Department of Health and Senior Services
Division of Consumer Support
Medical Services for the Aged
Selected Programs

July 1, 1996 to October 31, 1998

Richard L. Fair
State Auditor
The Honorable Christine Todd Whitman  
Governor of New Jersey

The Honorable Donald T. DiFrancesco  
President of the Senate

The Honorable Jack Collins  
Speaker of the General Assembly

Mr. Albert Porroni  
Executive Director  
Office of Legislative Services

Enclosed is our report on the audit of the Department of Health and Senior Services, Division of Consumer Support, Medical Services for the Aged, Selected Programs for the period July 1, 1996 to October 31, 1998.

If you would like a personal briefing, please call me at (609) 292-3700.

Richard L. Fair  
State Auditor  
December 21, 1998
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Scope

We have completed an audit of the Department of Health and Senior Services, Division of Consumer Support, Medical Services for the Aged, Selected Programs, for the period July 1, 1996 to October 31, 1998. Our audit included financial activities accounted for in the state’s General Fund and Casino Revenue Fund for payments to nursing facilities for Medicaid recipients. 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 $1.1 billion for 30,000 Medicaid eligible residents.

The scope of our audit was limited to financial transactions related to nursing facility care. Our scope did not include residents in home and community based programs.

The prime mission of the Division of Consumer Support 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.

As part of the consolidation of senior services, three separate areas came together effective July 1, 1996. The responsibility under the state’s Medicaid program as it relates to Medical Services for the Aged was moved to the Department of Health and combined with the department’s responsibility to monitor and license nursing facilities. The responsibility for payment by the Medicaid program still resides in the Department of Human Services (DHS). When the nursing facility responsibilities were moved to the new Department of Health and Senior Services (DHSS), they continued to follow the policies and procedures established by DHS.
DHSS is still in the stages of reorganization and development of its own policies and procedures.

**Objectives**

The objectives of our audit were to determine whether payments to nursing facilities for long-term care services were reasonable, related to the department’s programs, and recorded properly in the accounting system.

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, circular letters promulgated by the State Comptroller, and policies of the agency. Provisions that we considered significant were documented and compliance with those requirements was verified by interview and observation and through our samples of financial transactions. We researched industry and governmental publications and audit reports from other states. We determined spending trends by analysis of published reports of HCFA. We also read the budget message, reviewed other 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. We analyzed rate file documentation and recalculated the rates for eight facilities. We also visited eight facilities and tested information submitted on claims. Medicaid claim files were matched 100 percent with deceased files maintained by the DHSS Vital Statistic Unit as of January 31, 1998.
Conclusions

Federal law permits New Jersey discretion in the way it determines the amounts that it pays nursing facilities for residents’ care. Facility rates were set in accordance with current regulations. The current rate setting methodology has been approved by the federal government to be an adequate way of reimbursing nursing facility costs. We found that payments for nursing facility care were reasonable, properly recorded and related to the department’s programs. However, we found certain internal control weaknesses and matters of compliance with laws and regulations that merit management’s attention. The rate setting system is not timely, does not ensure that the rates are accurate, and does not adequately provide for the detection and recovery of funds if overpayments are made.
Recommendations
Computer system should be modernized.

The current computer system should be replaced with a modern Local Area Network system with client server based technology. A modern system would allow many of the current manual calculations to be done automatically and provide the agency’s analysts with on line access to nursing facilities information. Such a system would reduce the time needed for the pre-audit process, including performing analytical reviews of cost reports. In addition, by providing online access to current and prior year cost reports and per diem rate calculations for each nursing facility, analysts could quickly adjust cost reports and recalculate per diem rates when subsequent cost information is received or audits identify ineligible or inaccurate costs.

A multi-year rate system should be used.

We also recommend that consideration be given to changing the current annual rate setting system to a multi-year rate system. This would require that the actual detail rate calculation for each nursing facility only be done periodically, for example on a three or four year interval and the facility would be given an annual adjustment to their rate based upon a specific cost index. This type of system is used by a number of other states. One of the benefits of this approach would be a reduction in the work load for agency staff related to the annual calculation of rates. It would permit more time to address other issues such as appeals and rate recalculations, enabling them to be done in a more timely manner.

This approach would also reduce the audit effort needed to ensure the accuracy of the cost reports and claims, since only the base year of each cost cycle would have to be audited. In order to ensure the accuracy of the system, the audits would have to be done more timely than the current approach. Details of the timing and scope of the audits will be discussed later.
Nursing facilities would also be better able to plan and budget for future years. They would know that their rates are set and with more timely audits, any issues related to questioned costs or claims reimbursement could be addressed in a more timely fashion, thus reducing the dollar impact. Currently, inaccurate reporting may not be found for five or more years and errors could be repeated year after year.

Audits should be timely and provide broader coverage.

We recommend that audits be performed more timely. The following approaches would accomplish that goal. Audits should be conducted in the first year of the periodic rate cycle and the audit should include the base year cost report. Another approach would be to audit the cost report for the last year of a rate cycle and use the audited costs as a basis for the next cycle. It should be noted that under the multi-year rate cycle only one third or one forth of the facilities would be subject to audit each year.

The scope of the audits should include cost reports, nursing facilities claims/billings, and personal needs allowance. A risk based approach should be used to determine the scope of a specific audit. The risk analysis should be a joint effort between the auditors and agency personnel. Such an approach would target areas of concern.

When audits are performed and ineligible costs, calculation errors, or inaccurate claims are found, we recommend that the audit scope be expanded to review those areas in prior years, to determine if the findings are isolated instances or the facilities normal practice.

Upon completion of the audit any findings or questioned costs should be reviewed immediately by the division and the financial impact should be determined. If the audit discloses overpayments, the nursing home should be notified at the exit conference. Arrangements for repayment should be made immediately.

The rate setting system should be simplified.

A review of the current rate calculation system should be made to determine how it could be simplified or improved. Examples of areas for consideration are:
- Acuities could be removed from the overall per diem rate and a separate rate established. The reimbursement for acuities could then be based on actual services provided rather than estimates, thus increasing accountability.

- The practice of judgmentally eliminating very high or very low cost facilities from the process of establishing medians could be stopped, unless a material financial impact can be determined.

- Efforts could be increased to make the evaluations of capital improvements timely. This would reduce the number of facilities with temporary rates, which eventually require recalculation, and reduce the number of appeals since facilities may appeal provisional rates each year until a final determination is made.

**Level I appeals should be acted upon timely.**

When appeals are received they should be reviewed timely to determine if they have merit and the nursing facility should be notified that the appeal has been received. The rate setting unit should issue appeal decisions timely.

**Overpayments should be recovered timely.**

Efforts should be increased to recover overpayments to nursing facilities. More timely audits and rate recalculations, and the prompt scheduling of administrative law hearings should help improve this process. The division has also suggested that all overpayments to a facility must be reimbursed prior to the facility being permitted to change ownership and transfer their license. We agree with this proposal.

**Current Medicare facility rates should be obtained.**

The department should continue its efforts to implement procedures to obtain current Medicare facility rates. We also recommend that the department review all the Medicare co-payments made and recover any overpayments.

**Nursing facility residents should be reassessed.**

In addition, we recommend that the department periodically reassess Medicaid eligible nursing facility residents and recommend changes in their care needs when appropriate.
Auditee’s Response
December 17, 1998

Richard L. Fair  
State Auditor  
office of Legislative Services  
PO Box 068  
Trenton, NJ 08625-0068

Dear Mr. Fair:

Thank you for the opportunity to review the report of your audit of the Division of Consumer Support, Medical Services for the Aged, for the period July 1, 1996, through October 31, 1998. In 1996, the responsibility for nursing home rate setting payments and collection of money owed the State by nursing homes was transferred to the Department of Health and Senior Services as part of the Senior Services consolidation. In the two years since, the Department has thoroughly reviewed this 20 year old system, through which we pay more than $1 billion per year for the care of over 32,000 residents, and has determined that substantial reform is required. The Department 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. We have also instituted procedures to improve collections of amounts owed to the State by nursing homes. Finally, we are making organizational changes to improve collections and the auditing process.

The following are our specific responses to your recommendations:

Recommendation: The current computer system should be modernized.

Response: The Department agrees that a PC based system should be developed that contains all cost report data and permits analysts to automate current manual procedures. We are recruiting for a professional level staff person to develop and maintain such a system.
Recommendation: A multi year rate system should be used.

Response: The Department agrees. See our introductory paragraph above for a discussion of reforms. As discussed, the Department will be making regulatory changes to reform the system as well. For example, one necessary regulatory change to implement a multiyear system is to require facilities to adopt a common fiscal reporting period. Only 260 of the 335 nursing facilities in the State use a calendar fiscal year. The others use a different fiscal year. The Department must make numerous special adjustments to accommodate the array of fiscal years used.

Recommendation: Audits should be more timely and provide a broader coverage.

Response: We agree that audits should be done more timely. On February 9, 1998, a purchase order was issued to Watson Rice and Company to perform audits of nursing facilities cost reports and patient income records. Each year, beginning in 1998 and ending in 2000, Watson Rice will review 106 cost reports with the books and records of participating nursing homes. They will also review patient income records in 29 nursing homes, for a total of 135 audits each year. To date, field work has been completed on 110 of the 1998 reviews which cover calendar year 1995 cost reports. Draft reports have been completed on 66; and final reports on 21.

Phase 2 of the audit process includes 22 "yellow book" audits. These are more in-depth audits which will include an opinion on whether or not the books and records of the nursing home (which are the basis for the cost reports) provide an accurate reflection of each home's financial activities.

The Department has begun recruitment for a full time internal auditor to perform reviews of the entire nursing home billing, payment, and audit process, which will include facilities' claims and billings.

The Department has 135 audits awaiting a rate recalculation as of December 1, 1998. The Department will complete these in a timely manner. An additional staff person has been reassigned to perform these rate recalcuations and as a result the Department expects to process the rate recalculations faster. An RFP will be issued to obtain professional consultants to assist in this process as well.
Recommendation: The rate setting system should be simplified.

Response: See our opening paragraph.

Recommendation: Level I appeals should be acted upon more timely.

Response: The Department agrees that Level I appeals are 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 have resulted in the delays.

The Department is considering the elimination of the Level I appeal process. Instead, nursing facilities which have financial disagreements with the State's procedures should be able to take their issues directly to a hearing officer without being bottlenecked with a cumbersome appeals process. This would result in a fairer and efficient resolution than the current Level I appeal process.

Recommendation: Overpayments should be recovered timely.

Response: State auditors found considerable problems in the cost reports submitted by nursing facilities. A complete and accurate cost report forms the basis of an efficient reimbursement system. If cost reports were correctly filled out in the first place, then the State would not have to recalculate what should have been the correct reimbursement rate and recover the improperly obtained nursing facility payments.

The Department is considering what regulatory and procedural changes it can make to fix the problem at the source. For example, one regulatory way to reduce the number of incorrectly filed cost reports would be to require that cost reports be independently audited before they are sent to the State. The State makes payments worth over a billion dollars a year based on these reports and needs assurance that the amount and type of costs reported are correct.

A significant procedural change referred to in the audit report is to resolve any disagreements between the State's auditors and facilities immediately after the audit. If the auditors and the facility are unable to agree, then the facility should be able to request a hearing. Currently, these disagreements are discussed at the end of the process when the State issues an overpayment notice.

In 1996 the Department assumed responsibility for overpayment collections. In reviewing these operations the Department
concluded that they could be improved and in late 1997 recommended to the Governor that overpayment collection could be increased. This recommendation was accepted and in the fiscal year beginning July 1, 1998, collections were budgeted to increase by $1,750,000 (State). The Department improved its collections by transferring the Recovery Unit and integrating it with the licensing activities of the Department. These steps were taken prior to the audit.

Also, the audit established that nursing facilities incorrectly billed the State approximately $430,000 for patients who were deceased. As of December 8, 1998, the Department has recovered nearly $238,000, over 55 percent, of these incorrectly billed claims. The remaining claims require the assistance of UNISYS, the Medicaid claims processing agent and the Department expects to recover the remaining $192,000 by February 15, 1999.

The Department has worked jointly with the Department of Human Services to match Medicaid payments files with the Vital Statistics files. These tapes are now matched monthly and should prevent nursing facilities from collecting reimbursement for these erroneous claims.

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. Within this unit, the Department plans several initiatives to link the recovery of overpayments to other services performed by the unit. For example, approvals for the transfer of nursing home licenses, which are granted by the unit, can be withheld until a provider pays any overpayment due to the State. Additionally, the Department believes that the time frame during which these cases are open can be greatly reduced by transmitting any contested case to the Office of Administrative Law soon after the case is received by the unit. Pending an OAL hearing, N.J.S.A, 30:4D 17 permits the Department to recoup overpayments from Medicaid payments being made to the provider.

The OLS audit findings represent a rough estimate of outstanding recoveries and not the actual dollar amount. The value of the open cases in the Cost Recovery Unit is overstated by the OLS audit. The report does not attempt to determine whether an amount claimed on any individual file is actually collectible.

Together with more effective procedures, the improvement of the audit and re-calculation processes should help to avoid such problems in the future.
Recommendation: Current Medicare facility rates should be obtained.

Response: Nursing facilities have been submitting incorrect Medicare rates to the Department. This is a problem because the Medicare rate is used to determine the amount of the Medicaid payment for persons who have both Medicaid and Medicare coverage. The effect of these incorrect rates has been that Medicaid has overpaid the facilities.

The Department is working with UNISYS to recover the $955,000 in overpayments made to the 17 facilities identified in the audit and expects to recover the $955,000 within two months. In addition to these 17 facilities, the Department will check the Medicare rates of other facilities as well. The Department is working with UNISYS to implement a new procedure whereby the current Medicare rate shown on the Medicare billing claim will be used to determine the appropriate Medicaid payment to nursing facilities. This will eliminate future overpayments to facilities.

Recommendation: Nursing facility residents should be reassessed.

Response: Residents in nursing facilities that receive an enhanced rate of reimbursement are reassessed every six months. There is no requirement in State law or administrative regulation to require the reassessment of residents in nursing facilities. The Department will need to consider the cost and workload involved in performing these reassessments since there are approximately 32,000 residents who are Medicaid beneficiaries.

Our Department appreciates the careful and conscientious work done by your auditors and looks forward to working with your office again.

Sincerely,

Leslie Hendrickson, Ph.D.
Assistant Commissioner
Division of Consumer Support
Findings and Observations
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 costs 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 the per diem rates.

The current per diem rate setting process is a complicated, time consuming, and labor intensive process which relies on a significant amount of manual calculations due in large part to an outdated computer information system. Since the process is usually not completed until October for the rates effective July 1 of the same year, facilities are reimbursed at the prior year’s rates until the new rates are calculated. As a result, it is necessary to make retroactive adjustments for payments made to the facilities between July 1 to when the new rates actually go into effect. The following description of the system is to convey how the system operates and illustrate some of its complexities.

The rate setting process has five major components: 1) the desk audit, 2) the input of cost reports to the computer system, 3) the determination of medians and screens (ceilings) for each cost category, 4) the calculation of each facility’s per diem rate, and 5) a post audit of the cost reports to verify their accuracy.

We will discuss the first four components of the process in this section of the report and the post audit process will be discussed separately.

Desk audits of approximately 320 cost studies are performed annually. The audits are performed prior to entering the cost data into the computer system.
The purpose of the audits is to ensure the mathematical accuracy of the data submitted, identify costs which require additional support from the facility, review cost classifications and allocation methods used, and verify the elimination of unallowable expenses and revenues. Analysts also compare prior year and current year hard copy cost studies for reasonableness and consistency. Due to the limited functionality of the current computer system, analysts are required to perform a significant amount of manual work when performing the desk audits. A modern computer system would permit the unaudited cost data to be entered directly to the system and many of the analyses could be performed by the computer and any necessary corrections could be made directly.

Upon completion of the desk audit, revised costs are entered into the computer system to begin the process of determining the per diem median and establishing screens for each of the cost categories. A screen is the maximum allowable cost for a specific category. To determine the median for each cost category, the computer will list in descending order each nursing facility’s reported costs. An analyst then manually reviews the listing, judgmentally eliminates very high or very low costs and determines the median. Many of the cost categories are affected by additional calculations prior to median selection. For example, costs may be adjusted for inflation due to timing differences among nursing facilities’ fiscal years. Also, the administrator’s salary limit utilizes a formula which incorporates salary, per bed salary, median days per bed, and patient days as components of the formula.

The median value for a specific cost category may be increased, per regulation, by a fixed percentage to encourage spending in that area and the new value becomes the screen. Other cost categories are further affected by calculations done after the screen has been calculated. Examples include:

“Raw food” in excess of the screen may be reclassified and added to “other general services expense”.
Routine patient care expense is based on minimum nursing required hours, but also includes a 25 step calculation for additional nursing services related to acuities.

When all screens have been determined, the reimbursable amount per category is calculated for each facility based on the lower of the facility’s reported cost or the reasonable limit determined using the screen. The total per diem is the sum of the reimbursable amounts of all cost categories. Once the per diem is determined, some facilities receive “Add-Ons” to their per diem rate. Examples include:

- Therapy Add-on for facilities who administer physical, speech or occupational therapy.
- Capital Facility Allowance is calculated for homes that are waiting for an updated appraisal due to expansion or renovation.
- Appropriations act add-on of an $18 million allocation calculated for homes with 75 percent or more Medicaid patient days in a year.
- Pass throughs for specific facilities to allow them to recover costs which exceed the screens. These are determined on a case by case basis.

This process generally starts in April and continues through October and requires a staff of approximately ten. A review of the current rate calculation system should be made to determine how it could be simplified or improved.
Level I Appeals

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 ten years. Some homes are waiting for eight or more appeals to be resolved. The appeals involve issues such as requests for incorporation of normally unallowable costs, disagreements on reclassifications, allowance for overdue appraisal, errors made by the Rate Setting Unit or disagreement with the inflation factor.

N.J.A.C. 10:63-3.1 states that nursing facility rates should be reasonable and adequate to meet costs incurred by efficiently and economically operated facilities which function 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.

The regulations do not address a time frame for the resolution of Level I appeals nor do they provide a method of prioritizing the appeals. As a result, we found facilities waiting eight or more years for appeals to be addressed and resolved. Since the receipt of appeals are not formally acknowledged or addressed timely, facilities will often appeal the same issue year after year in an attempt to force a resolution of the issue. This has the effect of increasing the division’s work load and inflating the number of appeals. There is also a contingent liability associated with the pending appeals. This liability can not be estimated because the appeals have not been processed any further than entry into the appeals log.
Audits of Reported Costs

To monitor the accuracy and propriety of the information reported on the annual cost reports, audits are performed by the state. N.J.S.A. 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 Department of Human Services (DHS), Office of Auditing had been responsible for performing audits of the cost reports submitted by the nursing facilities. Each year, the Rate Setting Unit presented an audit request which specified facilities that DHSS believed should be examined. The DHS Office of Auditing, based on their staff resources, prepared an audit plan which outlined the final selection of audits to be performed.

Our review of the audit process noted the audits were for a period of only one year and were of payment periods at least three years prior. An average time span of 4.5 years occurred between the end of the period being audited and the date the report was issued to the Rate Setting Unit. As a result of the audits not being timely, the auditors and the nursing facility have to deal with changes in facility staff and the locating of old records. In some cases the facility could be out of business or bankrupt before an audit is even performed.

Of 361 audit requests submitted by the DHSS Rate Setting Unit from fiscal years 1995 through 1997, only 165 were scheduled for audit by the DHS Office of Auditing. An additional review of a five year period determined that approximately 100 nursing facilities were not even included in the audit plan. Approximately 250 of the 320 medicaid nursing facilities were not audited each year.

As of May 1998, the DHSS, in conjunction with the DHS Office of Auditing, contracted with a public accounting firm to conduct nursing facility audits. It appears the effectiveness of the audit process will be further reduced because of the limited audit scope of the contracted audits. The contract proposal specifies
approximately 50 hours of audit work at each facility, which is substantially less than audits previously done by DHS. The contract has just begun, but preliminary reports indicate little in the way of questioned costs. In addition, the audits will not examine reimbursement claims. We believe the scope of the audits should be expanded.

When an audit is completed, it is sent to the Rate Setting Unit to determine if the audit findings will result in a reduction of the facility’s per diem rate. Our review found that the rate recalculation process is often not timely. Of the 341 audits issued from fiscal years 1992 through 1998, only half have had the rates recalculated and been forwarded to the recovery unit. Each audit awaiting rate recalculation could result in an average recovery of $60,000. Considering the potential cost recoveries, eliminating the backlog should be a priority.

The auditing of nursing facilities on a more timely basis followed by a quick rate recalculation process could increase the recovery of Medicaid funds and reduce the amount of incorrect disbursements by identifying errors sooner.
Post audits of nursing facility claims should be performed.

Monitoring of Claim Payments

The DHSS contracts with a service provider to process and reimburse nursing facilities for $1 billion in claims annually. The service provider uses the per diem rates established by DHSS and resident days reported by the nursing facilities to calculate the monthly payments. Resident days are a critical element of the payment amount; however, there was no policy to audit or investigate the claims for accuracy. Although there are some edits applied by the automated payment system when the claims are processed, errors may still not be detected. Even though the payment system generated Surveillance Utilization Reports which identified abnormal activity, the reports were not being forwarded to the division. Without adequate monitoring or an independent review of the claims information, there is no assurance that payments are proper.

The reimbursement of nursing facility claims is based on the premise that the information submitted by the nursing facility is accurate and has been properly certified by the facility administrator. During our testing, we noted that information appearing on claims submitted for payment may not be accurate and the errors may not be detected. For example, an analysis of claims during fiscal years 1997 and 1998 found that nursing facilities had submitted claims for services provided to 349 residents subsequent to their death. These reimbursements to 145 different facilities totaled $430,000 and represented billings for periods from one day to six months post mortem. Other services such as prescription drugs and therapy were also submitted and paid. In one case, 44 prescription drug charges totaling $2,649 were billed during a five month period after the resident’s death. Such incorrect reimbursements may continue for extended periods if nursing facilities do not notify the County Welfare Offices of the residents’ deaths immediately and/or the change in the resident’s status is not updated on the claims payment system in a timely manner.

In response to our findings, the division has established a procedure to match claims against the Bureau of Vital Statistics’ deceased files. We further recommend
that DHSS initiate action to recover the $430,000 overpayments.

During our visits to eight nursing facilities, we reviewed the facilities’ records which supported their claims for one month. We noted that five nursing facilities had physical, occupational or speech therapy services reported on their billing documents. Four of these five billings could not be supported by their nursing records. We further noted that five of the eight nursing facilities reported 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. The division was aware of problems with the reporting of acuities. During 1998, the professional nursing staff performed clinical reviews of 155 facilities and found that 154 facilities had reported acuities inaccurately. Even though not all of the inaccuracies resulted in overpayments, the study did underline the need for reviews.

In addition, we found a facility that routinely predated residents’ admission dates to increase reimbursement and another facility that was not reporting residents’ hospital or therapeutic leave. When a resident leaves a nursing facility and is admitted to a hospital, Medicaid reimbursement to hold the resident’s bed is 90 percent of the per diem up to 10 days per month. After the 10 days, there is no reimbursement. For therapeutic leave (home visit) the facility is only reimbursed for 24 days per year. By not reporting leave, the facility was overreimbursed.

It should be noted that the above exceptions were not detected by the current monitoring system and all resulted in incorrect payments to the facilities.

Some of the errors will directly impact the monthly claims and they will all impact future per diem rate calculations. Therefore, the audit scope should include claims submitted by nursing facilities.
Cost Recoveries

Efforts to recover overpayments should be increased.

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’ costs reports and are subsequently determined to result in a reduction in the facility’s per diem reimbursement rate. The Cost Recovery Unit has not been successful in recovering overpayments in a timely manner. The 145 current receivables have been open for an average of 5.5 years and some date back to 1986. Of the original $15.9 million due for these receivables, only $1.5 million or 9.3 percent has been collected leaving the uncollected balance of $14.4 million. This amount did not include 164 audits awaiting rate recalculation which were discussed in our comments on the audit process. Collections during 1995 to 1997 averaged $1.2 million annually.

The Cost Recovery Unit was unable to provide us with a total of the accounts receivable and related collection activity. Furthermore, the case tracking and monitoring system did not produce reports necessary for management to monitor collection results and assess collection efforts. Such reports are important because management was not generally involved in the recovery process on a day to day basis. In addition, there were no written policies or procedures for the processing and handling of recoveries.

Factors contributing to the inability of the Cost Recovery Unit to adequately recover overpayments include long delays before the overpayments were determined and sent for recovery processing.

We reviewed 38 cases to assess the timeliness of the audit and rate recalculation process. From the end of an audit period to the time the Cost Recovery Unit received a case for collection averaged five years. These time delays impacted on the unit’s ability to collect. For example, during a six year period approximately $4.5 million in overpayments could not be recovered because nursing facilities had changed ownership or gone out of business.
Nursing facility appeals of overpayment assessments result in negotiations with the facility and a possible hearing by an administrative law judge. Our review of the settlement process found that even though settlements or other adjustments of the original assessments are normal occurrences in the recovery process there were no written policies or procedures for the processing and authorizing of settlement agreements. To illustrate the impact of the negotiation process, an analysis of 51 cases closed during fiscal years 1997 and 1998 found that they averaged 2.3 years from the date received by the Cost Recovery Unit to the closed date. In addition, the original overpayments totaling $4.6 million resulted in $2.8 million in collections. The remaining $1.8 million (40 percent) was not collected due to settlements or other adjustments.

An extreme example involved an overpayment of $380,000 for the fiscal years ending 1978 through 1982. The case was eventually settled for $50,000 which was subsequently received in 25 monthly installments of $2,000. It was finally closed in January 1998, sixteen years after the payment period.

Even though the unit has the ability to withhold payments from vendors who are paid monthly, it will normally only withhold payment with the consent of the facility. Even when the unit does withhold payment, it is a time consuming process, since the unit must initiate the withholding each month because the information system is unable to automatically withhold set amounts.

During the course of the audit, the DHSS took action to improve the collection process. Agency proposals related to administrative hearings and the transfer of licenses were discussed in our recommendations.
Current Medicare rates should be used to determine co-payments.

**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 review noted that the division reimbursed nursing facilities utilizing incorrect Medicare per diem rates. The per diem rate and co-payment are determined by Medicare annually. The division did not have current Medicare rates for all nursing facilities because it relied on nursing facilities to inform them of the rate, rather than obtaining them directly from Medicare. If a facility did not provide the new effective rate, the division continued using the old, normally lower, Medicare rate to calculate the co-payment. As a result, the state has been overpaying nursing facilities for years. We identified overpayments of $955,000 to 17 nursing facilities during 1996 and 1997. These overpayments were based on a review of facilities who received significant co-payments, and it is not the entire amount of overpayments.

Upon being made aware of the problem, the DHSS obtained the current effective rates directly from the third party fiscal agents for Medicare and updated the payment file. It is also implementing new procedures to obtain future nursing facility Medicare rates from the claim’s remittance advice which contains the rate Medicare actually uses to make its claim payments.
Periodic reassessments of residents should be performed.

Reassessment of Care Needs

The Office of Long Term Care Options (Office) is responsible for the initial assessment of care needs and authorizing placement of Medicaid eligible individuals in three tracks of care (1) long-term nursing facility placement, (2) short-term nursing facility placement and (3) community or alternative placement. During 1996 and 1997, the Office performed 26,220 and 24,201 initial assessments, respectively. Approximately 90 percent were approved for nursing facility placement.

Once residents are classified as requiring a long-term placement, they are not periodically monitored for changes in care needs. Because of limited staffing resources, the current policy is to periodically reassess only residents that were assigned short-term placements and community or alternative placements. The Office will perform reassessments if requested by the facilities, family members and/or residents.

N.J.A.C. 10:63-1.11 states that the Office is also responsible for oversight of nursing facilities care to assure timely and appropriate responses to changes in the care needs of residents. Periodically reassessing all nursing facility residents will ensure that a resident receives the appropriate level of care and is considered for alternatives such as home or community based programs. Both the resident and the state could benefit. The resident could be moved to a better quality of life situation and a cost savings may be realized by the state. The combination of a continually shrinking Medicaid budget and growing elderly population has created a need for the department to move toward community based programs.