Not Met	

PCA AUDIT DOCUMENTATION

43	Active Nursing Care	[redacted]	NO ERRORS	
44	Loving Hands	[redacted]	NO ERRORS	
45	Mercy Home Care	[redacted]	No Documentation	Memo to Medicaid Fraud Dept.
46	[redacted]	[redacted]	NO ERRORS	
47	Loving Care Agency, Camden	[redacted]	NO ERRORS	
48	Access Nursing Services	[redacted]	NO ERRORS	
49	Access Nursing Services	[redacted]	NO ERRORS	
50	Bayada, Maple Shade	[redacted]	No Nursing Supervision	Nursing Supervisor's Progress Report
51	Confident Care	[redacted]	NO ERRORS	
52	Confident Care	[redacted]	NO ERRORS	
53	Nursefinders, Verona	[redacted]	NO ERRORS	
54	Bayada Nurses, Linwood	[redacted]	No Nursing Reassessment No Nursing Supervision	Home Health Aide Time & Activity Report; Nursing Supervisor's Progress Report
55	Bayada Nurses, Union	[redacted]	No Prior Authorization	Prior authorization was not required at date of service; see narrative.
56	Care at Home	[redacted]	No Nursing Assessment No Prior Authorization	None-Agency no longer exists

PCA AUDIT DOCUMENTATION

57	Home Care Options	[redacted]	No Nursing Supervision No Documentation	Certified HHA Annual Performance Evaluation
58	Interim Healthcare	[redacted]	NO ERRORS	
59	Loving Care Agency, Hackensack	[redacted]	NO ERRORS	
60	Loving Care Agency, Dover	[redacted]	No Documentation	None-waiting for agency to forward documentation
61	Confident Care	[redacted]	NO ERRORS	
62	Confident Care	[redacted]	NO ERRORS	
63	Nursefinders, Verona	[redacted]	NO ERRORS	
64	People Choice Home Care	[redacted]	NO ERRORS	
65	Wanda Best Health Care	[redacted]	NO ERRORS	
66	Mercy Home Care	[redacted]	NO ERRORS	
67	Confident Care	[redacted]	NO ERRORS	
68	Nursefinders	[redacted]	NO ERRORS	
69	Confident Care	[redacted]	NO ERRORS	
70	Home Care Options	[redacted]	NO ERRORS	
71	Nursefinders, Hackensack	[redacted]	NO ERRORS	
72	Bayada Nurses, Union	[redacted]	NO ERRORS	
73	Care Management 2000	[redacted]	No Documentation	HM/HHA Activity Note; Nursing Progress Note

PCA AUDIT DOCUMENTATION

74	Metro Home Healthcare	[redacted]	NO ERRORS	
75	Confident Care	[redacted]	NO ERRORS	
76	Bayada Nurses, Millville	[redacted]	NO ERRORS	
77	Metro Home Healthcare	[redacted]	NO ERRORS	
78	Visiting Home Makers, Jersey City	[redacted]	No Prior Authorization Inservice Ed. Requirement Not Met	None-Agency cannot provide documentation. Database crashed and they cannot retrieve any information from it.
79	Loving Care Agency, Jersey City	[redacted]	NO ERRORS	
80	Interim Healthcare	[redacted]	NO ERRORS	
81	Metro Home Healthcare	[redacted]	NO ERRORS	
82	Carefinders, Hackensack	[redacted]	NO ERRORS	
83	Visiting Home Makers	[redacted]	No Nursing Supervision Inservice Ed. Requirement Not Met	Reassessment/Supervisory Report; 6 month reassessment; Reassessment/Supervisor Report. Cannot provide documentation for training - database crashed and they cannot retrieve information
84	Exclusive Care	[redacted]	NO ERRORS	
85	Nursefinders, Cherry Hill	[redacted]	NO ERRORS	
86	Confident Care	[redacted]	NO ERRORS	
87	Access Nursing Services	[redacted]	NO ERRORS	
88	Loving Care Agency, Springfield	[redacted]	NO ERRORS	
89	Exclusive Care	[redacted]	Inservice Ed. Requirement Not Met	None-Agency no longer exists
90	Access Nursing Services	[redacted]	No Prior Authorization	

PCA AUDIT DOCUMENTATION

91	Bayada Nurses, Union	[redacted]	No Prior Authorization Inservice Ed. Requirement Not Met	Prior authorization was not required at date of service; see narrative. Inservice Date Report
92	Loving Care, Dover	[redacted]	Inservice Ed. Requirement Not Met	None-waiting for agency to forward documentation
93	Exclusive Care	[redacted]	No Nursing Reassessment No Prior Authorization No Nursing Assessment Inservice Ed. Requirement Not Met	None-Agency no longer exists
94	Loving Care Agency, Jersey City	[redacted]	NO ERRORS	
95	Bayada Nurses, Morristown	[redacted]	No Prior Authorization	Prior authorization was not required at date of service; see narrative.
96	Visiting Home Makers, Hackensack	[redacted]	Inservice Ed. Requirement Not Met	None-unable to contact agency
97	Wanda Best Health Care	[redacted]	NO ERRORS	
98	Loving Care Agency, Jersey City	[redacted]	NO ERRORS	
99	Accredited Health Services	[redacted]	No Nursing Supervision	Supervisory Visit
100	Personalized Homecare	[redacted]	NO ERRORS	