Department of Health and Human Services
Office of Inspector General
Office of Audit Services

September 2025 | A-02-22-01024

New Jersey Did Not Ensure That Some Medicaid Personal Care Assistant Services Provided Under the Personal Preference Program Met Federal and State Requirements

REPORT HIGHLIGHTS

September 2025 | A-02-22-01024

New Jersey Did Not Ensure That Some Medicaid Personal Care Assistant Services Provided Under the Personal Preference Program Met Federal and State Requirements

Why OIG Did This Audit

- New Jersey's Medicaid Personal Preference Program (PPP) allows Medicaid participants to self-direct their personal care assistant (PCA) services and remain in their home and active in their community without requiring the use of a home health care agency.
- New Jersey pays managed care organizations (MCOs) fixed monthly payments to make PCA services available under the PPP. MCOs must assess participant eligibility using a PCA assessment and provide a monthly budget amount to be used for services. New Jersey contracts with a fiscal intermediary to provide a range of services for participants. The fiscal intermediary assists in establishing a cash plan for the participant and verifies that caregivers are eligible to provide services.
- This audit examined whether New Jersey ensured that its contracted MCOs and fiscal intermediary complied with Federal and State requirements for providing PCA services to selected PPP participants.

What OIG Found

New Jersey did not ensure that its contracted MCOs and fiscal intermediary complied with Federal and State requirements for providing PCA services to selected PPP participants. Specifically:

- MCOs did not meet PCA assessment and monthly budget amount requirements for 24 of the 150 sampled participant-months.
- The fiscal intermediary did not meet cash plan and caretaker verification requirements for 55 of the 150 sampled participant-months.
- On the basis of our sample results, we estimated that, for 41 percent of participant-months during the audit period, MCOs paid caregivers $197 million through the fiscal intermediary for PCA services provided under the PPP that did not comply with Federal and State requirements.

What OIG Recommends

We made two procedural recommendations to New Jersey to improve its oversight and monitoring of its Medicaid PPP. The full recommendations are in the report. New Jersey concurred with our recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Personal care assistant (PCA) services are nonemergency, health-related tasks that include help with activities of daily living and with household duties essential to a participant's health and comfort, such as bathing, dressing, meal preparation, and light housekeeping.

A previous Office of Inspector General (OIG) audit identified consumer-directed PCA services in one State as not meeting Medicaid requirements.[1] Based on this result, we decided to audit New Jersey's Medicaid Personal Preference Program (PPP). The PPP offers a monthly monetary allowance in place of traditional agency PCA services. The PPP allows participants to self-direct their PCA services and remain in their home and active in their community without requiring the use of a home health care agency. Participants are given both employer and budget authorities to employ a caregiver of their choice, such as a friend or relative. New Jersey pays managed care organizations (MCOs) fixed monthly capitation payments to make PCA services available under the PPP.[2] To facilitate the PPP, New Jersey contracts with a fiscal intermediary to provide a range of fiscal and business services for participants.[3]

OBJECTIVE

Our objective was to determine whether the New Jersey Department of Human Services (State agency) ensured that its contracted MCOs and fiscal intermediary complied with Federal and State requirements for providing PCA services to selected PPP participants.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. In New Jersey, the State agency administers its Medicaid program.

New Jersey's Medicaid Personal Preference Program

Applicants apply directly to the PPP through their MCO, which determines eligibility through a State-approved PCA assessment completed by a New Jersey licensed, professional registered

[1] OIG, *New York Claimed Federal Reimbursement for Consumer-Directed Personal Assistance Services That Did Not Meet Medicaid Requirements* (A-02-16-01026), June 4, 2018.

[2] New Jersey contracted with five MCOs during our audit period of calendar years (CYs) 2019 through 2021.

[3] New Jersey contracted with one fiscal intermediary during our audit period of CYs 2019 through 2021.

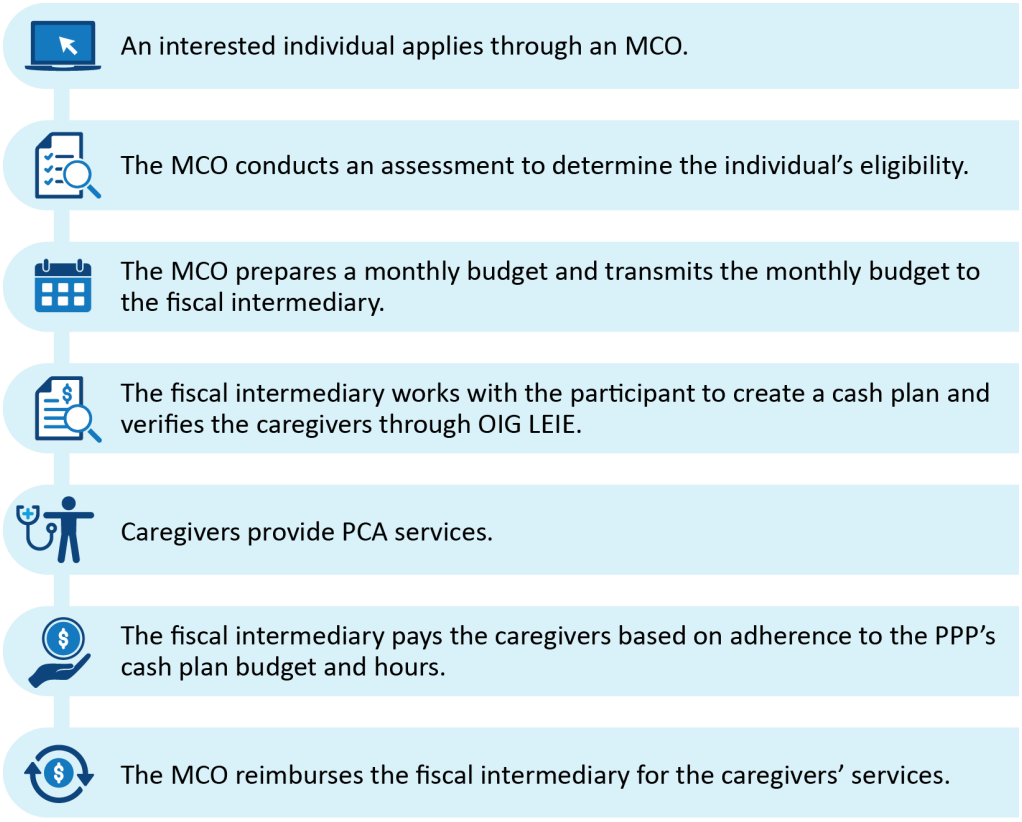
nurse.[4] The assessment is used to evaluate individual needs and determine a number of authorized PCA hours per week. The State agency requires the MCO to convert PCA hours to a monthly budget using a State-approved formula and to transmit this information to the fiscal intermediary through a data file exchange.[5] We refer to the budget transmitted from the MCO to the fiscal intermediary as the "monthly budget." This monthly budget is the initial basis amount for what is known as a cash management plan (cash plan). A cash plan is a predetermined monthly allowance that represents the amount available for participants to use to hire caregivers and purchase services or goods.

The fiscal intermediary works with the participant to complete the cash plan, which includes information such as a services budget, allotted hours, and a caregiver pay rate. The fiscal intermediary must ensure that the participant adheres to the cash plan budget and allotted hours for the caregiver to be paid for services. The fiscal intermediary monitors participant billing during the month to ensure that they stay within their budget. During this process, the fiscal intermediary must verify caregivers through the OIG List of Excluded Individuals/Entities (OIG LEIE). Finally, the MCO reimburses the fiscal intermediary for the services the caregiver performed. Figure 1 (next page) describes the PPP enrollment and payment process.

[4] New Jersey's model MCO contract, Appendix B, section B.4.1, paragraph 27.

[5] The MCO subtracts an administrative percentage for the fiscal intermediary.

Figure 1: New Jersey's Medicaid Personal Preference Program Enrollment and Payment Process



Personal Preference Program Payments for Aged, Blind, and Disabled Individuals

New Jersey's aged, blind, and disabled (ABD) programs provide medical coverage to individuals aged 65 or older as well as individuals determined blind or disabled by the Social Security Administration or by the State. MCOs receive monthly capitation payments from the State, which are jointly funded by the State and the Federal Government for ABD individuals.

For PPP participants identified as ABD that require PCA services, the State agency allocates a portion of the monthly capitation payment for the provision of such services, which the PPP delivers by allowing its participants to self-direct their PCA services. Throughout the report, we refer to these individuals as PPP participants.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 387,526 Medicaid participant-months of service (participant-months)[6] for

[6] A participant-month is defined as PCA services provided under the PPP identified in Medicaid encounter data for one participant during 1 month. The sampling frame included participant-months with a total Medicaid paid claim amount greater than $100.

which New Jersey MCOs paid $461,160,080 to caregivers of PPP participants identified as ABD and who received PCA services during CYs 2019 through 2021 (audit period).[7] We selected a stratified random sample of 150 participant-months and reviewed documentation provided by the MCOs and fiscal intermediary to verify whether each selected participant-month was billed in accordance with Federal and State requirements.

We reviewed the State agency's policies and procedures for ensuring that its MCOs and fiscal intermediary complied with Federal and State requirements for providing PCA services to PPP participants.

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

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

FINDINGS

The State agency did not ensure that its contracted MCOs and fiscal intermediary complied with Federal and State requirements for providing PCA services to selected PPP participants. Of the 150 participant-months we sampled, the MCOs and fiscal intermediary complied with Federal and State requirements for PCA services for 87 participant-months. However, for the remaining 63 participant-months, either the MCO or the fiscal intermediary did not comply with Federal and State requirements for providing PCA services. The following table summarizes the deficiencies we identified in the 63 participant-months for which we identified errors and whether an MCO or the fiscal intermediary was responsible for the deficiency.

Summary of Deficiencies in Sampled Months

Deficiency Type	Entity Responsible	Number of Participant-Months in Error
PCA Assessment Requirements Not Met	MCO	12
Monthly Budget Requirements Not Met	MCO	12
Cash Plan Requirements Not Met	Fiscal Intermediary	43
OIG LEIE Screen Not Adequately Documented	Fiscal Intermediary	12

Note: The total number of sampled months in error exceeds 63 because some sampled months had multiple deficiencies.

[7] Our audit period was determined based on the most recent data available at the time we initiated the audit.

On the basis of our sample results, we estimated that for 159,487 participant-months (41 percent) during the audit period, MCOs paid caregivers through the fiscal intermediary for PCA services provided under the PPP that did not comply with Federal and State requirements. For these participant-months, we estimated that the MCOs made payments totaling $196,584,979 to caregivers on behalf of PPP participants whose services were not provided in accordance with Federal and State requirements.[8]

These deficiencies occurred because the State agency did not adequately monitor the MCOs and fiscal intermediary for compliance with certain Federal and State requirements. As a result, the program was vulnerable to misuse of Federal funds, and the health and safety of PPP participants may have been placed at risk.

MANAGED CARE ORGANIZATIONS AND THE FISCAL INTERMEDIARY DID NOT COMPLY WITH FEDERAL AND STATE REQUIREMENTS FOR PROVIDING PERSONAL CARE ASSISTANT SERVICES UNDER THE PERSONAL PREFERENCE PROGRAM

Managed Care Organizations Did Not Meet Personal Care Assistant Assessment and Monthly Budget Amount Requirements

Personal Care Assistant Assessment Requirements Not Met

PCA assessments are performed to determine a participant's eligibility for PCA services.[9] PCA assessments are to be performed upon enrollment and reassessments are to be performed annually or upon a change in condition.[10]

[8] Noncompliance with Federal and State requirements does not mean that the full capitation payments for the participant-months were unallowable. We estimated total payments associated with noncompliance using payments made by MCOs to caregivers.

[9] New Jersey's model MCO contract, Appendix B, section B.4.1, paragraph 31.

[10] Title 10 § 142-1.2(e) of the New Jersey Administrative Code (NJAC); New Jersey's model MCO contract, Appendix B, section B.4.1, paragraph 31.

For 12 of the participant-months we sampled, the MCO did not meet PCA assessment requirements. Specifically:

- For 10 participant-months, the MCO did not conduct a PCA reassessment annually.[11, 12]

- For 2 participant-months, the MCO did not document that a PCA assessment was performed (i.e., no initial assessment or reassessments were maintained in the associated participant's service record).

Without adequate and timely documentation of PCA assessments, MCOs may have been unable to accurately monitor PPP participants' needs and therefore may not have provided the appropriate PCA service hours to these participants.

Monthly Budget Requirements Not Met

Federal regulations require the Medicaid agency to maintain or supervise the maintenance of the records necessary for the proper and efficient operation of the Medicaid State plan.[13] State regulations require a monthly budget amount to be used for services, supports, and goods to ensure that PPP participants can complete the activities of daily living consistent with their individual needs.[14] The State agency requires that, as part of its program process, the MCO convert PCA hours to a monthly budget using a State-approved formula and transmits this information to the fiscal intermediary through a data file exchange. During the COVID-19 public health emergency (PHE), the State agency reiterated that accurate data file exchanges between the MCOs and the fiscal intermediary should continue.[15]

[11] All PCA reassessment deficiencies occurred prior to the COVID-19 public health emergency (PHE) waiving of pre-existing authorizations, which began Mar. 1, 2020. We noted that section 1135(b)(1)(C) of the Act authorized CMS to waive preapproval requirements during the PHE. Further, CMS authorized the MCOs to use continuity-of-care for the redetermination of PCA services or an increase in service level. For example, if an MCO assessed a participant at a specific number of PCA hours prior to the PHE waiving of pre-existing authorizations, the MCO was not allowed to lower the participant's hours during the duration of the PHE. In practice, this allowed significant flexibility to the PCA reassessment requirement during the PHE.

[12] For 10 participant-months, reassessments occurred between 39 and 352 days (median of 101 days) after they were due, prior to the waiving of pre-existing authorizations during the PHE. We calculated this figure by determining the number of days between the first day that pre-existing authorizations were waived (Mar. 1, 2020) and when reassessments were due (i.e., 365 days after the previous assessment).

[13] 42 CFR § 431.17(b).

[14] NJAC 10:142-4.1(a).

[15] State agency, PPP Covid-19 Operations Policy Guidance, May 20, 2020.

For 12 of the participant-months we sampled, the MCO did not meet monthly budget requirements. Specifically:

- For 7 participant-months, the MCO did not provide a monthly budget amount to the fiscal intermediary.

- For 5 participant-months, the MCO did not transmit accurate monthly budget amounts to the fiscal intermediary.[16]

Without adequate and accurate documentation of monthly budgets, the fiscal intermediary may not have had the correct budget information to create the participant's cash plan.

Fiscal Intermediary Did Not Meet Cash Plan and Caregiver Verification Requirements

Cash Plan Requirements Not Met

State regulations require all cash plan-funded payments to be made by the fiscal intermediary, based on approved items in the cash plan and submission of required documentation. The fiscal intermediary is required to deny any requests to use cash plan funds to pay for unauthorized expenses.[17] In addition, the fiscal intermediary is required to review caregivers' timesheets and issue payments to vendors and service providers pursuant to the cash plan.[18] The cash plan must indicate the monthly cost and frequency of each service, and rate of pay for all individuals or vendors hired.[19]

For 43 of the participant-months we sampled, the fiscal intermediary did not meet cash plan requirements. We categorized the deficiencies we identified into three categories: general, caregiver-related, and billing. Specifically:

- For 26 participant-months, the fiscal intermediary did not meet general cash plan requirements. For these participant-months, the fiscal intermediary did not document the associated PPP participant's cash plan or provide support that a cash plan was completed.

[16] The fiscal intermediary relied on previously submitted monthly budgets that were not in accordance with associated participants' PCA assessments. Those PCA assessments occurred prior to the PHE waiving of pre-existing authorizations (Mar. 1, 2020).

[17] NJAC 10:142-4.5 (a) and (f).

[18] NJAC 10:142-7.1(b) (9–10).

[19] NJAC 10:142-4.5 (b).

- For 10 participant-months, the fiscal intermediary did not correctly document caregiver information within the associated PPP participant's cash plan. Specifically:

    - For 5 participant-months, the name of the caregiver indicated on the cash plan did not match the name of the caregiver paid to provide PCA services.[20]

    - For 3 participant-months, the associated PPP participant's cash plan did not correctly indicate the caregiver's rate of pay.[21]

    - For 2 participant-months, the cash plan did not indicate the name of any caregiver.

- For 7 participant-months, the fiscal intermediary did not deny PPP participants' requests to use cash plan funds to pay for unauthorized hours or expenses. Specifically:

    - For 5 participant-months, the hours billed by the caregiver exceeded the number of hours allotted on the PPP participant's cash plan.

    - For 1 participant-month, monthly billings exceeded the budget specified in the PPP participant's cash plan.

    - For 1 participant-month, the PPP participant billed financial counseling services not documented in their cash plan.

Without adequate or accurate cash plans, the fiscal intermediary cannot effectively monitor participant needs and therefore may not have authorized the appropriate services to participants.

OIG List of Excluded Individuals/Entities Verifications Not Adequately Documented

Federal regulations require that the State agency verify caregivers against the OIG LEIE upon initial enrollment and monthly thereafter.[22] Also, during the PHE, the State reiterated that OIG database reviews for newly hired caregivers should continue.[23]

For 12 of the participant-months we sampled, the fiscal intermediary did not adequately document that it verified caregivers against the OIG LEIE. Specifically, the fiscal intermediary

[20] For these participant-months, the fiscal intermediary documented PCA services through pay records and timesheets that indicated the caregiver who provided the service.

[21] For the 3 participant-months, we verified rate of pay through caregiver pay records; however, the recorded rate of pay differed between the cash plan and caregiver pay records.

[22] 42 CFR § 455.436.

[23] State agency, PPP Covid-19 Operations Policy Guidance, May 20, 2020.

did not document that it conducted the OIG LEIE verification prior to the sample month (for 11 caregivers), or did not complete the OIG LEIE verification process prior to the sample month (for 1 caregiver).[24] [25]

Without adequate documentation that the fiscal intermediary completed OIG LEIE verifications, we were unable to determine risk to participants' health and safety.

THE STATE AGENCY DID NOT COMPLY WITH STATE AND FEDERAL REQUIREMENTS FOR PERSONAL PREFERENCE PROGRAM SERVICES

The noncompliance related to selected participant-months occurred because the State agency did not adequately monitor MCOs and the fiscal intermediary for compliance with certain Federal and State requirements. Rather, the State agency issued guidance to MCOs and worked with its external quality review organization to conduct mandatory external quality reviews. These reviews provide for an annual independent external review of the quality outcomes, timeliness of, and access to the services included in the contract between the State agency and the MCO. However, these reviews did not include assessments of MCOs' or fiscal intermediary compliance with Federal and State guidelines related to assessing, documenting, and monitoring PPP participant needs and requirements. Also, the State agency did not ensure that the MCOs and fiscal intermediary had adequate procedures for ensuring that PPP services complied with program requirements.

RECOMMENDATIONS

We recommend that the New Jersey Department of Human Services improve its oversight and monitoring of its New Jersey Medicaid PPP by:

- requiring MCOs to revise their procedures to include: (1) maintaining PCA assessments, (2) completing PCA reassessments annually, (3) maintaining monthly budget amounts, and (4) updating monthly budget amounts in accordance with applicable PCA assessments; and

- requiring the fiscal intermediary to revise its procedures to include: (1) documenting participants' cash plans, (2) populating accurate information on cash plans, (3) documenting all services to be provided in participants' cash plans, and (4) completing and documenting OIG LEIE verifications for caregivers.

[24] For this caregiver, there was a name-match in the OIG LEIE that indicated a possible exclusion. If that occurs, the fiscal intermediary must input the caregiver's Social Security number to verify that the caregiver is not excluded. However, the fiscal intermediary did not input a Social Security number into the OIG LEIE after the database identified a name-match, as required.

[25] We also verified that none of the caregivers identified within these findings were listed in the OIG LEIE.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with our recommendations and described corrective actions it plans to address them, including reviewing MCOs' PCA policies and procedures to ensure appropriate program expectations for assessments for PPP participants and defining expectations for MCOs' PPP monthly cash plan reviews.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 387,526 Medicaid participant-months[26] for which New Jersey's MCOs paid $461,160,080 for participants identified as ABD who received PCA services through the PPP during CYs 2019 through 2021.[27] We selected a stratified random sample of 150 participant-months. We reviewed documentation provided by the MCOs and fiscal intermediary to verify whether each selected participant-month was billed in accordance with Federal and State requirements.

We did not assess the State agency's overall internal control structure. Rather, we limited our review of the State agency's internal controls to those applicable to our objective. This included reviewing the State agency's policies and procedures for ensuring that its MCOs and fiscal intermediary complied with Federal and State requirements for providing PCA services to PPP participants.

We performed our audit work from September 2022 through April 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State regulations and requirements for providing PCA services;

- met with State agency officials to discuss the State agency's administration and monitoring of the PPP;

- obtained Transformed Medicaid Statistical Information System encounter claim data for which PCA services were billed under the PPP during our audit period, grouping those claims by participant-month;[28]

[26] A participant-month is defined as PCA services provided under the PPP identified in Medicaid encounter data for one participant during 1 month. The sampling frame included participant-months with a total Medicaid paid claim amount greater than $100.

[27] Our audit period was determined based on the most recent data available at the time we began the audit.

[28] We ensured that participants who had a PCA encounter claim under the PPP also had a capitation payment through the ABD program.

- assessed the reliability of data by: (1) performing electronic testing, (2) reviewing existing information about the data, and (3) interviewing agency officials knowledgeable about the data; traced a statistically random sample of data to source documents; and determined that the data were sufficiently reliable for the purposes of responding to our objectives;

- selected a stratified random sample of 150 participant-months from our sampling frame of 387,526 Medicaid participant-months;

- obtained and reviewed documentation from the MCO and fiscal intermediary for PCA services under the PPP associated with each sampled participant-month to determine whether New Jersey's MCOs and its fiscal intermediary complied with Federal and State requirements;

- used the results of the sample to estimate total amount paid by MCOs for any PCA service delivered under the PPP in the sampling frame that did not meet Federal and State requirements, and the number and percentage of participant-months in the sampling frame that contained services that did not meet Federal and State requirements for our audit period;[29] and

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

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

[29] Because our sample unit was a participant-month, we considered an entire participant-month to be in error if we identified any number of deficiencies within that month.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 387,526 Medicaid participant-months for participants who received PCA services totaling $461,160,080 for our audit period.[30] Participant-months include PCA services provided to PPP participants identified as ABD.

SAMPLE UNIT

The sample unit was one participant-month.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample as follows.

Stratum	Dollar Range	Number of Frame Units	Frame Dollar Value	Sample Size
1	> $100 and ≤ $1,003.81	160,581	$113,673,283	50
2	≥ $1003.82 and ≤ $1,524.91	127,841	$156,861,342	50
3	≥$1,524.92	99,104	$190,625,455	50
Total		**387,526**	**$461,160,080**	**150**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

We sorted the participant-months in each stratum by State Medicaid ID, year, and then month in ascending order.[31] We consecutively numbered the items in each stratum in the sampling frame. After generating random numbers according to our sample plan, we selected the corresponding frame items for review.

[30] The sampling frame included participant-months with a total Medicaid paid claim amount greater than $100.

[31] We used these parameters to create a unique identifier for the frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to calculate the point estimate and 90-percent confidence interval for the total amount paid by MCOs for any PCA service delivered under the PPP in the sampling frame that did not meet Federal and State requirements, and the number and percentage of participant-months in the sampling frame that did not meet Federal and State requirements.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Details and Results

Stratum	Number of Frame Units	Value of Frame	Sample Size	Value of Sample	Number of Participant-Months That Did Not Meet Requirements	Value of Participant-Months That Did Not Meet Requirements
1	160,581	$113,673,283	50	$35,418	16	$10,860
2	127,841	$156,861,342	50	$61,380	26	$32,360
3	99,104	$190,625,455	50	$95,354	21	$39,841
Total	**387,526**	**$461,160,080**	**150**	**$192,152**	**63**	**$83,061**

Table 2: Estimated Number and Percentage of Participant-Months in the Sampling Frame That Did Not Meet Requirements and the Estimated Value of the Associated Payments

(Limits Calculated at the 90-Percent Confidence Level)

	Total Number of Participant-Months That Did Not Meet Requirements	Percentage of Participant-Months That Did Not Meet Requirements	Total Value for Participant-Months That Did Not Meet Requirements
Point estimate	159,487	41.16%	$196,584,979
Lower limit	133,662	34.49%	$165,753,244
Upper limit	185,312	47.82%	$228,438,978

APPENDIX D: STATE AGENCY COMMENTS

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RE: Draft Audit Report No. A-02-22-01024

Dear Ms. Webb:

The New Jersey Department of Human Services (DHS) is in receipt of the draft audit report issued by the Office of Inspector General (OIG) entitled **New Jersey Did Not Ensure That Some Medicaid Personal Care Assistance Services Provided Under the Personal Preference Program Met Federal and State Requirements**, A-02-22-01024. Thank you for the opportunity to respond to the draft report. The DHS Division of Medical Assistance and Health Services (DMAHS) generally agrees with OIG's findings and procedural recommendations on ways to improve oversight and monitoring of the Personal Preference Program (PPP). DMAHS also agrees with OIG's finding that noncompliance by Managed Care Organizations (MCOs) or the State's Fiscal Intermediary (FI) with program requirements does not mean that the State's full capitation payments for the sampled participant months were unallowable. Please see DMAHS's responses to the draft findings and recommendations below.

OIG Finding: Managed Care Organizations Did Not Meet Personal Care Assistant Assessment and Monthly Budget Amount Requirements

- ***Personal Care Assistant Assessment Requirements Not Met***

  Response: DMAHS concurs with OIG's finding that the MCOs conducted annual reassessments after they were due for 10 sampled participant-months, and did not document the performance of PCA assessments for 2 sampled participant-months. DMAHS intends to take the following corrective actions:

  - review each MCO's current Personal Care Assistance policies and procedures to ensure appropriate program expectations for assessments for PPP participants;
  - provide additional language where necessary to ensure MCO compliance;
  - add an MCO PCA assessment tracking report specific to PPP participants; and
  - align assessment tracking with PPP monthly budget amount reviews and updates.

- ***Monthly Budget Requirements Not Met***

  Response: DMAHS concurs with OIG's finding that the MCOs did not provide a monthly budget amount to the FI for 7 sampled participant-months, and did not transmit accurate monthly budget amounts to the FI for 5 sampled participant-months. DMAHS intends to take the following corrective actions:

  - define expectations for MCOs PPP monthly cash plan reviews;

- review each MCO's policies and procedures for reviewing and updating PPP monthly cash plans;
- provide additional language where necessary to ensure MCO compliance; and
- ensure monthly budget amount reviews and updates are included in MCO PCA assessment tracking report.

OIG Finding: Fiscal Intermediary Did Not Meet Cash Plan and Caregiver Verification Requirements

- ***Cash Plan Requirements Not Met***

  Response: DMAHS concurs with the OIG's finding that the FI did not meet cash plan requirements for the sampled participant-months. DMAHS intends to take the following corrective actions:

  - review the FI's current policies and procedures to ensure appropriate expectations for cash plans;
  - provide additional language where necessary to ensure cash plan compliance;
  - review FI's current CMP tracking documentation; and
  - implement FI reporting confirming accurate and timely CMP reviews and updates.

- ***OIG List of Excluded Individuals/Entities Verifications Not Adequately Documented***

  Response: DMAHS concurs with OIG's finding that the FI did not document that it conducted LEIE verification prior to the sampled month for 11 caregivers, and did not complete the LEIE verification process prior to the sampled month for 1 caregiver. DMAHS intends to take the following corrective actions:

  - review the FI's current policies and procedures to ensure appropriate expectations for OIG LEIE checks
  - provide additional language where necessary to ensure LEIE compliance; and
  - implement FI reporting confirming monthly LEIE checks.

OIG Recommendations:

We recommend that the New Jersey Department of Human Services improve its oversight and monitoring of its New Jersey Medicaid PPP by:

- **requiring MCOs to revise their procedures to include: (1) maintaining PCA assessments, (2) completing PCA reassessments annually, (3) maintaining monthly budget amounts, and (4) updating monthly budget amounts in accordance with applicable PCA assessments.**

  Response: DMAHS concurs with OIG's recommendation. DMAHS will take the corrective actions listed above to ensure timely PCA assessment expectations and monthly budget amount reviews and updates for PPP participants.

- **requiring the fiscal intermediary to revise its procedures to include: (1) documenting participants' cash plans, (2) populating accurate information on cash plans, (3) documenting all services to be provided in participants' cash plans, and (4) completing and documenting OIG LEIE verifications for caregivers.**

  Response: DMAHS concurs with OIG's recommendations. DMAHS will take the corrective actions listed above to ensure accurate participant cash plans that provide a clear budget allocation and service plans and monthly OIG LEIE verification for current caregivers.

Thank you again for the opportunity to comment on the draft audit report.

Sarah Adelman
Commissioner
New Jersey Department of Human Services

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