Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW JERSEY DID NOT ENSURE THAT ITS MANAGED CARE ORGANIZATIONS ADEQUATELY ASSESSED AND COVERED MEDICAID BENEFICIARIES' NEEDS FOR LONG-TERM SERVICES AND SUPPORTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Christi A. Grimm
Principal
Deputy Inspector General

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Office of Inspector General

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Report in Brief
Date: June 2020
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

New Jersey Did Not Ensure That Its Managed Care Organizations Adequately Assessed and Covered Medicaid Beneficiaries' Needs for Long-Term Services and Supports

Why OIG Did This Audit

New Jersey pays managed care organizations (MCOs) to make managed long-term services and supports (MLTSS) available to Medicaid beneficiaries in home and community-based settings. Recent OIG audits of Medicaid home and community-based and managed long-term-care services identified significant vulnerabilities. Therefore, we decided to audit payments in New Jersey for the provision of similar Medicaid services.

Our objective was to determine whether New Jersey ensured that its MCOs complied with Federal and State requirements for beneficiaries enrolled in its Medicaid MLTSS program.

How OIG Did This Audit

Our audit covered 305,539 monthly capitation payments made to 5 MCOs during calendar year (CY) 2016 for beneficiaries enrolled in the MLTSS program who resided in home and community-based settings and for which New Jersey claimed Medicaid reimbursement totaling $1 billion ($521 million Federal share). We reviewed a random sample of 100 payments and consulted with a Centers for Medicare & Medicaid Services physician to determine whether the beneficiaries received adequate service planning and care management.

What OIG Found

New Jersey did not ensure that its MCOs complied with certain Federal and State requirements for beneficiaries enrolled in its Medicaid MLTSS program. For 68 of the 100 monthly capitation payments in our random sample, MCOs did not comply with the requirements to adequately assess and cover the associated beneficiaries' needs for long-term services and supports. Specifically, MCOs did not comply with requirements for (1) providing adequate service planning and care management to the beneficiaries and (2) conducting and documenting assessments; and developing, reviewing, and updating beneficiaries' care plans. These deficiencies occurred because New Jersey did not adequately monitor MCOs for compliance with certain Federal and State requirements.

MCOs' failure to meet contract requirements for adequately assessing and covering beneficiaries' needs for long-term services and supports could have resulted in beneficiaries not getting the services that they needed and may have put their health and safety at risk. On the basis of our sample results, we estimated that New Jersey made monthly payments totaling approximately $386 million (Federal share) to MCOs that did not comply with certain Federal and State requirements.

What OIG Recommends and New Jersey Comments

We recommend that New Jersey improve its monitoring and follow-up activities to ensure that its MCOs comply with Federal and State requirements detailed in its contracts with the MCOs; and take actions, including imposing corrective action plans, fines, or other financial disincentives on MCOs, to address the MCOs' noncompliance affecting $721 million ($386 million Federal share) in capitation payments in CY 2016 and ensure future compliance with contract requirements.

New Jersey partially concurred with our recommendations and described steps it has taken or plans to take to improve its oversight of its Medicaid MLTSS program. We maintain that our recommendations are valid. We recognize New Jersey's efforts to improve its monitoring of the MLTSS program; however, we determined that New Jersey's monitoring during our audit period was not adequate.

The full report can be found at https://oig.hhs.gov/oas/reports/region2/21701018.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

New Jersey pays managed care organizations (MCOs) fixed monthly payments (monthly capitation payments) to make managed long-term services and supports (MTLSS) available to Medicaid beneficiaries in home and community-based settings. Recent Office of Inspector General (OIG) audits of home and community-based services in New York have identified significant areas of noncompliance with Federal and State requirements. In addition, a recent OIG audit of managed long-term-care services in New York identified significant program vulnerabilities.[1] Therefore, we decided to audit payments made to MCOs in New Jersey for the provision of similar services.

OBJECTIVE

Our objective was to determine whether the New Jersey Department of Human Services (State agency) ensured that its MCOs complied with Federal and State requirements for beneficiaries enrolled in its Medicaid MLTSS program.

BACKGROUND

Medicaid Program

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

New Jersey's Medicaid Managed Long-Term Services and Supports Program

Under New Jersey's Medicaid managed care program, MCOs that agree to the terms of the State agency's CMS-approved MCO contract (MCO contract) receive monthly capitation payments to make comprehensive healthcare services available to beneficiaries. For beneficiaries in need of long-term care, including long-term services and supports, the State agency attributed a portion of the monthly capitation payment for the provision of such services. MLTSS for beneficiaries in home and community-based settings (e.g., private residences, group homes, and assisted living facilities) may include personal care, respite care, care management, home and vehicle modifications, home-delivered meals, and personal emergency response system services.

[1] *New York State Improperly Claimed Medicaid Reimbursement for Some Managed Long-Term Care Payments* (A-02-15-01026), September 2017.

New Jersey issued guidance to MCOs and worked with its external quality review organization to conduct mandatory external quality reviews of MCOs, outlined in 42 CFR § 438.358, including annual assessments. Although the MCO contract does not include provisions that allow the State agency to recover capitation payments when the MCOs do not comply with certain contract requirements, the State agency may choose to impose liquidated damages (fines) if MCOs do not provide or perform the requirements stipulated in the contract (Article 7.16 of the MCO contract).[2]

During calendar year (CY) 2016, New Jersey made monthly capitation payments totaling $1 billion ($521 million Federal share) to five MCOs throughout the State for beneficiaries who received MLTSS and resided in home and community-based settings (i.e., settings other than nursing homes).[3, 4]

Requirements for Managed Long-Term Services and Supports Providers

States seeking Federal reimbursement for Medicaid services provided through a managed care model must receive prior approval from CMS for their contracts with MCOs. In New Jersey, the "Special Terms and Conditions" of the State's section 1115(a) Medicaid demonstration waiver and the MCO contract establish the requirements for documenting and delivering MLTSS services.

To be eligible for MLTSS, beneficiaries must qualify for a nursing home level of care (Article 9.6.1 of the MCO contract) but may reside in settings other than a nursing home. MCOs are required to use what is known as the "NJ Choice Assessment System" to determine a

[2] We note that the MCO contract does allow the State agency to withhold capitation payments when MCOs do not perform one or more medically necessary covered contract services. Under the contract, the State agency has the right to withhold a portion the MCOs' capitation payments for the following month or subsequent months ((Article 7.16.1.I of the MCO contract).

[3] Specifically, this figure comprises payments claimed under Medicaid capitation code 79399 (payments on behalf of beneficiaries who are eligible for both Medicare and Medicaid) and capitation code 89399 (payments on behalf of beneficiaries who are eligible only for Medicaid) that were final action payments in CY 2016. Under a separate capitation code, MCOs may receive monthly capitation payments to make long-term services and supports available to beneficiaries who reside in institutions.

[4] Of this amount, New Jersey attributed approximately $708 million ($364 million Federal share) for the provision of MLTSS for these beneficiaries. This figure represents both the medical expenses and care management portions of monthly capitation payments for the provision of MLTSS for beneficiaries residing in home and community-based settings.

beneficiary's eligibility[5] and his or her required level of care[6] and develop a written care plan based on the assessment system data.[7] For MLTSS beneficiaries who are determined as eligible for personal care services, a personal care assistant (PCA) nursing assessment tool serves as the basis for the number of PCA hours prescribed in the beneficiary's care plan. PCA nursing assessments must be performed by a registered nurse "at the start of service" and reassessments must be performed at least once every 6 months or more frequently if the beneficiary's condition warrants (New Jersey Administrative Code (NJAC) 10:60-3.5(a)(3)).

MCOs are also required to reassess each beneficiary's clinical eligibility annually[8] or when there is a significant change in the beneficiary's condition.[9] For beneficiaries residing in a community setting (e.g., a group home), care managers are required to review the beneficiary's placement and services onsite[10] and update the care plan (including a backup plan[11]) at least every 90 calendar days (Article 9.6.5.B.2 of the MCO contract).

MCOs are also required to provide beneficiaries with person-centered, goal-oriented, and culturally relevant service planning[12] and intensive care management,[13] including monitoring and reassessment of services based on changes in the beneficiary's condition and assessing and determining the need for services prescribed in the care plan (Article 9.6 of the MCO contract).

For details on Federal and State requirements related to MLTSS services, see Appendix B.

[5] The eligibility assessments must be performed by care managers who have been trained and certified by the State agency to conduct the assessments and receive training every 3 years (Article 9.2.3.C through E of the MCO contract).

[6] Article 9.6.1.B of the MCO contract.

[7] Article 9.6.3.C.1 of the MCO contract.

[8] Annual reassessments must be conducted 11 to 13 months from the prior NJ Choice assessment.

[9] Article 9.6.1.E of the MCO contract.

[10] During our audit period, the MCO contract required that all visits be face-to-face with at least two visits occurring in the beneficiary's place of residence.

[11] Backup plans are required to ensure that needed assistance will be provided if services and supports identified in the care plan are temporarily unavailable.

[12] Service planning ensures that beneficiaries receive services to meet their identified care needs in a supportive, effective, efficient, timely, and cost-effective manner.

[13] Care management should emphasize prevention, health promotion, and continuity and coordination of care, and it should advocate for and link beneficiaries to services as necessary across providers and settings.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 305,539 monthly capitation payments New Jersey made to 5 MCOs during CY 2016 for beneficiaries who received MLTSS and resided in home and community-based settings and for which the State agency claimed Medicaid reimbursement totaling approximately $1 billion ($521 million Federal share). We reviewed a random sample of 100 of these capitation payments for compliance with the requirements of the MCO contract. Our review included consulting with a CMS physician who reviewed the medical records for the 100 beneficiaries associated with the sampled payments to determine whether the beneficiaries received adequate person-centered service planning and care management during CY 2016.

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

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

FINDINGS

The State agency did not ensure that its MCOs complied with certain Federal and State requirements for beneficiaries enrolled in its Medicaid MLTSS program. Specifically, for 68 of the 100 monthly capitation payments in our random sample, MCOs did not comply with contract requirements to adequately assess and cover the associated beneficiaries' needs for long-term services and supports. For 64 of these payments, MCOs did not provide adequate service planning and care management to the beneficiaries. In addition, for 27 monthly capitation payments, MCOs did not comply with contract requirements for conducting and documenting assessments; and for developing, reviewing and updating beneficiaries' care plans.[14] MCOs complied with contract requirements for the remaining 32 monthly capitation payments.

MCOs' failure to meet contract requirements for adequately assessing and covering beneficiaries' needs for long-term services and supports could have resulted in beneficiaries not getting the services that they needed and may have put their health and safety at risk. On the basis of our sample results, we estimated that the State agency made monthly capitation

[14] The total number of payments exceeds 68 because 23 payments contained both deficiencies.

payments to MCOs totaling $721 million ($386 million Federal share)[15] during CY 2016 that did not comply with certain Federal and State requirements.[16]

MANAGED CARE ORGANIZATIONS DID NOT PROVIDE ADEQUATE SERVICE PLANNING AND CARE MANAGEMENT

For 64 of the 100 sampled monthly capitation payments, the State agency did not ensure that MCOs provided adequate service planning and care management for the associated beneficiaries. Specifically, the CMS physician found that the beneficiaries' MCOs did not comply with contract requirements for either person-centered service planning or care management or both.[17] Additionally, for seven other beneficiaries associated with our sampled payments, the physician could not determine whether the MCOs complied with these contract requirements because the beneficiaries' case files did not contain adequate information for the physician to make a determination.[18]

These deficiencies in service planning and care management occurred because the State agency did not adequately follow up on findings from its external quality reviews related to ensuring that (1) services were provided according to a care plan that was personalized and based on beneficiaries' assessed needs and (2) beneficiaries' physical health, behavioral health, and long-term-care needs were actively coordinated.[19]

Managed Care Organizations Did Not Provide Person-Centered Service Planning

MCOs are contractually required to provide beneficiaries with person-centered,[20] goal-oriented, and culturally relevant service planning. This ensures that beneficiaries receive

[15] Refer to Appendix D for the details of the estimate.

[16] Noncompliance with Federal and State requirements does not mean that the capitation payments were unallowable. We estimated total capitation payments that were associated with the noncompliance.

[17] Forty-three beneficiaries did not receive adequate service planning and 60 beneficiaries did not receive adequate care management. Thirty-nine of these beneficiaries did not receive either adequate service planning or care management.

[18] The CMS physician found that 29 of the 100 beneficiaries' MCOs complied with contract requirements for person-centered service planning and care management.

[19] According to a report by the State agency's external quality review organization covering July 2015 through June 2016, approximately 97 percent of MCOs' care plans were aligned with member needs; however, only about 45 percent of the plans were developed using person-centered principles. Additionally, MCOs' compliance with ongoing care management requirements averaged approximately 55 percent.

[20] Article 1 of the MCO contract defines person-centered planning as a "[p]lanning process which looks at the person's needs, strengths and preferences around services and desired outcomes."

services to meet their identified care needs in a supportive, effective, efficient, timely, and cost-effective manner.[21]

For 43 beneficiaries, the MCO did not establish and implement care plans that adequately addressed the beneficiary's medical and psychosocial needs. Specifically, the CMS physician found that the care plans were non-individualized, included only the most basic set of services (e.g., personal care assistance, transportation, durable medical equipment), and omitted covered services that would have benefited the beneficiary (e.g., physical and occupational therapy, rehabilitation services).

The CMS physician found that for some of these beneficiaries, the MCO did not conduct person-centered service planning to adequately address beneficiaries' diagnoses, including cancer, obesity, memory or visual impairment, and mental illness; fall prevention; additional covered services that would benefit the beneficiaries; or special needs (e.g., dialysis treatment). For example:

- For nine beneficiaries, the MCO did not provide service planning to address the beneficiary's diagnoses (e.g., cancer, obesity, dementia, blindness, or depression) or need for a mental health evaluation.

- For seven beneficiaries, the MCO did not provide service planning to address and prevent the at-risk beneficiary from falling in his or her home.

- For four beneficiaries, the MCO did not provide service planning to address additional covered services that would benefit the beneficiary (e.g., physical and occupational therapy and vision and dental services).

- For four beneficiaries diagnosed with end-stage renal disease, the MCO did not provide service planning that considered the beneficiaries' special needs, including emergency preparedness information and contingency plans for emergency dialysis.

Managed Care Organizations Did Not Provide Adequate Care Management

MCOs are contractually required to provide beneficiaries with intensive care management. This should emphasize prevention, health promotion, continuity and coordination of care, and advocate for and link beneficiaries to services.[22]

[21] Articles 9.5.1.B and 9.6.3 of the MCO contract.

[22] Articles 9.5.1.B and 9.6 of the MCO contract.

For 60 beneficiaries, the MCO did not provide adequate care management (i.e., referrals and coordination of necessary medical services). Specifically, the CMS physician found that MCOs documented beneficiaries' needs for covered and noncovered services (e.g., primary care, specialists) but did not follow through with making referrals and coordinating care.[23]

The CMS physician found that for some of these beneficiaries, MCOs did not conduct care management activities to adequately address the needs of beneficiaries that required care coordination, fall prevention, physical therapy, referrals to support psychosocial needs, and primary care. For example:

- For 42 beneficiaries, the MCO did not document communication with the beneficiary's primary care physician or specialists for care coordination or medication reconciliation.

- For seven beneficiaries who had experienced multiple falls in their home or had difficulty walking, the MCO did not make referrals for fall assessments or physical therapy.

- For three beneficiaries, the MCO did not address the beneficiaries' visual impairment by arranging for cataract surgery that would have removed a significant barrier to social engagement.

- For three beneficiaries, the MCO did not address interventions related to the beneficiaries' obesity (e.g., weight-loss interventions or ways to improve mobility) that would have allowed them to gain more independence.

- For one beneficiary who requested a primary care physician, the MCO did not make a timely referral.[24]

MANAGED CARE ORGANIZATIONS DID NOT COMPLY WITH CONTRACT REQUIREMENTS FOR CONDUCTING ASSESSMENTS; AND DEVELOPING, REVIEWING, AND UPDATING CARE PLANS

Of the 100 payments in our random sample, 27 payments did not comply with Federal and State requirements for conducting assessments; and for developing, reviewing, and updating beneficiaries' care plans. Of the 27 payments, 5 contained more than 1 deficiency. Specifically:

- For 20 payments, the MCO did not conduct in a timely manner a PCA nursing reassessment (16 payments), did not document an initial PCA nursing assessment

[23] According to the MCO contract, active coordination helps ensure proper management of beneficiaries' acute and chronic physical health or behavioral health conditions, including covered services that are beyond the scope of the nursing facility services benefit (Article 9.6.4.R of the MCO contract).

[24] The beneficiary initially requested a primary care physician referral in July 2016. She made a subsequent request almost 6 months later, in December 2016—the last month of our audit period.

(2 payments), or did not either perform or document PCA nursing assessments (2 payments).

- For seven payments, the MCO did not conduct in a timely manner eligibility reassessments (four payments) or document an initial eligibility assessment or reassessment (three payments).

- For five payments, the MCO did not develop an initial care plan or document care plan reviews and updates in a timely manner.

The noncompliant capitation payments occurred because the State agency did not adequately monitor MCOs for compliance with certain Federal and State requirements. New Jersey issued guidance to MCOs and worked with its external quality review organization to conduct mandatory external quality reviews.[25] These reviews, however, did not include assessments of MCOs' compliance with contract requirements related to assessing, documenting, and monitoring beneficiaries' service needs based on changes in their condition or assessment data.

Personal Care Assistant Nursing Assessment Requirements Not Met

MCOs are required to monitor, assess, and determine a beneficiary's service needs prescribed in the care plan on the basis of changes in the beneficiary's condition, assessment data, and any other State-mandated tools.[26] State regulations require PCA nursing assessments to be performed by a registered nurse "at the start of service" and reassessments to be performed at least once every 6 months or more frequently if the beneficiary's condition warrants.[27]

For 20 capitation payments, the MCO did not conduct in a timely manner a PCA nursing reassessment, did not document an initial PCA nursing assessment, or did not either perform or document PCA nursing assessments. Specifically:

- For 16 payments, the MCO did not conduct a PCA nursing reassessment within 6 months of the payment period.[28]

[25] The reviews included annual assessments of MCOs' operations, performance measures, quality improvement programs, and other requirements.

[26] Articles 9.6.E and 9.6.3.C.1 of the MCO contract.

[27] NJAC 10:60-3.5(a)(1) and (3).

[28] For nine payments, reassessments were conducted between 104 and 584 days (median of 217 days) after they were due. For the remaining seven payments, between 84 and 430 days (median of 117 days) elapsed after they were due and the MCO had not conducted a reassessment. (We calculated elapsed days by subtracting the first day of the sampled payment month from the assessment due date, i.e., 180 days after the previous assessment.)

- For two payments, the MCO did not document initial PCA nursing assessments before the start of PCA services.[29]

- For two payments, the MCO did not either perform or document PCA nursing assessments.[30]

Eligibility Reassessments Not Conducted in a Timely Manner or Initial Eligibility Assessments or Reassessments Not Documented

MCOs are required to assess beneficiaries' clinical eligibility and level of care[31] and reassess their clinical eligibility annually (i.e., every 11 to 13 months) or when there is a significant change in their condition.[32]

For seven payments, the MCO did not conduct in a timely manner eligibility reassessments or document the beneficiary's initial eligibility assessment or reassessment. Specifically:

- For four payments, the MCO did not conduct the beneficiary's eligibility reassessment within 13 months of the payment period.[33]

- For three payments, the MCO did not document the beneficiary's initial eligibility assessment (one payment) or reassessment (two payments).[34]

[29] For one payment, the initial assessment occurred 35 days after the date of service associated with our sampled payment. For the other payment, the initial assessment occurred 617 days after the date of service associated with our sampled payment.

[30] Specifically, for one payment, the MCO stated that no initial assessment or reassessment was completed. For the remaining payment, no initial assessment or reassessments were maintained in the associated beneficiary's service record.

[31] Article 9.6.1.B of the MCO contract.

[32] Article 9.6.1.E of the MCO contract.

[33] Reassessments were conducted between 201 and 342 days (median of 314 days) after they were due (i.e., 13 months after the previous assessment).

[34] Specifically, for one payment, the initial assessment was performed by the State agency and not provided to the MCO. For another payment, the MCO stated that it could not locate the eligibility reassessment. For the remaining payment, no reassessment was maintained in the associated beneficiary's service record.

Care Plans Not Developed or Reviewed and Updated in a Timely Manner

The MCO must develop a care plan for beneficiaries within 45 calendar days of being notified of their enrollment in the MLTSS program.[35] For beneficiaries residing in a community-based setting, MCO care managers must review the beneficiary's placement and services onsite and update the care plan at least every 90 days.[36]

For five payments, the MCO did not develop an initial care plan or document care plan reviews and updates in a timely manner. Specifically:

- For one payment, the MCO did not develop the initial care plan within 45 days of being notified that the associated beneficiary was enrolled in the MLTSS program.[37]

- For four payments, the MCOs did not document care plan reviews and updates within 90 days of the payment period.[38]

RECOMMENDATIONS

We recommend that the New Jersey Department of Human Services:

- improve its monitoring and follow-up activities to ensure that its MCOs comply with Federal and State requirements detailed in its contracts with the MCOs for providing services to beneficiaries according to personalized care plans and actively coordinating, monitoring, and documenting beneficiaries' physical health, behavioral health, and long-term-care needs; and

- take actions, including imposing corrective action plans, fines, or other financial disincentives on MCOs, to address the MCOs' noncompliance affecting $721 million ($386 million Federal share) in capitation payments in CY 2016 and ensure future compliance with contract requirements.

[35] Article 9.6.1.D of the MCO contract. The State agency provides what is referred to as "enrollment notifications" to MCOs for new MLTSS program enrollees.

[36] Article 9.6.5.B.2 of the MCO contract.

[37] The initial care plan was developed 364 days after the beneficiary was enrolled in the MLTSS program and began receiving services.

[38] For one payment, a subsequent care plan review and update was conducted 131 days after the required timeframe. For the remaining three payments, no subsequent care plan reviews and updates had been conducted 169 to 294 days (median of 240 days) after the associated beneficiary's care plan was initially developed. (We calculated elapsed days by subtracting the date the care plan was initially developed from the first day of the sampled payment month.)

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency partially concurred with our recommendations and described steps it has taken or plans to take to improve its oversight of its Medicaid MLTSS program. The State agency disagreed with our finding that its MLTSS monitoring activities need improvement and asserted that its current monitoring regimen represents efficient use of State resources. The State agency indicated that while its monitoring activities, including several activities implemented after our audit period, have improved over time, it agreed that there is room to improve how it follows up on findings identified during these monitoring activities.

In addition, the State agency agreed that corrective action plans, fines, and other financial disincentives are important tools to improve MCO performance and indicated that it will continue to identify opportunities to use these tools in the future. However, it disagreed with the potential monetary savings identified in our second recommendation. The State agency described OIG's treatment of MCO compliance with contract requirements as an "all or nothing" approach that assumes recoupment of 100 percent of MCOs' capitation payments in every case in which a single service did not comply with contract requirements.

In its response, the State agency also requested that OIG remove references to potential monetary savings in the report title and our second recommendation. The State agency asserted that OIG's audit scope and findings were related to certain components of care management activities that accounted for less than 6 percent of total capitation payments.

Finally, the State agency indicated that it was unable to match our reported totals for both the number and value of capitation payments.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we revised our second recommendation to clarify the magnitude of MCOs' noncompliance. We maintain that our findings and recommendations, as revised, are valid. We recognize the State agency's efforts to improve its monitoring of the MLTSS program; however, we determined that the State agency's monitoring during our audit period was not adequate. Of the 100 capitation payments in our sample, we found that the MCOs did not comply with contract requirements for 68 capitation payments—more than two-thirds of our sampled capitation payments.

The $721 million ($386 million Federal share) for CY 2016 payments identified in our draft report title and second recommendation is the total amount of monthly capitation payments that were affected by at least one instance of MCO noncompliance. It represents the magnitude of noncompliance by MCOs. We revised our second recommendation to clarify this point. Noncompliance means that beneficiaries may not have received comprehensive

healthcare services consistent with the MCO contract because MCOs failed to assess and adequately cover beneficiary needs for long-term service and supports.[39] We are not recommending that the State agency refund this identified amount. As we acknowledged in footnote 16, the noncompliance with Federal and State requirements that we identified does not mean that the capitation payments were unallowable. Rather, we recommend that the State agency use existing remedies it has in its MCO contract to ensure MCO compliance with Federal requirements. The magnitude of noncompliance represented by the identified amount is meant to provide context so that the scope of the problem is well understood. We believe the State agency has sufficient legal basis to use contractual remedies to address MCO noncompliance. In response to the State agency's request, we removed the dollar figure from the report title.

Contrary to the State agency's description of our audit scope, our audit covered *all* components of the capitation payments related to MLTSS: MLTSS medical expenses (e.g., personal care, respite, home-delivered meals, personal emergency response system services) and care management.[40] These components averaged about 67 percent of total capitation payments.[41]

Regarding the State agency's comment that it could not match our reported totals for both the number and value of capitation payments, we believe that our sampling frame fairly represented the capitation payments the State agency made to MCOs during CY 2016 for beneficiaries who received MLTSS in home and community-based settings. We considered all credits and voids that were processed by December 31, 2016. The capitation payments included in our sampling frame were final action payments extracted from New Jersey Medicaid Management Information System (MMIS). After receiving the State agency's comments, we discussed our sampling frame with State agency officials, including how we obtained our data, and provided supporting information for our sampling frame.

[39] We indicate in footnote 4 the amount of total capitation payments that the State agency attributed to the provision of MLTSS.

[40] We also note that our audit methodology included not only the CMS physician's review of beneficiaries' medical records for adequate service planning and care management, but also a review of beneficiaries' case files for eligibility assessments; care plan development, reviews, and updates; and a determination of whether beneficiaries received MLTSS services according to their care plans.

[41] We computed this percentage using the Medicaid managed care capitation rate calculation sheets provided by the State agency for State fiscal years 2015 through 2017.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 305,539 monthly capitation payments totaling $1,006,511,346 ($521,267,794 Federal share) that the State agency made to 5 MCOs during CY 2016 for enrolled beneficiaries who received MLTSS in home and community-based settings.[42] We reviewed a random sample of 100 of these payments and consulted with a CMS physician to determine whether the 100 beneficiaries associated with the sampled payments received adequate person-centered service planning and care management during CY 2016.

Our audit allowed us to establish reasonable assurance of the authenticity of the data obtained from the MMIS fiscal agent for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claim data in the MMIS with the State agency's claims for reimbursement through the Form CMS-64, Quarterly Medicaid Statement of Expenditures.

The scope of our audit did not require us to perform a comprehensive medical review or an evaluation of medical necessity for eligibility and enrollment for MLTSS. We did not assess the State agency's overall internal control structure. Rather, we limited our review of internal controls to those applicable to our objective. We reviewed the MCOs' internal controls for documenting MLTSS services provided to enrolled beneficiaries. We did not assess the appropriateness of MLTSS payment rates.

We performed our fieldwork at the State agency's offices in Trenton, New Jersey, and at MCOs' offices located throughout New Jersey.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements and the MCO contract;
- met with CMS financial and program management officials to gain an understanding of and to obtain information on MLTSS in New Jersey;
- met with State agency officials to discuss the State agency's administration and monitoring of MLTSS;
- interviewed officials at MCOs associated with the sampled payments regarding their MLTSS policies and procedures, including procedures for conducting initial eligibility assessments

[42] Of this amount, approximately $708 million ($364 million Federal share) was attributed for the provision of MLTSS.

and enrolling beneficiaries, preparing written care plans and conducting reassessments, disenrollments, and documenting MLTSS services;

- obtained from New Jersey's MMIS a sampling frame of 305,539 monthly capitation payments made to 5 MCOs totaling $1,006,511,346 ($521,267,794 Federal share) for enrolled beneficiaries who received MLTSS in home and community-based settings and for which the State agency claimed Medicaid reimbursement during CY 2016;[43]

- selected from our sampling frame a simple random sample of 100 capitation payments[44] and for each capitation payment determined whether:

    - the beneficiary was Medicaid-eligible,

    - the beneficiary was enrolled in the MLTSS program,

    - the initial eligibility assessment or reassessment of the beneficiary was conducted within the required timeframe and performed by a qualified individual using an eligibility assessment tool designated by the State agency, and

    - the beneficiary received MLTSS according to his or her care plan;

- estimated the potential Medicaid savings for noncompliant MLTSS capitation payments in the sampling frame of 305,539 monthly capitation payments;

- consulted with a CMS physician who reviewed the medical records for the beneficiaries associated with our sampled payments to determine whether the beneficiaries received adequate person-centered service planning and care management during CY 2016;[45] and

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

Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

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

[43] The original data file contained 305,718 capitation payments made to 5 MCOs totaling $1,006,533,505 ($521,278,873 Federal share) for which the State agency claimed Medicaid reimbursement for enrolled beneficiaries during CY 2016. These were final action payments made in CY 2016. From this file, we removed 179 capitation payments totaling $22,159 ($11,079 Federal share) for which the Federal share was $100 or less.

[44] The random sample consisted of payments made to 5 MCOs for 100 unique beneficiaries.

[45] Specifically, the physician reviewed the beneficiaries' health records maintained by the MCOs, including beneficiary assessments, service planning documents, and care managers' notes.

sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: FEDERAL AND STATE REQUIREMENTS RELATED TO MANAGED LONG-TERM SERVICES AND SUPPORTS

All managed care plans are subject to Federal requirements (§§ 1903(m) and 1932 of the Social Security Act) as implemented in 42 CFR part 438. States seeking Federal Medicaid reimbursement for services provided through a managed care model must receive prior approval from CMS for their MCO contracts (42 CFR § 438.806).

The Special Terms and Conditions for New Jersey's Medicaid section 1115(a) demonstration "Comprehensive Waiver" and the MCO contract establish the requirements for documentation and delivery of MLTSS, including eligibility assessments, service planning, and care management.

To be eligible to enroll for MLTSS, applicants must meet financial and clinical requirements for Medicaid (Article 9.4.1.A.1 of the MCO contract) and qualify for nursing home level of care (clinical requirement) (Article 9.6.1 of the MCO contract).

MCOs are required to use the NJ Choice Assessment System to determine an applicant's clinical eligibility and level of care for MLTSS enrollment (Article 9.6.1.B of the MCO contract). This assessment must be performed by individuals (i.e., care managers) who have been trained and certified by the State agency to conduct NJ Choice assessments[46] and be either (1) a licensed clinical or certified social worker; (2) a licensed, registered nurse; or (3) a graduate from an accredited college or university with a bachelor's degree, or higher, in a health-related or behavioral service field, with a minimum of 1 year paid professional experience working with and assessing the needs of the elderly or physically disabled in an institutional or community setting (Articles 9.2.3.E and 9.5.2.A of the MCO contract).

For current managed care enrollees, an initial assessment must be conducted by the MCO within 30 days of the time a referral is received from a provider (Article 9.6.1.C of the MCO contract). For new enrollees, the MCO is responsible for obtaining or conducting an initial assessment, completing an initial face-to-face visit,[47] and developing an individualized plan of care within 45 calendar days of enrollment notification (Article 9.6.1.D of the MCO contract).[48]

[46] Care managers should receive from the State a certificate of completion for NJ Choice assessment training every 3 years (Article 9.2.3.C of the MCO contract). Before January 1, 2016, certifications were provided annually (Article 9.2.3.C of the July 2015 contract).

[47] Before January 1, 2016, the initial face-to-face visit for new enrollees was required to be completed within 10 business days of receipt of the State agency's Office of Community Choice Options' (OCCO's) assessment status notification (Article 9.6.2.A of the July 2015 contract).

[48] Before January 1, 2016, the plan of care was required to be developed within 30 calendar days of the effective date of enrollment into the MLTSS program.

MCOs must reassess the enrollee's clinical eligibility annually[49] or when there is a significant change in the enrollee's condition (Article 9.6.1.E of the MCO contract).

For members residing in a community setting, care managers must review member placement and services onsite[50] and update the plan of care at least every 90 calendar days (Article 9.6.5.B.2 of the MCO contract). In addition, care managers must also develop a "back-up plan for members [residing in community settings] to assure [sic] that needed assistance will be provided in the event that services and supports identified in the plan of care are temporarily unavailable and allow the member to remain in their home." Care managers must review the back-up plan with the enrollee at least quarterly (Article 9.6.4.M of the MCO contract).[51]

MCOs are also required to provide beneficiaries with person-centered, goal-oriented, and culturally relevant service planning[52] (Article 9.6.4 of the MCO contract) and care management[53] (Article 9.6 of the MCO contract).

[49] Annual reassessments must be conducted 11 to 13 months from the last NJ Choice assessment authorized by OCCO.

[50] All visits must be face-to-face with at least two visits occurring within the member's place of residence.

[51] For members residing in a community alternative residential setting (e.g., assisted living residence, adult family care, community residential services), care managers must review member placement and services onsite and update the plan of care at least every 180 calendar days (Article 9.6.5.B.1 of the MCO contract). Care managers are not responsible for completing backup plans for these individuals (Article 9.6.4.M.2 of the MCO contract).

[52] Service planning ensures that members receive services to meet their identified care needs in a supportive, effective, efficient, timely, and cost-effective manner.

[53] Care management should emphasize prevention, health promotion, and continuity and coordination of care and advocate for and link members to services as necessary across providers and settings.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our target for this audit was capitation payments made to MCOs on behalf of beneficiaries who received MLTSS in home and community-based settings during CY 2016 and for which the State agency claimed Medicaid reimbursement.

The sampling frame was an Access file containing 305,539 capitation payments made to 5 MCOs for enrolled beneficiaries totaling $1,006,511,346 ($521,267,794 Federal share) on behalf of beneficiaries who received MLTSS in home and community-based settings during CY 2016 and for which the State agency claimed Medicaid reimbursement. The sampling frame did not include 179 capitation payments totaling $22,159 ($11,079 Federal share) for which the Federal share of payments was $100 or less. The data for capitation payments were extracted from the New Jersey MMIS.

SAMPLE UNIT

The sample unit was a capitation payment.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 capitation payments.

SOURCE OF THE RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample items in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the noncompliant payments for both the total Medicaid dollars and Federal share. We also used the program to calculate the lower and upper limits for a 90-percent confidence interval.[54]

[54] Our estimates are based on total capitation amounts for the noncompliant payments.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Details and Results for Noncompliant Managed Long-Term Services and Supports Payments (Medicaid Dollars)

No. of Capitation Payments in Frame	Value of Frame	Sample Size	Value of Sample	No. of Noncompliant Payments	Value of MLTSS Noncompliant Payments
305,539	$1,006,511,346	100	$347,482	68	$236,007

Table 2: Estimated Value of Noncompliant Payments (Medicaid Dollars)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$721,092,878
Lower limit	605,129,690
Upper limit	837,056,066

Table 3: Sample Details and Results for Noncompliant Managed Long-Term Services and Supports Payments (Federal Share)

No. of Capitation Payments in Frame	Value of Frame	Sample Size	Value of Sample	No. of Noncompliant Payments	Value of MLTSS Noncompliant Payments
305,539	$521,267,794	100	$189,838	68	$126,291

Table 4: Estimated Value of Noncompliant Payments (Federal Share)
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$385,867,495
Lower limit	311,616,869
Upper limit	460,118,121

APPENDIX E: STATE AGENCY COMMENTS

State of New Jersey
Department of Human Services
P.O. BOX 700
TRENTON NJ 08625-0700

PHILIP D. MURPHY
Governor

Sheila Y. Oliver
Lt. Governor

Carole Johnson
Commissioner

February 7, 2020

Brenda M. Tierney
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region II
Jacob K. Javitis Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Dear Ms. Tierney:

The New Jersey Department of Human Services (the Department) is in receipt of the draft audit report issued by the Office of Inspector General (OIG) entitled "*New Jersey Did Not Ensure That Its Managed Care Organizations Adequately Assessed and Covered Medicaid Beneficiaries' Needs for Long-Term Services and Supports for Which They Received Monthly Capitation Payments Totaling $386 Million*" for the period of calendar year 2016. Thank you for the opportunity to respond to the draft report.

OIG Summary Recommendation

"We recommend that New Jersey improve its monitoring and followup activities to ensure that its MCOs comply with Federal and State requirements detailed in its contracts with the MCOs; and consider actions, including imposing corrective action plans, fines, or other financial disincentives on MCOs, to ensure future compliance with contract requirements, which could have saved the Medicaid program up to $721 million ($386 million Federal share) for CY 2016."

Response

We provide a more detailed response to OIG's draft findings below. However, before addressing these points, we note that we are unable to match the draft report's totals for both the number of capitation payments as well as the value of capitation payments, which the report states were in excess of $1 billion. Our records indicate that capitation payments made on behalf of MLTSS non-institutional members totaled approximately $720 million. We would welcome the opportunity to further discuss this point with OIG and attempt to resolve this apparent disparity.

Apart from the total dollar amount at issue, we strongly non-concur with the underlying logic of OIG's suggestion that its recommended actions "could have saved the Medicaid program up to

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$721 million ($386 million Federal share) for CY 2016." This amount equals the full payment for all medical and long-term care services for community-based enrollees, despite the fact that the OIG draft report is clear in its audit methodology that it reviewed only service planning and care management. Similarly, we strongly object to the title of the draft report, which references the $386 million federal share figure. These estimates are wholly unsupported by the draft report.

The $721 million figure represents OIG's calculation of all capitation payments made to the MCOs for community-based MLTSS members for whom OIG claims there was at least one instance of MCO non-compliance. These capitation payments include funding for not only MLTSS services, but medical and administrative costs as well. In order to arrive at the draft's claim that "up to $721 million" could have been saved, one must conclude that *all* of these resources were expended for non-compliant services despite the draft report making no such claim. The draft findings relate to certain components of care management activities and documentation. The whole of care management activities, including the select components at issue and various others, account for less than 6% of the capitation payments. The vast majority of expenditures on MLTSS during the study period represent payments made by MCOs to service providers.

Given that the OIG draft findings relate to select components of the MCO care management activities provided through the 6% portion of the caption payment, we doubt that OIG means to conclude that all other payments to providers for adult day care, nursing home services, assisted living programs, personal care assistance and other services provided to our MLTSS members were categorically inappropriate. However, the draft headline and recommendations imply exactly that.

OIG's logic is particularly confusing given that the majority of examples cited in the draft report represent cases where OIG believes that members did not receive needed services (which we question and are reviewing in detail). While limited, short-term savings can be achieved through fines or liquidated damages related to contract performance, these accountability tools are ultimately intended to modify MCO behavior and changes that increase services would ultimately be reflected in increased cost trend and capitation payment, not generate long-term savings.

New Jersey's MLTSS program is designed to ensure that people get all of the appropriate services they need through a person-centered approach – and even in its early days (the report reflects 2016 performance) represented a significant improvement in our system of care for people who need help with activities of daily living. OIG's characterization of MLTSS expenditures is misleading, innovation stifling, and contradictory to the practical reality of the MLTSS program. Prior to the publication of the audit report, New Jersey requests a substantial revision to the headline and executive summary to revise this misleading characterization. We ask that OIG remove the dollar amount reference from the title and modify the main recommendation wording, to remove the up to $721 million ($386 million Federal share) for CY 2016 in savings because these points are factually incorrect and misleading. Also, OIG suggests that they undertook this audit because of findings in a recent New York State (Report No. A-02-15-01026) report. We note that OIG did not include dollar figures in the title of that report.

OIG Recommendation

"We recommend that the [Department]... improve its monitoring and followup activities to ensure that its MCOs comply with Federal and State requirements detailed in its contracts with the MCOs for providing services to beneficiaries according to personalized care plans and actively coordinating, monitoring, and documenting beneficiaries' physical health, behavioral health, and long-term care needs."

Response

1. **The Department non-concurs with OIG's finding that MLTSS monitoring activities are in need of improvement. Below, we detail the robust monitoring activities and improvements already in place.**

Each of the contract requirements discussed in the draft report is identified in the table below, along with a description of existing monitoring activities related to the requirement. We note that several of the existing activities listed in the table below were not in place during the audit period, but have been instituted since.

Requirement	Existing Monitoring Activities
MCOs must establish on a timely basis person-centered care plans for each beneficiary that address beneficiaries' medical and psychosocial needs.	New Jersey's external quality review organization (EQRO) conducts annual care management audits by reviewing a stratified sample of case files of MLTSS members who reside in the community. From this sampling, MCOs are assessed on the following performance measures: • Performance Measure 8: Initial plan of care established within 45 calendar days of enrollment into MLTSS/HCBS • Performance Measure 10: Plans of care are aligned with members' needs based on the results of the NJ Choice Assessment • Performance Measure 11: Plans of care developed using "person-centered principles" Initial Plans of Care including Back-Up Plans are reviewed during the audit to include: • Documentation to reflect a member-centric approach demonstrating involvement of the member in the development and modification of agreed-upon goals • Member given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the plan of care

MCOs must update care plans in accordance with timelines specified in their contract	As noted above, New Jersey's EQRO conducts annual care management audits. From this sampling, MCOs are assessed on the following performance measure: Performance Measure 9: Plan of Care reviewed annually within 30 days of Members anniversary and as necessary
MCOs must provide beneficiaries with intensive care management, including referrals and coordination.	As noted above, New Jersey's EQRO conducts annual care management audits. During these audits, in addition to assessing performance on the measures described above, the EQRO also assesses MCOs' care management processes more broadly, using a structured audit tool. This tool assesses MCO compliance with care management contract requirements along the following dimensions: ▪ Assessment; ▪ Outreach; ▪ Face-to-Face Visits; ▪ Initial Plan of Care; ▪ Ongoing Care Management; and ▪ Gaps in Care/Critical Incidents Documentation MCOs must also provide evidence that they have implemented an internal MLTSS monitoring program.
MCOs must reassess on a timely basis beneficiaries' needs for personal care assistance (PCA) services.	New Jersey integrates MCOs' compliance with PCA requirements into the broader EQRO care management audit activities described above. These include: ▪ Performance Measure 10: Plans of care are aligned with members' needs based on the results of the NJ Choice Assessment. This includes assessment of member needs for PCA, and CNA services, including in type, scope, amount, and frequency ▪ Assessment of MCOs' ongoing care management activities, with the expectation that if there is a significant change in member condition, the member's Plan of Care should be amended, including with respect to PCA. ▪ Performance Measure 13: MLTSS HCBS services are delivered in accordance with the Plan of Care including the type, scope, amount, frequency, and duration. MLTSS HCBS Services that are assessed include PCA.
MCOs must conduct timely assessments and reassessments of clinical eligibility for MLTSS	The Division of Aging Services compiles quarterly reports on the timeliness of clinical assessments. Such reports identify all overdue assessments, the source of the delay, requires corrective action and outcomes for each overdue assessment.

The monitoring regimen described above is robust, has evolved substantially over the course of the program, and represents efficient use of limited State resources. While we are always looking for additional opportunities for improvement and may introduce additional or modified monitoring, we do not believe that existing monitoring efforts could be reasonably characterized as inadequate or insufficient.

2. **The Department concurs with OIG's finding that there is room to improve follow-up activities.**

While our monitoring requirements are robust and have continued to improve over time, we always believe in enhancing our accountability efforts and acknowledge the opportunity to improve follow-up on the findings of such monitoring activities.

A number of incentives, requirements, and penalties are already in place to address MCO non-compliance with requirements around MLTSS care management, including protocols in response to specific audit findings and quality incentives focused on overall program outcomes. Yet we believe in continuous quality improvement and are exploring additional steps to enhance our follow-up processes and achieve further improvements in care coordination and documentation at our health plans, including identifying best practices adopted by other states.

OIG Recommendation

"We recommend that the [Department]... consider actions, including imposing corrective action plans, fines, or other financial disincentives on MCOs, to ensure future compliance with contract requirements, which could have saved the Medicaid program up to $721 million ($386 million Federal share) for CY 2016."

Response

The Department concurs in part and non-concurs in part with this recommendation. Specifically:

1. **We concur that corrective action plans, fines, and other financial disincentives are important tools to improve MCO performance, and will continue to identify opportunities to use these tools in future.**

In addition to quality incentives and corrective action plans, we are working to enhance our accountability tools, based on the work in high performing states, which may include contract changes related to fines and financial disincentives specific to MLTSS performance. Mindful of the importance of ongoing collaboration and innovation with our MCO care management teams, New Jersey wants to create an environment that is high performing and accountable, that supports full engagement of clinical leaders and their care managers, and that, in doing so, serves NJ MLTSS members the best way possible.

2. **We strongly non-concur with the statement that OIG's recommended actions, if adopted, "could have saved the Medicaid program up to $721 million."**

OIG's suggestion that its recommendations could have saved the Medicaid program up to $721 million is mistaken because it treats MCO compliance with hundreds of contract requirements as an "all or nothing" consideration, disregards appropriate monitoring, oversight, and accountability measures that occurred, and assumes recoupment of 100% of MCO capitation in every case where a single compliance issue was identified. As OIG acknowledges in its draft report, non-compliance with certain Federal or State requirements does not mean that capitation payments were unallowable.

Thank you for the opportunity to review and respond to the OIG's draft audit report.

Sincerely,

Carole Johnson
Commissioner

c: Jennifer Langer Jacobs, Assistant Commissioner
Sarah Adelman, Deputy Commissioner
Allan Brophy, Office of Auditing