Department of Health and Senior Services
Division of Senior Benefits and Utilization Management
Medical Services for the Aged

July 1, 2000 to May 31, 2002
The Honorable James E. McGreevey  
Governor of New Jersey

The Honorable John O. Bennett  
President of the Senate

The Honorable Richard J. Codey  
President of the Senate

The Honorable Albio Sires  
Speaker of the General Assembly

Mr. Albert Porroni  
Executive Director  
Office of Legislative Services

Enclosed is our report on the status of conditions as of May 31, 2002 on our previous report of the Department of Health and Senior Services, Division of Senior Benefits and Utilization Management, Medical Services for the Aged dated December 21, 1998. If you would like a personal briefing, please call me at (609) 292-3700.

October 24, 2002
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Department of Health and Senior Services  
Division of Senior Benefits and Utilization Management  
Medical Services for the Aged  

**Scope**

We have completed a compliance audit on the status of conditions as of May 31, 2002 from our previous report of the Department of Health and Senior Services, Division of Senior Benefits and Utilization Management, Medical Services for the Aged dated December 21, 1998. Our audit encompassed financial activities accounted for in the state’s General Fund and Casino Revenue Fund for payments to nursing facilities for Medicaid recipients during the period July 1, 2000 to May 31, 2002. Expenditures are funded by the federal Health Care Financing Administration (HCFA) at a rate of 50 percent. The annual federal and state expenditures for these programs are approximately $1.2 billion for 28,000 Medicaid eligible residents.

The prime mission of the Division of Senior Benefits and Utilization Management is to offer senior citizens and their families the greatest choice in planning long-term care needs while maintaining dignity and encouraging independence. This is provided through various means including clinical assessments for persons in need of long-term care services, setting reimbursement rates of nursing facilities and paying for nursing facility services. The responsibility for payment by the Medicaid program still resides in the Department of Human Services (DHS).

**Objectives**

The objective of our audit was to determine whether the division has corrected the significant conditions noted in our previous audit.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section 1, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.
Methodology

Our audit was conducted in accordance with Government Auditing Standards, issued by the Comptroller General of the United States.

In preparation for our testing, we studied legislation, administrative code, and policies of the agency. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation and through our samples of financial transactions. We researched industry and governmental publications and audit reports from other states. We also read the budget message, reviewed financial trends, and interviewed agency personnel to obtain an understanding of the programs and internal controls.

A nonstatistical sampling approach was used. Our samples of financial transactions were designed to provide conclusions about the validity of transactions as well as internal control and compliance attributes. Transactions were judgmentally selected.

Conclusions

Our previous audit detailed many significant control weaknesses that had merited management’s attention. The agency’s response on December 17, 1998 indicated it is “…seeking a national consultant with experience in other states to conduct a two-year study and recommend ways to make this substantial reform. We will be issuing regulations to improve the accuracy of cost reporting and the collection of money owed the State. The Department, through its contracted auditors, will conduct 135 audits each year. Appeals of audit findings will be streamlined and resolved directly after the audit. We have begun clinical audits of patient conditions…. Finally, we are making organizational changes to improve collections and the auditing process.”

The current rate setting system continues to be un timely, does not ensure that the rates are accurate, and does not adequately provide for the detection and recovery of overpayments.
The department should resolve its impasse with the nursing facility industry to implement the new rate setting system for which it has paid.

Setting Rates for Nursing Facilities

New Jersey reimburses nursing facilities based on annual prospective facility specific per diem rates. A facility’s current year per diem rate is based on the previous year’s cost for all facilities in the program. In accordance with N.J.A.C. 10:63-3, nursing facilities submit annual cost studies to the Department of Health and Senior Services, Rate Setting Unit. These cost reports provide the information necessary to establish per diem rates.

Our prior audit recommended, and the department agreed, that a multi-year rate system should be instituted. The department contracted with an outside vendor to design and develop a new rate setting system to replace the existing method for reimbursing long-term care facilities for care of Medicaid-eligible individuals. The department paid the vendor $634,000 of the $1,100,000 awarded amount for the completion of the first four phases of the contract and 20 percent of the operations portion of the contract. To date the case mix software has not been delivered or installed on the department’s computers as required in the contract because the department is at an impasse with the nursing facility industry. As a result, the department continues the time-consuming process of reimbursing nursing facilities utilizing the nursing facility’s prior year rates until new rates are calculated.

Recommendation

We recommend that the department resolve the impasse with the nursing facility industry and provide the vendor with the necessary information which will allow them to complete the project and to install the application on the department’s computer.

Auditee’s Response

The department contracted with a nationally recognized consulting firm to develop a new nursing facility rate setting methodology that would incorporate the best features of other rate setting models and cutting edge concepts into the New Jersey model. After months of meetings with
representatives from the nursing home industry, department staff, and the consultants, we acknowledge that the industry does not agree with the proposed new rate setting system. It has been difficult to achieve consensus.

Nevertheless, the department has completed the transition to a “desktop” rate setting environment, which significantly improves the accuracy of rate calculations and the timeliness of the issuance of rates to facilities. If and when the “new” reimbursement system receives approval and the proper regulations are in place, the necessary software would be easily installed without any disruption to rate setting.

Level I Appeals

Nursing facility rate appeals should be reviewed timely and the department should move to reduce backlogs.

N.J.A.C. 10:63-3.1 states that nursing facility rates should be reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities functioning in conformity with applicable regulations. Additionally, N.J.A.C. 10:63-3.21 allows facilities to appeal rates if, due to an unusual situation, the strict application of the rules results in an inequitable rate. They are given 80 days to submit all required documentation for Level I appeals, which are heard by representatives from the DHSS Rate Setting Unit. If unsatisfied by the outcome of a Level I appeal, the facility is entitled to a Level II appeal, which is heard by an administrative law judge.

It was noted in our previous report that the Level I appeals were not acted upon in a timely manner. The complexity of the rate setting system, the volume of appeals, and amount of staff time to research the appeals had resulted in backlogs.

As of September 1998, there were 573 outstanding appeals which had been submitted by 193 different facilities. Individual appeals had up to 11 separate
issues and had been on file for as long as 10 years. The appeals involve issues such as requests for incorporation of normally allowable costs, disagreements on reclassifications, allowance for an overdue appraisal, errors made by the Rate Setting Unit, or disagreement with the inflation factor.

The circumstances that produced the prior audit finding have not changed significantly. In February 2002 there were 424 outstanding appeals, of which 148 were from the September 1998 backlog. The oldest appeal was for the 1992 rate year. The regulations still do not address a time frame for the resolution of Level I appeals nor do they provide a methodology for prioritizing the appeals.

The Department was considering the elimination of the Level I appeals process. Nursing facilities could take their issues directly to a hearing officer without being lost in the cumbersome appeals process; however, no progress has been made toward this resolution.

**Recommendation**

As noted in our previous recommendation, when appeals are received they should be reviewed timely to determine if they have merit. The rate setting unit should issue appeal decisions timely.

**Auditee’s Response**

One of the major goals for developing a new rate setting system was to change the methodology to be less complex and minimize disputes between the industry and the state. The RFP for the consultant for the new rate setting system clearly identified the state’s intention to substantially reduce appeals by changing the rate setting system. Since the last audit, the department spent months working with the consultants and industry representatives to develop a new methodology that would have reduced the frequency and number of appeals. The Department could not achieve consensus with the industry.

However, the department did move forward with a regulation change and State Plan Amendment that
would change the reporting of acuity information, which was the basis for many appeals. With the endorsement of nursing facility associations, acuity information will now be reported on the annual cost report instead of on the Unisys billing document. This is expected to reduce mistakes in reporting acuities and subsequent appeals. Of the 124 appeals filed in FY 2001, 23 percent included appeals concerning acuities.

The department also plans to change regulations that would revise the timeframe for filing of Level 1 appeals from 80 days to 60 days. These changes should significantly reduce the processing time for current Level 1 Appeals.

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**Audits of Reported Costs**

Nursing facilities are required to submit annual cost reports to the Department of Health and Senior Services, Rate Setting Unit for the purpose of establishing annual per diem rates. Annual audits are performed to monitor the accuracy and propriety of the information reported on the annual cost reports. N. J. A. C. 10:63-4.3c requires that overpayments be collected when the audited rate is lower than the original rate. The resulting overpayment, interest and/or penalties are subsequently calculated by the Rate Setting Unit. The state contracted with a public accounting firm to perform audits of the cost reports submitted by the nursing facilities.

The accounting firm was paid approximately $2.7 million for audits over a three-year period and identified $2.6 million in overpayments. This amount does not include 58 audits where questioned costs have not been recalculated or finalized.

Nursing facility audits are not performed timely and over 50 percent of the facilities are not audited at all.
<table>
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<tr>
<th>Year</th>
<th>Number of Audits</th>
<th>Overpayments</th>
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<tbody>
<tr>
<td>1999</td>
<td>179*</td>
<td>$985,061</td>
</tr>
<tr>
<td>2000</td>
<td>44</td>
<td>$663,223</td>
</tr>
<tr>
<td>2001</td>
<td>40</td>
<td>$932,121</td>
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<td>Total</td>
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<td>$2,580,405</td>
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* This number includes 133 Phase I income and per diem audits which are limited scope audits. The department deemed these audits are not cost effective.

During this three-year period, 192 of the 350 nursing facilities (55 percent) were not audited because they were at the bottom of the priority listing. These unaudited facilities received $3.2 million in Medicaid payments annually. Each year, the Rate Setting Unit develops an audit plan with specific facilities that they want reviewed. The methodology used in the creation of the priority listing was developed many years ago, when the audits were performed by the Department of Human Services. The lack of adequate audit coverage increases the risk that overpayments to these nursing facilities will go undetected or grow so large that full recovery may not be possible.

The prior audit noted that the audits of nursing homes were not timely. Our current analysis of the timeliness of the audit process included a review of 35 completed audits. We determined the time it took from the end of a selected audit period to the date the final audit report was received by the department to be 4.86 years on average. This is a slight increase over the 4.5 years in our previous report. There could be as much as 3.5 years from the end of the audit period selected for review to the date the field work was started. Such delays increase the probability that potential recoveries could be lost due to the transfer or the financial failure of a nursing facility.
**Recommendations**

We recommend the Rate Setting Unit review their audit plan to consider nursing facilities that have not been audited in the last three years. The department should consider selecting current audit periods; if the audit results in material overpayments the prior years could also be reviewed. Another consideration would be to contract for the completion of additional audits to close the gap.

**Auditee’s Response**

The audit contract with the Department is limited, due to funding. Approximately 40-45 nursing home audits are completed during the fiscal year. These audits are prioritized based upon expected recoveries. However, nursing homes, which have not been audited within a three-year period, will be given a higher priority in the assignments of homes to be audited. The department has already instituted changes that allow audits of current period cost reporting.

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**Cost Recoveries**

The department should review its recovery process to improve the collections of overpayments.

The Cost Recovery Unit is responsible for recovering overpayments made to nursing facilities. Overpayments result when ineligible costs are detected during audits of nursing facilities which subsequently result in a reduction in a facility’s per diem reimbursement rate. When an overpayment is determined by the Nursing Facility Auditing unit, a formal written notice is sent to the Recovery Unit. The collection process begins when the Recovery Unit logs the information on the notice.

It takes on average 100 days from the date on the formal notice to the date that the Recovery Unit logs receipt of the notice to collect overpayments. We found that the Recovery Unit was in possession of ten notices which were not logged and thus no recovery efforts were undertaken. The Recovery Unit had these notices for a period of three months to more than one year. In addition, there was an
average of 26 days from the time the case was logged until a Notice of Claim Letter was sent to the nursing home provider. Delays in processing recoveries increase the risk that the department will not be able to fully recover overpayments.

Our previous audit identified $14.4 million accounts receivables due the state as result of overpayments. Currently, the department can not determine the accounts receivable because the system used to capture receivable and recovery data was abandoned in 1999. A replacement database was developed by the department’s Long Term Care Licensing and Certification Unit, but has not yet been implemented.

Our test of receivables for 35 nursing homes disclosed that after adjustments, waived interest, and settlements there was a receivable balance of $2 million. We found that from May 1998 until March 2002 the Recovery Unit had only collected $360,000 of the outstanding receivable balance in our sample. We expanded our test to include an analysis of settlements. There are no formal policies and procedures to control reductions in the receivable due to a settlement. In addition, the test showed that three out of four facilities that had settlements totaling $26,000 did not have written approval from the director of the unit.

Formal polices and procedures are necessary to ensure that the state is able to maximize recoveries when overpayments are identified and to provide assurances that the department treats each provider equally. Without adequate controls there is an increased risk of inappropriate reductions in the amounts being recovered. As previously noted, the unit does not have adequate accounting records and reports that would allow management to monitor collection results or to assess the efficiency of its collection efforts.

In order to improve supervision over the collection process, the Cost Recovery Unit was transferred to the department’s Long Term Care Licensing and
Certification Unit for the purpose of linking the recovery of overpayments to approvals for the transfer of nursing home licenses. These licenses are granted by the certification unit and can be withheld until a provider pays overpayments due to the state. Our review of license transfers and bankruptcies during a four-year period from 1999 through 2002 disclosed that 18 of the 32 transfers of ownership occurred without an audit. Six facilities transferred ownership while their audits were still in the process of recalculation. Seven audits were completed after the transfer of ownership occurred and resulted in $835,000 of overpayments that can’t be collected. In addition, $1.8 million of overpayments were not recoverable due to nursing facility bankruptcies.

**Recommendation**

The department should review the operations of the Recovery Unit and give consideration to adapting procedures which will expedite notification of nursing homes of the department’s intent to collect overpayments.

We recommend that the department begin using the database application they have developed. The application should include periodic reports to management detailing all aspects of the collection function. Collections should improve if management has the information on where recovery efforts need to be enhanced.

We recommend that the department immediately adopt procedures and policies that will strictly monitor and control the reduction of receivables.

We recommend the department reconsider its decision of transferring the Recovery Unit to the department’s Long Term Care Licensing and Certification Unit. The recovery unit’s collection efforts would improve substantially by transferring the unit to the Provider Relations unit. This unit, with the assistance of Unisys (the Medicaid claims processing agent), is capable of automatically deducting the overpayments from provider’s monthly claim reimbursements.
Auditee’s Response

The Recovery Unit (the Unit) has a policy and procedure for logging audit reports. In general, the reports come into the Unit and are then systematically entered into the Unit’s audit report log, or “logged in”, as they are received, unless there is a reason (i.e.: facility bankruptcy) not to begin the collection process. With regard to the 10 notices referred to in the OLS Report that were not logged in at the time of the audit, those cases have not only been logged in, but recoveries have been either under way or completed for them. A substantial number of facilities in the sample were either bankrupt or subject to a change in ownership or, in one case, criminal indictment. For those reasons, those matters were not logged into the system during the timeframe that the Unit was barred from implementing recovery activity.

The calculation of days on the audit work papers did not account for weekends and holidays. In a given 100-day period, there are 13 to 14 weekends. Accordingly, even including those facilities whose recoveries were not able to be processed, the timeframe is closer to 74-76 working days. Additionally, if the bankrupt facilities are removed from the sample, the average number of days (including weekends) to log the matters into the Unit is closer to 75. Removing weekend days, that number is further reduced to 55-57, roughly half the number of days indicated in the audit report.

The computers used within the unit at the time of the audit are not capable of running the database in question. New computers were ordered and approved many months ago and were received on September 20, 2002. The database will be implemented immediately after the new computers are installed.

At the time of that previous OLS audit, it was demonstrated to the auditors that the actual amount of those receivables was closer to $6 million. Unfortunately, this is due to the fact that the accounts receivable total calculated (both during the previous
audit and this most recent audit) based on the audit reports includes overpayments that are uncollectable from the outset. At times, audit reports received in the Unit are 5 years old or more when they come to the Unit for collection. Identified overpayments are not collectable when they are received in the Unit after a facility has closed, gone bankrupt or has long since been transferred. Additionally, the receivable amounts contained in the reports are not always accurate. There are instances when the initial audit report identifies a very large overpayment and, sometime thereafter, a mistake is found and the overpayment is recalculated to zero. Unfortunately, in those cases, the Audit Unit does not go back and change the overpayment amount stated in its original report and the amount is included in determining receivables, even though it is erroneous. Upon implementation of the aforementioned database, a column will be added for downward adjustments so that a more realistic receivable can be identified.

The Unit has policies and procedures, adapted from the current CMS policy, for reducing recovery amounts through a settlement where circumstances indicate that the Unit is unlikely to collect the full amount.

Additionally, the Unit has standardized policy with regard to recoveries of audit overpayments through a revision of its Notice of Claim to nursing facilities. A Formal Notice of Claim is sent to the nursing facility (NF) advising it of audit results, overpayments and interest due. The NF is given 20 days to pay by direct check otherwise withholdings of the amount due is processed by an offset of the NF’s monthly Medicaid monies. The NF can request a formal hearing and the case is transmitted to the Office of Administrative Law. However, our claim is protected through the Withholding Procedure. The collection is tracked monthly through access of an MMIS data base record with UNISYS, the Department’s Fiscal Agent. Checks are recorded in the file with a copy when received in the recovery
unit and the original check is transmitted for bank deposit and record keeping. The case is closed and date entered in a card catalog file and an accounting ledger.

Also, the Recovery Unit advises the division’s Long Term Care Licensing and Certification Unit on outstanding audit claims and pending audits in progress when a transfer application is under review to allow for payment of the audit prior to approval of a license to operate. The department’s policy requires that the new owners assume the liability of future overpayments for any pending audits unless a new provider number is granted. This policy is stated in written correspondence to the prospective buyer and current owners. This procedure is ongoing and has resulted in settlement of claims without the cost of litigation.

Monthly reports are sent to the Assistant Commissioner showing the collection activity amounts for the month with fiscal year-to-date figures. Management is also apprised of highlights and problems encountered in the unit. Monthly staff meetings are held on the first Tuesday of each month for discussion of the unit’s activities, problems and progress. Quarterly figures are reported to management and yearly amounts are submitted for establishing projected recoveries for budget information for the next state fiscal year.

Recoveries can be and are currently linked to transfers of ownership, as described more fully above. Additionally, Unisys already implements automatic collection of overpayments through withholding on the provider’s monthly remittance, unless the provider opts to pay through another means. Nevertheless, the department agrees with the auditor’s suggestion that transferring the Recoveries Unit to Provider Relations would resolve some of the problems addressed in the audit report.
The department should review its clinical audit process and actively pursue overpayments resulting from the improper reporting of acuities.

Monitoring of Claims

Our previous audit noted that there was no policy to audit or investigate the claims for accuracy. In addition, we noted that the department reimbursed nursing facility claims for services for residents subsequent to their death. In response to our recommendation, the DHSS has established a procedure to match claims against the Bureau of Vital Statistics’ deceased files and subsequently has recovered approximately $2.4 million in overpayments for deceased beneficiaries as of March 2002.

Our previous audit also noted that facilities were reporting patient acuities on billing documents that could not be supported by nursing records. Acuities are services provided when patient conditions require additional nursing services such as trachea tubes, respirator use, head trauma, intravenous therapy, wound care, oxygen therapy and tube feeding. During 1998, the professional nursing staff performed acuity audits of 155 facilities participating in the Medicaid system and found that 154 facilities had reported acuities inaccurately for 1995. The DHSS recovered approximately $1.7 million in overpayments as a result of that review. Our current review noted that the department’s professional nursing staff continues to perform clinical reviews of nursing facilities annually. However, the reported discrepancies are not being pursued or recalculated to determine whether overpayments exist. There were 119 clinical audits completed for rate years 1996, 1997, and 1998 which identified 9,800 instances of acuities that were not supported by the documentation reviewed. The audits have been forwarded for recalculations; however, since the division had not performed recalculations, the amount of overpayments involved cannot be determined.
**Recommendation**

We recommend any questioned or invalid acuities be reviewed immediately upon the completion of clinical audits and overpayments resulting from the improper reporting of acuities be recovered timely.

**Auditee’s Response**

The goal of the Clinical Audit Unit is to review any questioned or non-valid acuity with the facility representatives at an exit conference. This process has been implemented. Clinical audit summary reports are forwarded to the Nursing Facility Auditing Unit for re-calculation upon completion of the audit by the Clinical Unit.

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**Medicare Co-Payment**

When a Medicare eligible individual enters a nursing facility, Medicare pays 100 percent of the cost for the first 20 days. During the next 80 days, the resident is required to pay a standard co-payment. If the resident is also Medicaid eligible, Medicaid will pay the co-payment based on a formula, with a maximum amount equal to the Medicare co-payment.

Our previous audit noted that the division reimbursed nursing facilities utilizing incorrect Medicare per diem rates. We had identified overpayments of $955,000 to 17 nursing facilities during 1996 and 1997. These overpayments were subsequently recovered by the division. Upon being made aware of this problem, the DHSS obtained current rates directly from third-party fiscal agents for Medicare and updated the payment file.

During our current review, we noted that the rates have not been updated since 1999 due to extensive changes in Medicare’s reimbursement policy effective for all claims submitted on or after July 1, 1998. This new policy is a resident-specific case mix system that results in 44 possible per diem rates for each facility, which can change periodically during a resident’s stay. The current design of the system...
The billing/payment system cannot accommodate multiple rates for a single facility or allow for rate changes for a resident within a monthly billing cycle.

The division is working with the payment processing vendor to implement a new procedure whereby the current Medicare rates shown on the Medicare billing claim will be averaged to determine the appropriate Medicaid payment to nursing facilities for crossover claims.

**Recommendation**

The division should continue its efforts in implementing a new system to recognize current Medicare rates, thus eliminating any future overpayment for crossover claims.