Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW JERSEY DID NOT ALWAYS CLAIM FEDERAL MEDICAID REIMBURSEMENT FOR PERSONAL CARE SERVICES MADE BY BAYADA NURSES, INC., IN ACCORDANCE WITH FEDERAL AND STATE REQUIREMENTS

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Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

BACKGROUND

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

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income.

The American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, provided, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provided an estimated $87 billion in additional Medicaid funding based on temporary increases in States' FMAPs.

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

Pursuant to Federal regulations (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 persons with intellectual disabilities, or institutions for mental diseases. A physician authorizes personal care services for Medicaid beneficiaries within a plan of treatment or according to a service plan approved by the individual State. Examples of personal care services are cleaning, shopping, grooming, and bathing.

Pursuant to chapter 60 of the New Jersey Administrative Code Title 10, (1) a registered nurse must perform an initial assessment and a reassessment of the beneficiary's need for personal care services at least once every 6 months; (2) a registered nurse must provide direct supervision of the personal care assistant at least once every 60 days or more often, as required; and (3) personal care assistants must receive inservice education from the provider.

Bayada Home Health Care (Bayada), headquartered in Moorestown, New Jersey, provides home health and personal care services to children and adults in 18 States. During our audit period, Bayada operated 18 offices that individually oversaw Medicaid personal care services in New Jersey and had the largest geographic coverage of any personal care provider in the State.

OBJECTIVE

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

SUMMARY OF FINDINGS

The State agency did not claim Federal Medicaid reimbursement, for some personal care services claims that Bayada submitted, in accordance with Federal and State requirements. Of the 100 claims in our random sample, 90 claims complied with Federal and State requirements, but 10 claims did not. Of the 10 noncompliant claims, 1 contained more than 1 deficiency. Specifically:

- For nine claims, there was no nursing supervision.
- For one claim, the personal care assistant did not receive inservice education.
- For one claim, there was no nursing assessment.

These deficiencies occurred because some of Bayada's office managers did not ensure that personal care services claims complied with certain Federal and State requirements.

Based on our sample results, we estimated that the State improperly claimed $774,274 in Federal Medicaid reimbursement during our January 1, 2008, through June 30, 2009, audit period.

RECOMMENDATIONS

We recommend that the State agency:

- refund $774,274 to the Federal Government and
- direct Bayada to ensure that all of its offices comply with Federal and State requirements.

BAYADA HOME HEALTH CARE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Bayada disagreed with most of our findings and our recommended financial disallowance. Specifically, Bayada stated that some of the errors may be based on different interpretations of State regulations. Bayada also provided details on its quality assurance program for complying with Federal and State requirements.

After reviewing Bayada's comments and the additional documentation provided, we revised our findings and modified our statistical estimates accordingly. Bayada's comments appear as Appendix D. We did not include the attachments to the comments because of their volume and inclusion of personally identifiable information.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our first recommendation (financial disallowance) and did not indicate concurrence or nonconcurrence with our other recommendation. Specifically, the State agency stated that our interpretation of State law was flawed and that the deficiencies we identified were technical in nature. In addition, the State agency indicated that none of our findings involved demonstrated overpayments of any kind; rather, they related only to missing documentation. The State agency also contended that Federal law does not provide a basis on which the Department of Health and Human Services (HHS) may recoup Federal funds for these types of technical or documentation deficiencies when State law does not require repayment or recoupment.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. Specifically, we maintain that our reading of State law is valid and not contrary to its intent. Regarding the State agency's contention that Federal law does not provide a basis for HHS to recoup Federal funds related to technical or documentation-related deficiencies, we maintain that OMB Circular A-87 cost principles and CMS's *State Medicaid Manual* explicitly require States to document allowable costs. The State agency's comments appear as Appendix E.

TABLE OF CONTENTS

Page

APPENDIXES

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.

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income.

American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009, P.L. No. 111-5 (Recovery Act), enacted February 17, 2009, provided, among other initiatives, fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provided an estimated $87 billion in additional Medicaid funding based on temporary increases in States' FMAPs.

New Jersey's Medicaid Program

In New Jersey, the Department of Human Services (State agency) is the State agency responsible for operating the Medicaid program. Within the State agency, the Division of Medical Assistance and Health Services administers the Medicaid program. The State agency uses the Medicaid Management Information System, a computerized payment and information reporting system, to process and pay Medicaid claims, including personal care services claims. From January 1, 2008, through June 30, 2009, the FMAP in New Jersey varied from 50 percent to 61.59 percent.

New Jersey's Personal Care Services Program

New Jersey's personal care services program is operated by the State agency's Division of Disability Services. The program provides beneficiaries with long-term chronic or maintenance health care, as opposed to short-term skilled care required for some acute illnesses. The New Jersey Administrative Code (NJAC) 10:60-3.1 states that 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."

Federal and State Requirements for 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. Section 1905(a)(24) of the Act and implementing Federal regulations (42 CFR § 440.167), require that personal care services be (1) authorized for an individual by a physician within a plan of treatment or according to 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 (OMB) 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.

Pursuant to chapter 60 of the NJAC Title 10, (1) a registered nurse must perform an initial assessment and a reassessment of the beneficiary's need for personal care services at least once every 6 months; (2) a registered nurse must provide direct supervision of the personal care assistant at least once every 60 days or more often, as required; and (3) personal care assistants must receive inservice education from the provider.

Appendix A lists specific Federal and New Jersey requirements for personal care services.

Bayada Home Health Care

Bayada Home Health Care (Bayada), headquartered in Moorestown, New Jersey, provides home health and personal care services to children and adults in 18 States. During our audit period, Bayada operated 18 offices that individually oversaw Medicaid personal care services in New Jersey and had the largest geographic coverage of personal care providers in the State. Each of Bayada's offices was responsible for implementing companywide policies and procedures for providing personal care services.

Office of Inspector General Audits

This audit is one of a series of audits that addresses Medicaid personal care services providers that we identified as high risk. We are conducting these audits in response to the estimated $87 billion in increased FMAP under the Recovery Act.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Our review covered 784,945 claim lines totaling $34,709,694 ($19,104,399 Federal share) that Bayada submitted for the period January 1, 2008, through June 30, 2009. (We refer to these lines in this report as "claims.")

During our audit, we did not review the overall internal control structure of Bayada, 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 the State agency's offices in Trenton, New Jersey, and at 12 of Bayada's 18 offices throughout the State.[1]

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State regulations and guidelines;
- held discussions with State agency officials to gain an understanding of the personal care services program;
- obtained from the State agency a database of Medicaid personal care services claims that the State paid to Bayada;
- identified a sampling frame of 784,945 personal care services claims, totaling $34,709,694 ($19,104,399 Federal share);
- selected a simple random sample of 100 claims from the sampling frame of 784,945 claims;
- reviewed the provider's documentation supporting each sample claim; and
- estimated the unallowable Federal Medicaid reimbursement paid in the population of 784,945 claims.

Appendix B describes our sample design and methodology.

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 objective.

[1] We visited only offices that oversaw personal care services claims included in our random sample. As a result, we did not visit 6 of Bayada's 18 offices.

FINDINGS AND RECOMMENDATIONS

The State agency did not claim Federal Medicaid reimbursement, for some personal care services claims that Bayada submitted, in accordance with Federal and State requirements. Of the 100 claims in our random sample, 90 claims complied with Federal and State requirements, but 10 claims did not. Of the 10 noncompliant claims, 1 contained more than 1 deficiency. Table 1 lists the types of deficiencies and the number of claims for each type.

Table 1: Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Unallowable Claims[2]
No nursing supervision	9
Inservice education requirement not met	1
No nursing assessment	1

These deficiencies occurred because some of Bayada's office managers did not ensure that personal care services claims complied with certain Federal and State requirements.

Based on our sample results, we estimate that the State agency improperly claimed $774,274 in Federal Medicaid reimbursement during our January 1, 2008, through June 30, 2009, audit period.

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 9 of the 100 claims in our sample, there was no evidence that a registered nurse directly supervised a new personal care assistant before that assistant provided the personal care services we sampled.

[2] The total exceeds 10 because 1 claim contained more than 1 error.

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 1 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.[3]

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 must also perform a reassessment visit at least every 6 months to reevaluate the beneficiary's need for continued care.

For 1 of the 100 claims in our sample, the provider did not perform the required reassessment within 6 months of the previous reassessment.

CAUSE OF UNALLOWABLE CLAIMS

The unallowable claims occurred because some of Bayada's office managers did not ensure that personal care services claims complied with certain Federal and State requirements. Of the 12 Bayada offices that oversaw personal care services claims included in our random sample, 9 offices oversaw 57 sample claims that complied with Federal and State requirements. However, the 3 offices that oversaw the remaining 43 sample claims had 10 claims that contained deficiencies. Table 2 details the deficiencies by type and office.

Table 2: Number of Deficiencies by Type and Office

Office	Nursing Supervision	Inservice Education	Nursing Assessment	Total Deficiencies	Sample Claims
Clifton	6	--	1	7	18
Bloomfield	2	--	--	2	15
Union	1	1	--	2	10

ESTIMATION OF THE UNALLOWABLE AMOUNT

Of the 100 personal care services claims that we sampled, 10 were not claimed in accordance with Federal and State requirements. Based on our sample results, we estimated that the State improperly claimed $774,274 in Federal Medicaid reimbursement from January 1, 2008, through June 30, 2009. The details of our sample results and estimates are in Appendix C.

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

RECOMMENDATIONS

We recommend that the State agency:

- refund $774,274 to the Federal Government and
- direct Bayada to ensure that all of its offices comply with Federal and State requirements.

BAYADA COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Bayada disagreed with most of our findings and our recommended financial disallowance. Specifically, Bayada stated that some of the errors may be based on different interpretations of State regulations. Bayada also provided details on its quality assurance program for complying with Federal and State requirements.

After reviewing Bayada's comments and the additional documentation provided, we revised our findings and modified our statistical estimates accordingly. Bayada's comments appear as Appendix D. We did not include the attachments to the comments because of their volume and inclusion of personally identifiable information.

Inservice Education Requirement Not Met

Bayada Comments

Bayada stated that it appears that we applied a monthly inservice requirement instead of the per year requirement noted in NJAC 10:60-1.2. Bayada provided additional documentation to support its position that the inservice requirement was met for eight of the nine claims that we identified in our draft report as being in error.

Office of Inspector General Response

After reviewing the additional documentation, we agree that eight of the nine claims met the inservice education requirements.

No Nursing Supervision

Bayada Comments

Bayada stated that the last sentence of NJAC 10:60-3.5(a)(2) ("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.") is "an example only of when additional supervisory visits may be needed, but not part of the regulation." Bayada also stated that it does not believe that the New Jersey Medicaid regulations require a supervisory visit each time an existing employee provides services to an existing patient for the first time. Further, Bayada stated that it believes that the requirement is for a registered nurse to provide supervision to an aide assigned to a newly admitted client within 48 hours of the start of care. In addition, Bayada

stated that the regulation is tied to the start of service for each client and is client focused, not employee focused. Finally, Bayada provided additional documentation to support its position that nursing supervision requirements were met for the nine claims.

Office of Inspector General Response

We disagree that the last sentence of NJAC 10:60-3.5(a)(2) is not part of the regulation. The citation clearly states that additional supervisory visits shall be made as the situation warrants, such as a new personal care assistant. Each of the claims that we questioned were related to aide turnover (i.e., a new aide was assigned) or weekend aides who provided services to the associated beneficiary without receiving supervision from a registered nurse. Regarding the additional documentation provided by Bayada for nine claims, we note that the documentation was previously provided and did not indicate that a registered nurse directly supervised the new personal care assistant before the assistant provided the sampled service.

No Nursing Assessment

Bayada Comments

Bayada stated that it was in compliance with nursing assessment requirements for one claim and provided documentation to support its position.

Office of Inspector General Response

Pursuant to State regulations (NJAC 10:60-3.5(a)(2)), a registered nurse must perform a reassessment visit at least every 6 months to evaluate the beneficiary's need for further care. Regarding the claim in question, Bayada stated that reassessments were performed on December 20, 2006, and June 14, 2007. The June 14, 2007, reassessment would cover the 6-month period up to December 14, 2007. However, our sampled service date was December 22, 2007, and another reassessment was not performed on the beneficiary until December 31, 2007, which is 17 days after the 6-month requirement.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency disagreed with our first recommendation (financial disallowance) and did not indicate concurrence or nonconcurrence with our other recommendation. Specifically, the State agency stated that our interpretation of State law was flawed and that the deficiencies we identified were technical in nature. In addition, the State agency indicated that none of our findings involved demonstrated overpayments of any kind; rather, they related only to missing documentation. The State agency also contended that Federal law does not provide a basis on which the Department of Health and Human Services (HHS) may recoup Federal funds for these types of technical or documentation deficiencies when State law does not require repayment or recoupment.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. Per OMB A-87, "To be allowable under Federal awards, costs must meet the following general criteria: ... (c) Be authorized or not prohibited under State or local laws or regulations." Therefore, pursuant to OMB Circular A-87, HHS Office of Inspector General may conduct an audit to determine whether Federal payments have been made in violation of State laws and regulations and may recommend disallowance of Federal funding on the findings of such an audit. In addition, failure to document services provided by a qualified provider is a violation of section 1902(a)(27) of the Act. Further, section 2497.1 of CMS's *State Medicaid Manual* states that expenditures require adequate supporting documentation to be allowable for Federal reimbursement. The State agency's comments appear in their entirety as Appendix E.

Inservice Education Requirement Not Met

State Agency Comments

The State agency stated that there is no Federal requirement that personal care assistants undergo 12 hours of annual inservice education; therefore, there is no justification for withholding Federal funds based on a finding that documentation of such education was not provided. The State agency further noted that that the employee associated with our one sample claim underwent "at least 13 hours of inservice training within 14 months of the date of service." The State agency also indicated steps that it has taken or planned to take to prevent future violations of the inservice education requirement.

Office of Inspector General Response

To provide a valid and payable service, personal care services must meet the Federal requirements in section 1905(a)(24) of the Act and implementing regulations in 42 CFR § 440.167, which require, among other things, that personal care services be provided "by an individual who is qualified to provide such services." Section 4480(E) of CMS's *State Medicaid Manual* instructs States to develop qualifications for providers of personal care services. The State implemented some of its qualification requirements for personal care assistants in NJAC 10:60-1.2. Pursuant to this provision, personal care assistants must successfully complete a minimum of 12 hours of inservice education per year. For the sample claim in question, this requirement was not met. A provider that does not meet the inservice education requirement cannot be considered a qualified provider as required by Federal regulations and, therefore, cannot provide a valid and payable service.

No Nursing Supervision

State Agency Comments

The State agency stated that there is no Federal requirement that direct nursing supervision be periodically performed and documented; therefore, there is no justification to withhold Federal funds based on a finding that such documentation was not provided. The State agency further noted that in all nine cases, HHS applied the 48-hour requirement when a personal care assistant

who did not previously care for the beneficiary took over care of the beneficiary. However, the State agency stated that the regulation "does not apply the 48-hour requirement in this circumstance," limiting the 48-hour requirement to the initial start of service.

Office of Inspector General Response

Section 1905(a)(24) of the Act and implementing regulations at 42 CFR § 440.167 require that personal care services be provided by a qualified individual. Section 4480(E) of CMS's *State Medicaid Manual* instructs States to develop qualifications for providers of personal care services.

The State implemented these requirements by stating that, among other things, a qualified "personal care assistant" in New Jersey "means a person who: … (3) Is supervised by a registered professional nurse employed by a [Division of Disability Services]-approved homemaker/personal care assistant provider agency" (NJAC 10:60-1.2). State regulations further note the importance of supervision by indicating that "[a]dditional supervisory visits [by a registered professional nurse] 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" (NJAC 10:60-3.5(a)(2)). Therefore, to meet the Federal definition of service, a personal care assistant must be supervised as required by State regulations. Further, OMB Circular A-87 requires that to be allowable under a Federal award, costs must be authorized or not prohibited by State or local laws or regulations.

Contrary to the State agency's comments, we did not apply a 48-hour requirement for our sample claims. Of the nine claims in error, we found no documentation demonstrating that the personal care assistant associated with four claims was ever supervised by a registered nurse, as required by NJAC 10:60-3.1(b). Therefore, services provided for these four claims are not valid and payable per Federal and State law.

For the remaining five claims, we noted that Bayada failed to provide supervision to a new personal care assistant, as required by NJAC 10:60-3.5(a)(2). The regulation states that "[a]dditional supervisory visits shall be made as the situation warrants, such as a new [personal care assistant] …." The new personal care assistant associated with these five claims did not receive a supervisory visit from a registered nurse within a reasonable amount of time (ranging from 8 to 37 days). Therefore, services provided for these five claims are not valid and payable per Federal and State law.

No Nursing Assessment

State Agency Comments

The State agency stated that there is no Federal requirement that a nursing assessment be periodically performed and documented; therefore, there is no justification to withhold Federal funds based on a finding that such documentation was not provided. The State agency also contended that Bayada completed an assessment within every 6-month period following the service start date.

Office of Inspector General Response

To provide a valid and payable service, personal care services must meet Federal requirements in 42 CFR § 440.167, which require, among other things, that personal care services be provided "accordance with a service plan approved by the State." Pursuant to State regulations at NJAC 10:60-3.5(a)(1), the "registered professional nurse … shall perform an assessment and prepare a plan of care for the personal care assistant to implement." Further, the regulations require that "a personal care assistant nursing reassessment visit shall be provided at least once every six months ... to reevaluate the beneficiary's need for continued care." The assessment and reassessment validate a beneficiary's plan of care by confirming their continued need for services. Without the required 6-month reassessment, a beneficiary's plan of care is not valid under NJAC 10:60-3.5(a)(3). Therefore, any claims for services provided past the 6-month reassessment deadline are not payable per Federal and State law.

Regarding the claim in question, reassessments were performed on December 20, 2006, and June 14, 2007. The June 14, 2007, reassessment would cover the 6-month period up to December 14, 2007, at which time a reassessment was required. However, our sampled service date was December 22, 2007, and another reassessment was not performed on the beneficiary until December 31, 2007, which was 17 days after the 6-month requirement.

APPENDIXES

APPENDIX A: FEDERAL AND NEW JERSEY REQUIREMENTS FOR 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 intellectual disabilities, 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 according to 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* (the Circular), establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. Section C.1.c. of Attachment A to the Circular provides that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.

- 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)).

- A registered nurse must provide direct supervision of a personal care assistant at a minimum of one 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 successfully complete a minimum of 12 hours inservice education per year offered by the provider agency (NJAC 10:60-1.2).

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population was personal care services claim lines submitted by Bayada Home Health Care (Bayada) in New Jersey during our January 1, 2008, through June 30, 2009, audit period that the State claimed for Federal Medicaid reimbursement.

SAMPLING FRAME

The sampling frame was a computer file containing 784,945 detailed claim lines for personal care services submitted by Bayada in New Jersey during our audit period. The total Medicaid reimbursement for the 784,945 claim lines was $34,709,694 ($19,104,399 Federal share). The Medicaid claim lines were extracted by staff of New Jersey's Division of Medical Assistance and Health Services. (We refer to these lines in this report as "claims.")

SAMPLE UNIT

The sample 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 consecutively numbered the 784,945 detailed claim lines. 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)	Number of Unallowable Claims	Value of Unallowable Claims (Federal Share)
784,945	$19,104,399	100	$2,368	10	$216

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

Point estimate	$1,697,871
Lower limit	774,274
Upper limit	2,621,469

APPENDIX D: BAYADA HOME HEALTH CARE COMMENTS

BAYADA®
Home Health Care

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March 30, 2012

Mr. Kevin W. Smith
Audit Manager
Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region II
26 Federal Plaza, Room 3900
New York, NY 10278

RE: BAYADA Home Health Care Error Report A-02-10-01001 Response

Dear Mr. Smith:

Thank you for offering BAYADA Home Health Care (formerly Bayada Nurses) the opportunity to review and respond to the Office of Inspector General Report relating to the personal care assistant (PCA) services audit from 2009. I also appreciate the time you and your auditors took to speak to members of my staff to help clarify the audit findings.

Members of BAYADA have spent significant time researching each of the 19 violations cited in the draft report. Based on the enclosed findings, some of the violations from the audit may be based on differing interpretations of the *New Jersey Medicaid Program Home Care Services Manual*, Section 10:60-1.4 Covered home health services and the N.J.A.C. Section 10:60. I hope this letter and the 259 pages of supporting documentation will provide a basis for reassessing the violations and updating the draft report.

BAYADA is a quality focused company grounded in *The BAYADA Way*, which is the company's mission, vision and core values. We believe that we must demonstrate honesty and integrity at all times which includes being accurate and truthful in all client care documentation and billing practices.

We have proudly provided personal care services to Medicaid beneficiaries in New Jersey since 1988. Currently, BAYADA employs approximately 2,000 employees who provide Medicaid personal care assistant services to 2,700 clients for 43,500 hours in an average week. With this high volume of cases, BAYADA strives to provide home care services to our clients with the highest professional, ethical, and safety standards under the regulations that govern our work.

In response to the OIG draft report, BAYADA provides the following information and attached documentation:

- Nine of the total violations cited by the OIG were due to deficiencies in "employee in-services".

  New Jersey Administrative Code (N.J.A.C.) Section 10:60-1.2, *A home health aide will successfully complete a minimum of 12 hours in-service education* ***per year*** *offered by the agency.*

  Based on the findings in the OIG draft report, it appears the auditors applied a "monthly" in-service requirement instead of the **per year** requirement stated above. That is, they based it on the month in which the aide provided care instead of the total hours accrued at year's end. The regulation does not specify hours must be distributed on a month by month basis.

  It is important to note there are four third party accreditation providers who currently oversee the New Jersey's Personal Care Program; they are the National HomeCaring Council, JCAHO, CAHC and CHAP. Based on the CHAP standards and the New Jersey regulations, Bayada is not required to adhere to a month to month standard for in-service education; however, there is a Commission on Accreditation for Home Care (CAHC) Standard IV, Section 16B which states, "Certified homemaker home health aides shall attend, at minimum, 12 hours of in-service each calendar year. Aides who have worked only a portion of the calendar year (such as a new hire) or have a documented period of inactivity (such as a leave of absence) must attend a pro-rated number of in-service hours – a minimum of one hour of in-service per calendar month worked." The auditors may have referred to the CAHC standard instead of the New Jersey regulatory requirement or the CHAP standard.

  For example, BAYADA was cited for not meeting the in-service requirements for [redacted]. The date of service audited was 4/6/09 and the draft report states "there was no evidence that the personal care assistant

Office of Inspector General note: The deleted text has been redacted because it contains personally identifiable information.

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received the minimum required in-service education during the calendar year in which the service was provided or during the preceding 12 months". In this case, the aide did not have the required amount of hours at the date of service in April; however, she did have 12 hours of in-service at the end of the calendar year 2009 which is evidenced in the attached documentation. Additionally, she also had the required amount of in-service hours for the prior calendar year of 2008.

Our interpretation of the **"per year"** in-service requirement relates to a conventional calendar year (January through December) which is consistent with state and accreditation standards and industry practice.

In applying the in-service education requirement on a conventional calendar basis, 7 of the 9 aides for which an exception was initially identified by the OIG would have met the in-service requirements as required under the Administrative Code. *(Please see BAYADA's attached pages 1-33 and 54-184 which detail the timing of the in-service education provided for each of the 7 aides affected and conformance with the Administrative Code when applied on a standard calendar year basis.)*

In addition, the regulations require providers to **offer** at least 12 hours of in-services each calendar year; however, the hours associated with attendance of in-service education from an outside source is also acceptable. It is common practice in home care for an aide to work for multiple agencies. If an aide can show appropriate documentation of completing the required in-service hours from another approved Medicaid provider, it is deemed acceptable by the state and accrediting bodies. This circumstance would apply to one of the cited deficiencies for which an exception is noted. *(Please see BAYADA's attached pages 34-38 which detail both the internal and external in-service education received by this aide and conformance with the Administrative Code when applied on a standard calendar year basis.)*

After consideration of the above, only one instance was noted in which the aide did not participate in the required number of in-service education hours for the period assessed. (Please see BAYADA's attached pages 39-53.)

- Nine of the total violations cited by the OIG were due to deficiencies in "nursing supervision".

N.J.A.C., Section10:60-3.5(a) (2), states: *Direct supervision of the personal care assistant shall 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. At this time, appropriate revisions to the plan of care shall be made. Additional supervisory visits shall be made as the situation warrants, such as a new PCA or in response to the physical or other needs of the beneficiary. We believe this last sentence is an example only of when additional supervisory visits may be needed, but not part of the regulation.*

Based on the findings of the OIG draft report, BAYADA was consistently providing supervision to each of its clients with an aide present, not less than every 60 days. However, it seems the auditors applied a "48" hour supervision rule each time an existing home health aide provided services to a client for the first time.

We do not believe the NJ Medicaid regulations require BAYADA to provide a supervisory visit each time an existing employee provides services to an existing patient for the first time. We believe the requirement is for a registered nurse to provide supervision to an aide assigned to a **newly admitted client** within 48 hours of the start of care, and BAYADA has met this requirement with the cited clients and employees. Based upon this, it appears the OIG's application of the 48 hour rule is inconsistent with NJ Medicaid requirements. The regulation is tied to the start of service for each client and is client focused, not employee focused.

Currently and during the time of the audit, BAYADA provides a client assessment prior to the start of care with in-home visits conducted by a registered nurse at least every 60 days for direct supervision of the aide to ensure the client's needs are being met and the care plan has been properly implemented. Further, BAYADA's requirements for ongoing supervision actually exceed the regulations for PCA services. We require a written plan of care be completed and present in the client's home at the time services are initiated, the registered nurse conducts telephone reviews with the client between in-home visits and increases in-home visitation to monthly frequency for clients whose condition meets certain criteria (Please see BAYADA's attached pages 255-259).

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Additionally, we did not provide a supervisory visit each time an existing employee began work with an existing client; however, we do orient the aide to the case by telephone or when warranted, a home visit is made. To provide that level of supervision would require each of our personal care offices to hire additional registered nurses, which would make providing personal care services cost prohibitive and intrusive to clients. Therefore, BAYADA's practice is one we believe to be consistent with the intent and meaning of the regulation, as well as consistent with industry practice.

After consideration of the above, we find no instances in which BAYADA failed to meet the requirements of the applicable Medicaid regulations. *(Please see BAYADA's attached pages 185-246 which documents supervisions for each client cited not less frequently than every 60 days, the date of hire and start of care dates for the employee with the client and supervision notes.)*

We believe that the interpretation and evaluation for compliance that was applied by the OIG auditors is actually consistent with a specific accreditation standard of CAHC. Specifically, CAHC Standard V, Section 13E. states "Orientation of certified homemaker-home health aides/field nurses who are ongoing employees on an ongoing case:

- The orientation shall be performed by the second day of placement on the case.
- It may be conducted either in-home, by telephone, or in the office.

While this standard does not apply to BAYADA because we are accredited by CHAP, the auditors may have referred to the CAHC standard instead of the New Jersey regulatory requirement or the CHAP standard.

- One of the violations cited by the OIG was due to a deficiency in providing an initial client assessment.

  N.J.A.C., Section 10:60-3.5(a) states: *The registered professional nurse, in accordance with the physician's certification of need for care, shall perform an assessment and prepare a plan of care for the personal care assistant to implement. The assessment and plan of care shall be completed at the start of service. However, in no case shall the nursing assessment and plan of care be done more than 48 hours after the start of service. A personal care assistant nursing reassessment visit shall be provided at least once every six months or more frequently if the beneficiary's condition warrants, reevaluating the beneficiary's need for continued care.*

  BAYADA's practice was and currently is to provide an initial assessment at or prior to the start of the client's care, with additional visits not less than every six months, and more often when warranted by client status or change in condition. In the one case cited by the OIG for this deficiency, pages 247-254 provide the assessment documentation for Rickie R. (the client was admitted to service on July 18, 2006 and a Nursing Assessment was completed at that time. A reassessment was then completed on December 20, 2006 and again on June 14, 2007 meeting the Medicaid 6 month requirement).

BAYADA Home Health Care will continue to provide services with excellence in accordance with the program requirements and regulations that govern our work.

To ensure BAYADA's offices providing personal care services remain compliant with federal and state regulations governing our work, a quality assurance program is conducted by the corporate Nursing office which includes:

- quarterly unannounced audits of each office
- direct observation of office and field staff performing their jobs
- a standard process measurement tool,
- randomly selected client and employee file review
- randomly selected home visits
- immediate feedback provided to each office Director
- mandatory corrective action planning and implementation if needed
- ongoing performance improvement planning and implementation

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To supplement quarterly audits, data is collected regularly, reviewed and analyzed including information from ongoing client and annual employee satisfaction surveys, client incident reports and client infection reports. If any deficiencies are found, a performance improvement plan is put into place and monitored for improvement to ensure expected outcomes. All data is shared with and reviewed by BAYADA's leaders, including me.

Further, BAYADA maintains a close relationship with representatives of the Division of Medical Assistance and Division of Disability Services. Our Directors regularly review Bulletins and implement any needed changes to the way services are delivered. If any concerns arise, we routinely reach out to the Division for clarification and direction.

BAYADA remains highly focused on compliance with program requirements including a pre-billing checklist which is reviewed prior to a bill being submitted for services rendered and confirming supervisory visits and reassessments are completed in accordance with program requirements and state regulations. As a result of the limited findings, we have established additional measures to provide us further confidence in the accuracy of our billed services.

I hope this letter will serve to resolve the deficiencies listed in the OIG draft report. If there are discrepancies between what your auditors found and what we have proceeded, we would welcome the opportunity to further discuss the findings with you.

Sincerely,

J. Mark Balada
President

Enclosures

APPENDIX E: 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

July 25, 2012

Mr. 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

Re: New Jersey Response—Review of Medicaid Personal Care Claims Submitted by Bayada Home Health Care, A-02-10-01001

Dear Mr. Edert:

Enclosed are the New Jersey Department of Human Services's comments on the Department of Health and Human Services Office of Inspector General's draft audit report A-02-10-01001 entitled *New Jersey Did Not Always Claim Federal Medicaid Reimbursement for Personal Care Services Made by Bayada Home Health Care in Accordance with Federal and State Requirements.*

Thank you for the opportunity to comment. If you should have any questions, please contact me or Richard H. Hurd at 609-588-2550 or by e-mail at Richard.H.Hurd@dhs.state.nj.us.

Sincerely,

Valerie Harr
Director

Enclosure
c: Jennifer Velez
Richard H. Hurd

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
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VALERIE HARR
Director

New Jersey Department of Human Services Comments on the Department of Health and Human Services Office of Inspector General Draft Audit Report A-02-10-01001 on Medicaid Personal Care Claims Submitted by Bayada Home Health Care

Table of Contents

A. Introduction

In June 2012, the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") issued a draft report entitled *New Jersey Did Not Always Claim Federal Medicaid Reimbursement for Personal Care Services Made by Bayada Home Health Care in Accordance with Federal and State Requirements* ("Draft Audit") covering claims from January 1, 2008 through June 30, 2009. The New Jersey Department of Human Services ("DHS") has reviewed the Draft Audit, and collected information from DHS's Division of Disability Services ("DDS"), DHS's Division of Medical Assistance and Health Services ("DMAHS"), and Bayada Home Health Care ("Bayada"). DHS also requested, received, and reviewed information from the OIG on the amount it recommended recouping for each allegedly deficient claim.

B. Summary of Response

DHS strongly disagrees that the OIG's findings support the recommendation of the Draft Audit that the State return $774,274 in Federal funds paid for personal care claims provided by Bayada. The Draft Audit identifies three categories of "deficiencies" with respect to 100 reviewed claims, selected on a random basis. It concluded that the claims (or portions of claims) affected by these "deficiencies" amounted to an overpayment by the Federal government of $216.[1] It then extrapolated this conclusion to the full universe of Bayada personal care claims for the 18-month review period, to arrive at the amount of $774,274 in alleged "overpayments" of Federal funds.

We respectfully disagree with this conclusion. All but two of the OIG's "deficiency" findings are predicated upon a flawed reading of State law: the OIG faults Bayada for failing to comply with a requirement that is neither in the text of the relevant regulations nor consistent with State practice. These nine claims, therefore, are not deficient.

In addition, none of the three categories of "deficiencies" involved demonstrated overpayment of any kind. Rather, the findings were only that particular documents were missing from the reviewed file. But the overall evidence produced by the review clearly demonstrates that the underlying personal care services were valid, allowable, and rendered to eligible beneficiaries, notwithstanding the absence of certain documents. For all of the alleged deficiencies, the missing documentation related not to federal requirements but to state requirements. Neither applicable State law nor State practice requires recovery of payments made to providers even if there was a violation of those state requirements. When the State determines that violations of these requirements have occurred, it has a policy and practice of requiring prior authorization and/or issuing remediation to prevent further violations. Moreover, for each of the "deficiency" categories at issue, there is no requirement under State law that providers keep records documenting compliance.[2]

DHS also challenges the OIG's findings concerning the specific claims selected for review because providers in New Jersey have been able to provide documentation demonstrating that they complied with the applicable laws. For the reasons detailed below, it would be unreasonable for the Federal government to require recoupment of close to $800,000 for services provided by Bayada.

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[1] The Draft Audit examined only claims for personal care services. Throughout this response, when this response refers to the amount of a claim, it refers only to the amount included on the personal care services line of each claim and excludes any amounts claimed for other Medicaid services.

[2] Nothing in this statement is intended to address situations covered by Medicaid fraud and abuse provisions.

C. Background

DHS is the single state agency responsible for administering New Jersey's participation in the Medicaid program. DDS operates the State's personal care assistant ("PCA") services program, which provides personal care, household duties, and other health-related tasks to beneficiaries with long-term chronic or maintenance health care needs in their place of residence. *See* N.J. Admin. Code § 10:60-3.1.

Prior to 1998, DDS recognized that certain personal care providers were underperforming, and determined that personal care providers should be required to obtain prior written or electronic authorization for PCA services pursuant to a State-mandated procedure. Beginning in 1998, the State phased in providers to obtain prior authorization on a county-by-county basis. Effective July 3, 2006, the State amended its regulations to include this prior authorization requirement. *See id.* § 10:60-3.9. Since this prior authorization requirement was implemented, the PCA program's growth has decreased substantially from 25% per year, to between 3% and 4% per year.

DDS requires each personal care provider to be accredited by at least one of four accrediting organizations[3] both "initially and on an ongoing basis" in order to participate in the State personal care program. *Id.* § 10:60-1.2; *see also id.* § 10:60-3.1(a). DDS has entered into memoranda of understanding ("MOUs") with the accrediting organizations that clarify that these organizations must complete a comprehensive on-site organizational audit once every three years and an annual on-site clinical service audit for each PCA agency. The MOUs further provide that the accreditation process includes an assessment of the agency's "fiscal processes as they relate to documenting service provision, time tracking, preparation and submission of claims data to the state." Standard Memorandum of Understanding Between DDS and Accrediting Body, App'x A, Division Standards for Accrediting Bodies (on file with State). This provision is "intended to determine if the PCA agency *has a system in place* . . . which results in the production of reasonable claims to the state agency." *Id.* App'x B. Under the MOUs, an accrediting agency must notify DDS if it learns that a PCA agency is not in compliance with accrediting standards or the PCA agency is in danger of losing its accreditation. Given its limited staffing, the State relies upon the accrediting agencies to monitor PCA providers' fiscal processes and to alert it to deficiencies in these processes so that corrective action can be taken.

On September 9, 2011, New Jersey submitted to the Centers for Medicare & Medicaid Services ("CMS") a comprehensive demonstration waiver application pursuant to Section 1115 of the SSA, 42 U.S.C. § 1315. *See* http://www.state.nj.us/humanservices/dmahs/home/waiver.html. The waiver application seeks to implement effective, long-term, cost-containing changes to the State Medicaid program. New Jersey's application provides improved quality and outcomes through a variety of measures, including mandatory managed care enrollment, which the State has already begun implementing. The PCA program was subsumed into managed care in July 2011. Currently, over 80 percent of PCA cases have been transitioned to managed care, and the remaining cases will be rolled in over the coming months. Under the State's managed care model, PCA services must receive prior authorization and are, along with other covered medical services, monitored by the managed care organizations. The accrediting agencies continue to have monitoring responsibilities, meaning that after the full transition to managed care, both managed care organizations and accrediting agencies will monitor PCA providers' compliance with applicable Medicaid regulations.

[3] The four accrediting organizations are the Commission on Accreditation for Home Care Inc., the Joint Commission on Accreditation of Healthcare Organizations, the National Association for Home Care, and the Community Health Accreditation Program

The State has also implemented corrective measures specific to the types of "deficiencies" identified by the Draft Audit that are detailed below.

D. Alleged Deficiencies

The OIG's Draft Audit concluded that DHS did not always ensure that Bayada's claims for Medicaid PCA services complied with applicable Federal and State requirements. The auditors determined that of the 100 sample claims from January 1, 2008 to June 30, 2009, that were examined, 90 (totaling $2,152) were in full compliance, and 10 (totaling $216) were not. The auditors recommend disallowing the entire amount of the "deficient" claims. The Draft Audit identified 11 alleged deficiencies contained in those 10 claims which fall into the following three categories:

- Missing documentation of personal care assistant's in-service education (1 claim)
- Missing documentation of nursing supervision (9 claims)
- Missing documentation of nursing assessment (1 claims)

The OIG's finding of "deficiencies" for alleged lack of nursing supervision—which constitute nine of the eleven "deficiencies"—is premised upon an incorrect reading of the relevant State regulations. The OIG reads requirements into the regulations that are neither in the text of the regulations nor consistent with the State's reading of, and enforcement of non-compliance with the regulations. It would be unreasonable to seek recoupment for these deficiencies.

In addition, as is shown in the following paragraphs, all three categories of alleged deficiencies involved technical or documentation problems. Unlike other State regulations not at issue in the Draft Audit, the regulations for these categories do not expressly provide for recovery of payments or recoupment as the appropriate remedy for non-compliance. *Compare id.* §§ 10:60-1.2, 10:60-3.5 (excluding any reference to recoupment or repayment), *with id.* §§ 10:60-1.8, 10:60-4.9(c) (specifying that violations will be remedied by "recover[y of] any payments" and "recoupment"). Nor is it New Jersey's practice to seek repayment or recoupment from providers for violations of these provisions. Instead, New Jersey generally requires the PCA provider to engage in remediation and obtain prior authorization of PCA claims to prevent future violations. If a provider repeatedly violates State Medicaid provisions, especially those relating to Medicaid fraud and abuse, the accrediting organization may strip it of its accreditation, DDS may recommend that its license be revoked or not renewed, and/or DDS may suspend Medicaid payments to the provider, effectively preventing it from continuing to participate in the State Medicaid program. Thus, the alleged technical or documentation "deficiencies" do not support a conclusion that payments were improperly made.

Federal law does not provide a basis upon which HHS can recoup for these types of technical or documentation problems when the State does not require repayment or recoupment. In the past, the OIG has taken the position that claims may be disallowed by the Federal government pursuant to a provision in OMB Circular A-87 that states: "To be allowable under Federal awards, *costs must . . . [b]e authorized or not prohibited under State or local laws or regulations.*" 2 C.F.R. Pt. 225, App'x A, C.1.c (emphasis added). Under the plain language of this provision, the Federal government's ability to recoup *turns on State law.* Here, for all three "deficiency" categories, neither State law nor State practice provide for recoupment as the appropriate and general remedy, and therefore the "costs"—that is, payments to Medicaid providers—are "not prohibited" under State law. Thus, recoupment is unwarranted and inappropriate for the in-service education, nursing supervision, nursing assessment, and Board of Nursing certification "deficiencies."[4]

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[4] The three categories of documentation "deficiencies" discussed above are distinguishable from a case in which the underlying state law expressly conditions Medicaid payments upon compliance with state Medicaid rules and the

Nor are PCA providers required to retain records relating to these technical regulations in order to be reimbursed for furnished services. Federal law requires that Medicaid providers keep "*fiscal records* to assure that claims for Federal funds are in accord with *applicable Federal requirements*" for three years, but does not mandate the keeping of records required by State law. 42 C.F.R. § 433.32 (emphases added). The State Medicaid statute requires only "maintenance of *records required for reimbursement*"—which means "individual records as are necessary to fully disclose the name of the recipient to whom the service was rendered, the date of the service rendered, the nature and extent of each such service rendered, and any additional information"—rather than maintenance of all records showing compliance with State law, including technical Medicaid regulations. N.J. Stat. § 30:4D-12 (emphasis added); *see also* N.J. Admin. Code § 10:49-9.8(b)(1) (requiring Medicaid providers "to keep such records as are necessary to disclose fully the *extent of services provided*, and, as required by N.J.S.A.30:4D-12(d)" (emphasis added)).[5] The State's standard Medicaid provider agreement in effect during the audit period states that the provider agrees "[t]o keep such records as are necessary to *fully disclose the extent of services* provided to individuals receiving assistance under the programs administered" by DHS. Standard New Jersey Medicaid provider agreement (on file with the State) (emphasis added). Thus, the fact that the providers could not provide certain records relating to these technical regulations does not provide a basis for recoupment of the Federal share paid for the underlying claims.

Below, we turn to each category of "deficiency" in turn.

1. Missing Documentation of In-Service Education

Draft Audit Finding: The Draft Audit determined that for one of the 100 sampled claims Bayada could not provide evidence that the personal care assistant in question had completed 12 hours of annual in-service education in the calendar year in which services were administered or during the preceding 12 months, as required by section 10:60-1.2 of the NJAC. The FFP paid for the allegedly deficient claim is $8.08. The Draft Audit would reject the entire amount of this claim.

DHS Response: There is no Federal requirement that attendants undergo 12 hours of annual in-service education and therefore no justification for withholding Federal funds based on a finding that documentation of such education was not provided. Even if the State requirement had been violated, State law does not require either withholding payment from providers for all services furnished by the attendant during a year in which the annual in-service education cannot be documented, or the maintenance of records relating to in-service education.

In the sole "deficiency," Bayada has provided documentation demonstrating that the employee underwent at least 13 hours of in-service training within 14 months of the date of service. Far from indicating that Bayada systematically violates the in-service training requirement, the fact that there is only one isolated case of the 100 sampled cases in which documentation of in-service education is alleged to be missing demonstrates that Bayada

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state has not explained the "circumstances or conditions pursuant to which the [State] would have excused an overpayment sanction," *N.Y. State Dep't of Soc. Servs.*, DAB No. 1235 (1991). *Cf. N.Y. Dep't of Soc. Servs.*, DAB No. 1112 (1989) (concluding payments were not authorized under state law as required by OMB Circular A-87 because the New York regulation at issue (1) did not grant New York discretion to pay for noncompliant services and (2) had served as the basis for the New York's own provider-specific disallowances).

[5] The "clinical records" provision in the NJAC does not provide the time period for which a beneficiary's clinical records need to be maintained, *see* NJAC § 10:60-3.6, nor are the records covered by the State Medicaid recordkeeping provisions described above, which relate only to records of reimbursable services. While these clinical records may be relevant to the accreditation process, the State does not require recoupment from a provider that does not maintain these records for several years.

uniformly requires that attendants undergo the requisite training and documents such training. Rather than demonstrating that the training did not in fact take place, the copies of the training documentation for this case may have been misplaced or lost. In the sole case in question, the record documents that eligible services were provided to eligible recipients in an appropriate setting, in accordance with a physician-approved plan of care. This satisfies the Federal requirements for FFP, and the failure to meet a State requirement of prior approval for legal guardians, even if proved, does not justify withholding that FFP.

In any event, the State is prepared to take corrective actions to prevent future violations of the in-service education requirement. DDS plans to modify its MOU with the PCA accrediting agencies to require them to report any deficiencies and areas of non-compliance to DDS, and for these deficiencies to be corrected, prior to issuing a final rating score. Moreover, DDS is encouraging accrediting bodies to develop standards on ownership and maintenance of PCA in-service training records, including for transferring employee training records in the event that employees subsequently leave the agency after they are trained.

2. Missing Documentation of Nursing Supervision

Draft Audit Finding: The OIG auditors determined that for nine of the 100 sampled claims Bayada did not provide documentation of direct nursing supervision which must be prepared within 48 hours after the start of service and at least every 60 days thereafter pursuant to section 10:60-3.5(a)(2) of the NJAC. Under State law, "[a]dditional 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." The total FFP paid for the allegedly deficient claims is $208.24. The Draft Audit would withhold these claims in their entirety.

DHS Response: There is no Federal requirement that direct nursing supervision be periodically performed and documented, and therefore no justification for withholding Federal funds based on a finding that such documentation was not provided.

In all nine cases, the OIG applied the 48-hour requirement to the "additional supervisory visits" required when a personal care assistant who did not previously care for the beneficiary takes over the beneficiary's care. The State regulation, however, does not apply the 48-hour requirement in this circumstance. Instead, it describes personal care assistant turnover as a circumstance warranting an additional supervisory visit, without providing that nursing supervision be provided within 48 hours of such turnover; the 48 hour requirement, thus, applies only to the initial start of service for a beneficiary. This is consistent with the State's long-standing practice of finding violations of the 48-hour rule only when the supervision does not take place within 48 hours of the initial start of service for each beneficiary. Thus, none of the claims that allegedly fail to comply with the nursing supervision regulation are in fact "deficiencies."

3. Missing Documentation of Nursing Assessment

Draft Audit Finding: The Draft Audit determined that for one of the 100 sampled claims Bayada could not provide copies of a registered nurse's assessment of the beneficiary's need for PCA care, which must be prepared within 48 hours after the start of service and at least every six months thereafter pursuant to section 10:60-3.5(a) of the NJAC. The FFP paid for the claim in question is $24. The Draft Audit would reject this entire claim.

DHS Response: There is no Federal requirement that a nursing assessment be periodically performed and documented, and therefore no justification for withholding Federal funds based on a finding that such documentation was not provided. Even if the State requirement had been violated, State law does not require either withholding payment from providers for the services furnished by the attendant or maintenance of records relating to nursing assessments. For the single claim in question, Bayada has already provided copies of nursing assessment forms demonstrating that after an initial assessment was performed on the day services started,

reassessments were completed within every six months thereafter. The OIG faults Bayada for completing one assessment six months and 17 days after the prior assessment, when in fact this resulted only because this prior assessment had been completed early. It stretches credulity to find a deficiency under these circumstances. The fact remains that Bayada completed an assessment within *every six month period following the service start date*. It would be unreasonable to seek recoupment every time a provider is unable to perform a re-assessment exactly 180 days after the last assessment.

E. Response to Proposed Overpayment Recovery

After calculating that ten claims or portions of claims derived from the sample resulted in overpayments by the Federal government of $216, the Draft Audit used "statistical software" to extrapolate the total refund due to the Federal government to be $774,274 in FFP for allegedly unallowable PCA service claims by Bayada from January 1, 2008 through June 30, 2009. The State takes strong exception to this conclusion.

As shown above, there is no justification for recovery of any Federal funds, with or without extrapolation, with regard to *any* of the questioned claims. These claims do not involve instances of overbilling that are subject to recoupment.

As for the claims allegedly "deficient" solely for not providing adequate documentation, the findings of the Draft Audit do not support a conclusion that payments were improperly made. Rather, they show that only a small number of files are missing a document that would confirm the satisfaction of a particular requirement. The overwhelming demonstration in the 100 sample case records of compliance with several of the requirements in question (including compliance in 99% cases with the State in-service education and nursing reassessment requirements) negates any conclusion of non-compliance in the few instances where a document was missing from a file.

Further, given that the absence of documentation in all claims relates to State requirements that do not mention recoupment, rather than to provisions of the Federal regulations, it is inappropriate to withhold Federal funding. Nothing in State law requires that funds necessarily be withheld in any instance where a case record fails to document compliance with these State requirements.

In addition, extrapolation of the results to the caseload as a whole to recover a substantial amount from the State is inappropriate given the continuing efforts of the State (detailed above) to assure high quality and compliant performance by PCA providers after the conversion to a managed care delivery system.

F. Conclusion

The results of the OIG investigation, reflected in the Draft Audit, are encouraging to DHS because they demonstrate Bayada's extremely high level of compliance. Especially given the substantial corrective measures the State has taken since the audit period, including switching over to managed care and implementing a number of quality control measures, the results of the Federal review should provide comfort to Federal officials that Federal funds are being properly spent in the case of Bayada's PCA services.

Based on the Draft Audit results, the State is not prepared to repay any amount of the recommended disallowance, as the vast majority of the OIG's "deficiency" findings are predicated upon a flawed reading of State law, and there are no instances of overbilling or violations for which recoupment is the appropriate remedy under State law and practice. Moreover, *all* the alleged deficiencies identified by the OIG investigation, reflected in the Draft Audit, are technical in nature and by no means demonstrate that Bayada systematically provides PCA services to beneficiaries who are ineligible for the services, or provides services not covered by the Medicaid program. Given the isolated nature of the "deficiencies," it would

also be inappropriate to extrapolate any "deficiencies" from the 100 sampled claims to the 784,945 PCA claims Bayada submitted during the time period covered by the audit.