Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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Office of Inspector General

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EXECUTIVE SUMMARY

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

WHY WE DID THIS REVIEW

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

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

BACKGROUND

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

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

HOW WE CONDUCTED THIS REVIEW

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

WHAT WE FOUND

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

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

WHAT WE RECOMMEND

We recommend that the State agency

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

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

STATE AGENCY COMMENTS AND OUR RESPONSE

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

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

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INTRODUCTION

WHY WE DID THIS REVIEW

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OBJECTIVE

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

BACKGROUND

The Medicaid Program

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

Home and Community-Based Services Waivers Under the Medicaid Program

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

To be eligible for Federal Medicaid reimbursement, HCBS must be furnished under a written plan of care (care plan) and, on at least an annual basis, beneficiaries receiving HCBS must be reevaluated. 7R EH HOLJLEOH IRU +&%6 D EHQHILFLDU\¶V FDUH SODQ PXVW VSHFLI\ the services needed to prevent the beneficiary from requiring institutionalization. The care plan must specify the medical and other services to be provided and their frequency.

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[1] $ 6WDWH¶V +&%6 ZDLYHU SURJUDP PXVW EH DSSURYHG E\ &06 DQG DOORZ EHQHILFLDULHV WR UHFHLYH services not usually covered by Medicaid. HCBS are generally provided to Medicaid-eligible beneficiaries in the community rather than in an institutional setting.

[2] &KDQJHV LQ WHUPLQRORJ\ DUH EHLQJ PDGH LQ WKH)HGHUDO UHJXODWLRQV. For more information, see CMS's Final Rule, 77 Fed. Reg. 29002, 29021 & 29028 (May 16, 2012).

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

In New Jersey, the State agency (the Division of Medical Assistance and Health Services) administers the Medicaid program and is responsible for the State's Medicaid GO-LTC waiver program. Until the Medicaid GO-LTC waiver program transitioned to a managed care program in July 2012, the program was operated by the Division of Aging Services. The GO-LTC waiver program enabled Medicaid beneficiaries assessed as needing nursing facility level of care and who met financial requirements to remain in the community or return from institutional care to the community.

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

HOW WE CONDUCTED THIS REVIEW

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

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

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

FINDINGS

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

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

Table 1: Summary of Deficiencies in Sampled Beneficiary-Months

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

[a] The total exceeds 62 because29beneficiary-months contained more than 1 deficiency.

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

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

SERVICES NOT DOCUMENTED

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

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

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

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

[5] Specifically, costs must be adequately documented to be allowable under Federal awards (2 CFR § 225, App. A § C.1.j (Office of Management and Budget (OMB) Circular A-87,Cost Principles for State, Local, and Tribal Governments)). After our audit period, OMB consolidated and streamlined its guidance regarding all entities that receive and administer Federal awards. The consolidated guidance is now located at 2 CFR part 200. Expenditures are allowable only to the extent that, when a claim is filed, there is adequate supporting documentation in readily reviewable form to assure that all applicable Federal requirements have been met (see State Medicaid Manual§ 3 6 ¶ V H E W L R Q I & 0 6 ¶ V I R

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

SERVICES NOT PROVIDED IN ACCORDANCE WITH APPROVED CARE PLAN

HCBS must be furnished under a written care plan subject to approval by the State agency (42 CFR § 441.301(b)(1)(i)). Q G G L W L R Q W K H 6 W D W H ¶ V D S S U R Y D O R I H D F K beneficiary's waiver services would be furnished pursuant to a written care plan and that Federal Medicaid reimbursement would not be claimed for waiver services that were not included in a E H Q H I L F L D U \ ¶ V F D U H S O D Q . Each care plan must have specified the services to be provided, their I U H T X H Q F \ D Q G W K H W \ S H R I S U R Y L G H U (State Medicaid Manual § 2373.1). Further, R I the waiver agreement required the care plan to be signed by the E H Q H I L F L D U \ ¶ V F D U H P D Q the care manager's supervisor.

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

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

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

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

- Services exceeded maximum units allotted. During 2 beneficiary-months, the State agency claimed reimbursement for some services that exceeded the maximum units allotted in the E H Q H I L F L D U \ ¶ V care plan. For example, for one E H Q H I L F L D U \ ¶ V care plan indicated that the beneficiary should receive a maximum of 6 hours of homemaker services each day; however, the provider billed for 8 hours of homemaker services.

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

PROVIDER QUALIFICATIONS NOT DOCUMENTED

Home Health Aides

In order to be an HCBS, the service must meet the Federal standards concerning health and welfare assurance (42 CFR § 430.180(a)(2)). Those standards include assuring that the standards of any State licensure or certification requirements are met for individuals furnishing HCBS (42 CFR § 441.302(a)(2)). In New Jersey, home health aides must be certified by the Department of Law & Public Safety, Division of Consumer Affairs (N.J.A.C. 13:60-1.2).

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

Social Workers

In order to be an HCBS, the service must meet the Federal standards concerning health and welfare assurance (42 CFR § 430.180(a)(2)). Those standards include assuring that adequate standards exist for all types of providers that provide services under the waiver (42 CFR § 441.302(a)(1)). The GO-LTC waiver requires that social workers be licensed, have a college degree or higher, or have relevant work experience.[7]

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

LEVEL- OF-CARE ASSESSMENT NOT DOCUMENTED

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

During 9 beneficiary-months, the State agency claimed reimbursement for some services when the level-of-care assessment was not documented. Without the beneficiary's case file

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

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

STATE LICENSE NOT DOCUMENTED

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

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

SERVICES INAPPROPRIATELY BILLED TO THE WAIVER

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

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

SERVICES CLAIMED AT AN INAPPROPRIATE RATE

Federal regulations state that Federal medical assistance percentages (FMAP) is determined by the formula described in section 1905(b) of the Act. For States with per capita income exceeds the national average, the Federal share is a statutory minimum of 50 percent (42 CFR § 433.10(b)). For States whose per capita income exceeds the national average. Therefore, CMS reimbursed GO-LTC waiver services at an FMAP of 50 percent.

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

CONCLUSION

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

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

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

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

RECOMMENDATIONS

We recommend that the State agency

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

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

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

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

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OFFICE OF INSPECTOR GENERAL RESPONSE

$IWHU UHYLHZLQJ WKH 6WDWH DJHQF\¶V FRPPHQWV ZH PDGH recommendations are valid. We reviewed the additional documentation provided by the State agency before issuing our draft report and reduced our preliminary recommended disallowance accordingly. However, we determined that the remaining claims for Federal Medicaid reimbursement for GO-LTC waiver services still did not comply with certain Federal and State requirements.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
0 R V W R I 1 H Z - H U V H \ ¶ V & O D L P Supported Employment Services Were Unallowal	A-02-12-01009	12/14/13
Review of Medicaid Payments for Services Provided Under New Jersey¶ V 6 H F W L R Q Community F Care Waiver From January 1, 20 0, Through December 31, 20 0	A-02-10-10129	4/20/12
Review of Medicaid Payments for Services Provided Under New Jersey¶ V 6 H F W L R Q Community F Care Waiverby Bancroft NeuroHealth From January 1, 2005, Through December 31, 2007	A-02-09-01034	3/22/12
Review of Medicaid Payments for Services Provided Under New Jersey¶ V 6 H F W L R Q Community F Care Waiverby Elwyn New Jersey From January1, 2005, Through December 31, 2007	A-02-09-01033	7/27/11

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

FEDERAL REQUIREMENTS FOR DOCUMENTATION NEEDED TO SUPPORT SERVICES BILLED

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

FEDERAL REQUIREMENTS FOR SERVICES BEING APPROPRIATELY BILLED TO THE WAIVER

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

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

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

6 H F W L R Q 5 H 6 W D W H 0 H G L F D L G ¶ V 0 D Q X D O requires an assessment of the individual to determine the services needed to prevent institutionalization that must be included in the care plan. In addition, the care plan must specify the medical and other services to be provided, their frequency, and the type of provider. No Federal financial participation is available under a § 1915(c) waiver for HCBS furnished without a written care plan.

The 6 W D W H ¶ V 0 H G L F D L G : D L Y H U ¶ V agreement with CMS requires that the care plan be signed by the E H Q H I L F L D U \ ¶ V F D U H P D Q D J H U D Q G W K H F D U H P D Q D J H U ¶ V

FEDERAL AND STATE REQUIREMENTS TO QUALIFY PROVIDERS

In order to be an HCBS, the service must meet the Federal standards concerning health and welfare assurance (42 CFR § 430.180(a)(2)). Those standards include assuring that the standards of any State licensure or certification requirements are met for individuals furnishing HCBS (42 CFR §441.302(a)(2)).

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

FEDERAL AND STATE REQUIREMENTS FOR ELIGIBLITY TO RECEIVE SERVICES

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

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

FEDERAL REQUIREMENTS TO ENSURE PROVIDERS MAINTAIN A STATE LICENSE

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

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

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

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered beneficiary-months of service for which the State agency received Medicaid U H L P E X U V H P H Q W I R U V H U Y L F H V S U R Y L G H G X U L Q J W K H 6 W D W H - H U July 1, 2009, through June 30, 2013. We limited our review to Medicaid costs claimed for services greater than $100 for a beneficiary-month of service. A beneficiary-month is defined as all services for one beneficiary for 1 month.

: H O L P L W H G R X U U H Y L H Z R I W K H 6 W D W H D J H Q F \ ¶ V internal control applicable to the services reviewed because our objective did not require an understanding of all internal controls over the waiver program.

We performed our fieldwork at S U R Y L G H U V ¶ R I I L F H V L Q New Jersey from March through May 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State Medicaid laws, regulations, and guidance;
- met with CMS financial and program management officials to gain an understanding of the Z D L Y H U V ¶ D S S U R Y D O and assessed internal controls;
- met with State agency R I I L F L D O V W R G L V F X V V W K H 6 W D W H ¶ V D G P L Q waiver program;
- obtained from New Jersey¶ V 0 H G L F D L G 0 D Q D J H P H Q W 6 \ V W H P (MMIS) a sampling frame of 427,223 beneficiary-months greater than $100 for GO-LTC waiver services for which the State agency claimed reimbursement totaling approximately $68 million ($35 million Federal share) from July 1, 2009, through June 30, 2013;[10]
- reconciled the GO-LTC waiver services that the State agency claimed for Federal reimbursement on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, to the sampling frame of all payments for GO-LTC waiver servi F H V W R S U R Y L G H U V V W D W H Z L G H f r o m J u l y 1, 2009, G I U R P 1 H Z through June 30, 2013;
- selected a stratified random sample of 131 beneficiary-months from the sampling frame and for each beneficiary-month:

[10] Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the MMIS file for our audit period. We also established reasonable assurance of the completeness of the data by U H F R Q F L O L Q J W K H F O D L P V G D W D L Q W K H 0 0 , 6 o w h F W K C M S 6 4 . D W H D J H Q F \ ¶

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

- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 427,223 beneficiary-months;[11] and
- discussed the results of our review with State agency officials.

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

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

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

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

POPULATION

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

SAMPLING FRAME

The sampling frame was an Access file containing 427,222 beneficiary-months for services totaling $668,163,783 ($335,408,466 Federal share) for which the State agency received Medicaid reimbursement under the New Jersey GO-LTC waiver program from July 1, 2009, through June 30, 2013. We extracted the data for the beneficiary-months from the New Jersey MMIS.

SAMPLE UNIT

The sample unit was a beneficiary-month.

SAMPLE DESIGN

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

- Stratum 1: beneficiary-months with total payments greater than $100 and less than or equal to $5,000: 427,192 beneficiary-months totaling $667,870,735 ($335,219,559 Federal share).

- Stratum 2: beneficiary-months with total payments greater than $5,000: 30 beneficiary-months totaling $303,048 ($188,907 Federal share).

SAMPLE SIZE

We selected a sample of 131 beneficiary-months:

- [illegible] from stratum 1 and

- [illegible] from stratum 2.

SOURCE OF THE RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

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

ESTIMATION METHODOLOGY

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

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Details and Results

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

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

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

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

Legend

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

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

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

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

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

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

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

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

62 Beneficiary-months in Error