New Jersey Legislature

Office of LEGISLATIVE SERVICES

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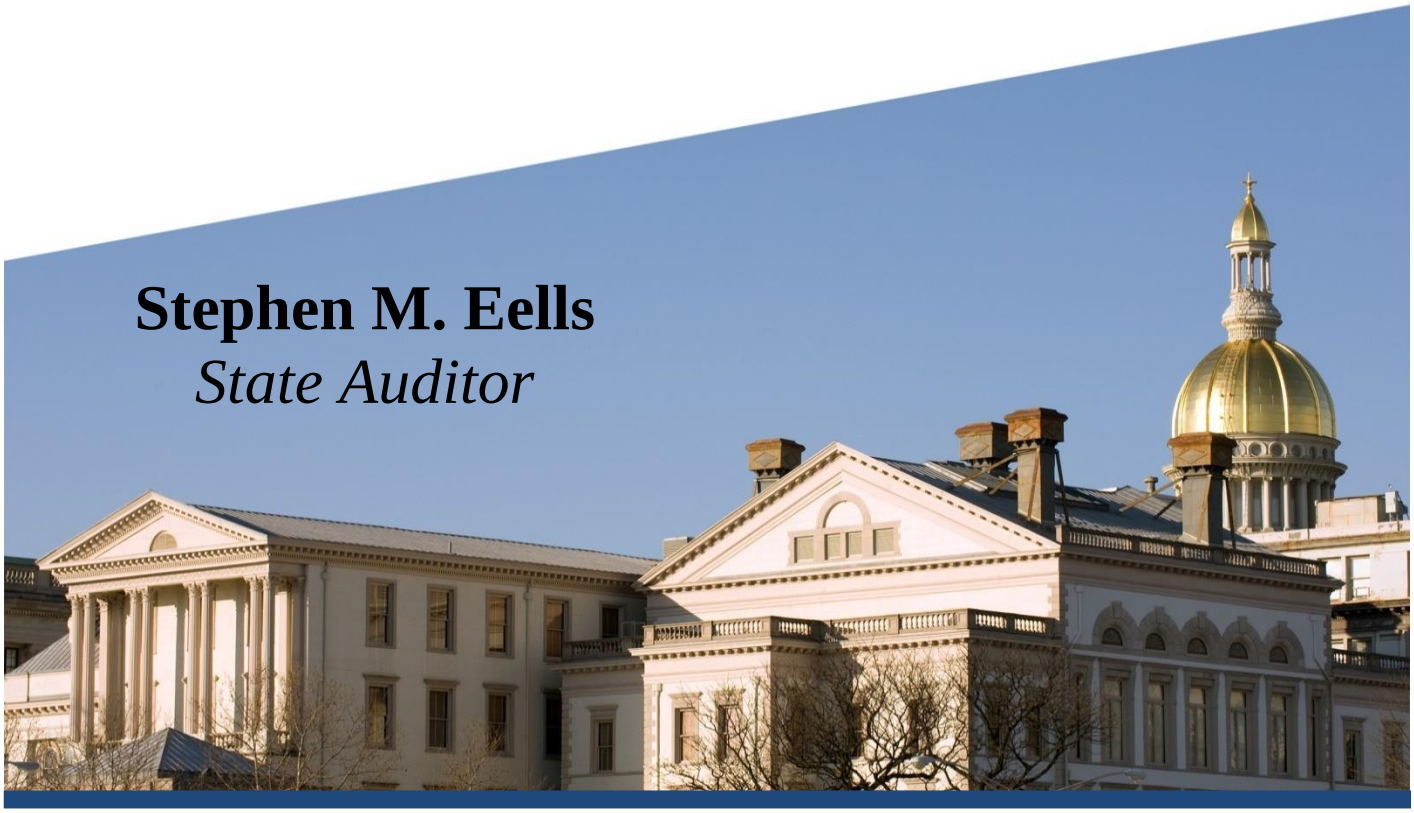
Department of Human Services
Division of Medical Assistance and Health Services
and
Division of Aging Services
Managed Long-Term Services and Supports

July 1, 2014 to June 30, 2018



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Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services and the Division of Aging Services, Managed Long-Term Services and Supports for the period of July 1, 2014 to June 30, 2018. If you would like a personal briefing, please call me at (609) 847-3470.

Stephen M. Eells
State Auditor
November 14, 2018

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Scope

We have completed an audit of the Department of Human Services, Managed Long-Term Services and Supports (MLTSS), which is jointly administered by the Division of Medical Assistance and Health Services (DMAHS) and the Division of Aging Services (DoAS), for the period July 1, 2014 to June 30, 2018. MLTSS refers to the delivery of long-term services and supports through the NJ FamilyCare managed care program. MLTSS provides long-term care (LTC) services and supports to beneficiaries in three settings: home-based, assisted living, and nursing home. For the fiscal year ended June 30, 2018, the state paid five Managed Care Organizations (MCOs) $2.1 billion to provide MLTSS and acute care services to approximately 53,000 MLTSS beneficiaries. A portion of the Medicaid services are funded by the federal government.

The Program of All-Inclusive Care for the Elderly (PACE) was excluded from our audit scope; however, it is referred to in this report to identify the entirety of the long-term care population. PACE is an alternative for beneficiaries 55 and older to receive long-term care services at home as well as in a community-based setting. PACE beneficiaries receive nursing home care when needed. For the fiscal year ended June 30, 2018, the state paid six agencies approximately $50 million to provide services to 1,270 PACE beneficiaries.

Objectives

The objectives of our audit were to determine if MLTSS home-based beneficiaries were receiving MLTSS services and to determine if DoAS was timely terminating MLTSS coverage for beneficiaries who no longer met clinical eligibility. In addition, we tested to determine if clinical assessments, which are used to determine clinical eligibility, were current.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, 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. 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.

In preparation for our testing, we studied legislation, the administrative code, policies of DMAHS and DoAS, the Comprehensive Medicaid Waiver, and the MCO contract. Provisions we considered significant were documented and compliance with those requirements was verified by interview, observation, and testing. We interviewed personnel from DMAHS and DoAS as well as individuals employed by the MCOs to obtain an understanding of the contract and the MLTSS process.

A nonstatistical sampling approach was used. Our samples were designed to provide conclusions on our audit objectives as well as internal controls and compliance. Sample populations were sorted and transactions were judgmentally selected for testing.

Conclusions

We found that home-based MLTSS beneficiaries were not always opting to receive MLTSS services and neither the MCOs nor DMAHS adequately monitored whether beneficiaries utilized MLTSS services at a level warranting enrollment in MLTSS rather than non-MLTSS Medicaid which has significantly lower monthly capitation rates. We determined that continued enrollment of 2,777 home-based beneficiaries, who opted not to receive any long-term care services at the level requiring MLTSS enrollment for a period of one year, resulted in an estimated $76.2 million in enhanced capitation paid to the MCOs.

We also found beneficiaries, who no longer met MLTSS clinical eligibility, were not being removed from MLTSS coverage timely. In addition, beneficiaries were automatically enrolled in MLTSS based on outdated clinical eligibility determinations, and MCOs were not clinically assessing those beneficiaries timely.

Lastly, we observed DMAHS' assertion regarding the extent to which MLTSS has shifted the long-term care population away from nursing home care and into home and community-based care is impacted by the MLTSS home-based beneficiaries not receiving MLTSS services.

Background

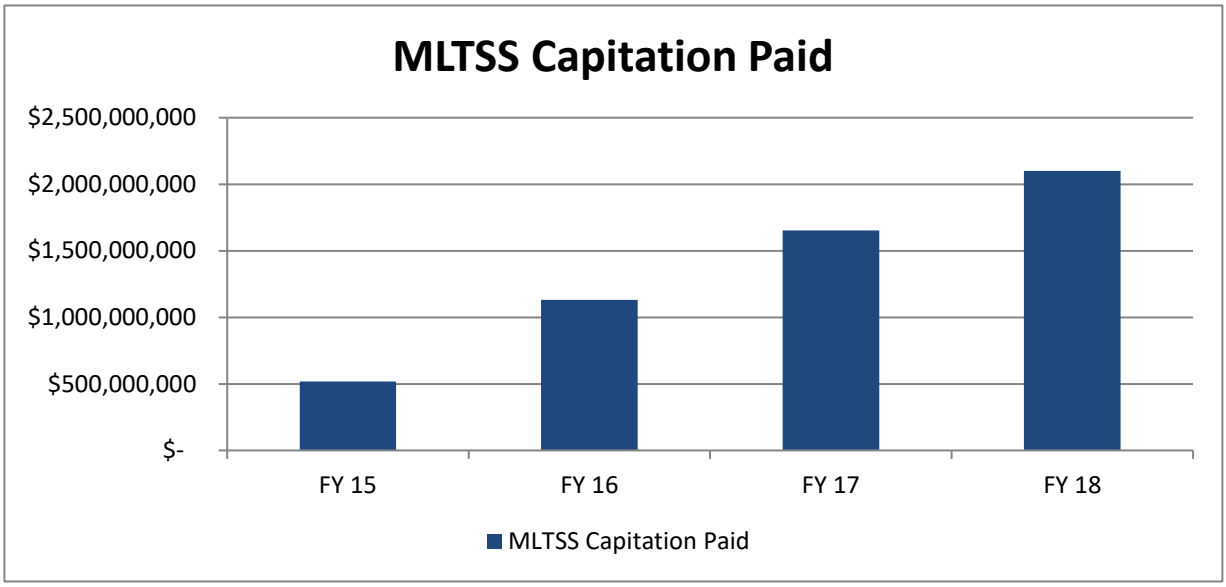
New Jersey received federal approval in 2012 for MLTSS under the 1115(a) demonstration waiver known as the Comprehensive Medicaid Waiver. MLTSS shifted how the state paid for long-term care services from fee-for-service (FFS) to a managed care capitation payment methodology. MLTSS was implemented in July 2014 with the goals of improving the quality of long-term care, rebalancing the state's long-term care system from its traditional reliance on nursing homes towards a greater emphasis on home and community-based services, and reducing the cost of long-term care. Medicaid beneficiaries who entered a nursing home for the first time after July 1, 2014 were required to enroll in MLTSS. Medicaid beneficiaries residing in nursing homes prior to July 1, 2014 were exempt from MLTSS enrollment and remained FFS.

MLTSS provides comprehensive services and supports to beneficiaries, whether at-home, in an assisted living facility, or in a nursing home. The following chart shows the MLTSS population as of June 2018, by setting and by year, since implementation.

MLTSS Population by Setting

Setting	July 2014	July 2015	July 2016	July 2017	June 2018
Assisted Living	2,864	3,086	3,342	3,078	3,079
Home-Based	8,152	10,416	15,228	20,126	23,726
Nursing Home	85	4,069	10,202	13,979	17,064
Totals	11,101	17,571	28,772	37,183	43,869

The state contracts with five MCOs to coordinate and deliver MLTSS and acute care services to clinically eligible beneficiaries. The MCOs receive an enhanced (higher) capitation payment each month for Medicaid beneficiaries enrolled in MLTSS than for those not enrolled. Services available to home-based MLTSS beneficiaries include private duty nursing, home delivered meals, structured day program, physical and occupational therapy, speech/language/hearing therapy, personal emergency response systems, chore services, and home and vehicle modifications. Although not considered an MLTSS service, MCOs are required to provide care management services such as annual clinical assessments, development of and review of plans of care, and periodic face-to-face visits with beneficiaries. MCOs are required to conduct a face-to-face visit at least every 180 days with a beneficiary in a nursing home and every 90 days with a beneficiary in a home-based setting. MLTSS monthly capitation rates vary based on a beneficiary's setting and whether they have Medicare. The following chart shows the growth in capitation paid to MCOs for MLTSS beneficiaries through June 2018.



MLTSS eligibility is dependent on an individual meeting financial and clinical eligibility criteria. Financial eligibility is determined by local County Welfare Agencies. MLTSS allows for a greater monthly income than non-MLTSS Medicaid. Effective January 2018, the MLTSS monthly income limit for a household size of one was $2,250 compared to $1,012 for the non-MLTSS NJ FamilyCare Aged, Blind, and Disabled Programs. The financial eligibility process for MLTSS also includes a five-year lookback to determine if assets were transferred for less than fair market value.

MLTSS clinical eligibility is determined by the Office of Community Choice Options (OCCO) within DoAS. Clinical eligibility is defined as meeting the qualifications for nursing home level of care; which means an individual requires at least limited assistance with activities of daily living such as bathing, toileting, and mobility. Limited assistance is defined as requiring guided maneuvering of limbs without taking weight. Individuals with cognitive deficits only require supervision with activities of daily living. Clinical eligibility is determined by conducting a face-to-face comprehensive clinical assessment.

OCCO is responsible for completing all initial clinical assessments of non-managed care individuals seeking MLTSS. The MCOs are responsible for assessing beneficiaries already enrolled in managed care who are seeking MLTSS. The MCOs forward all initial assessments to OCCO for review and final determination.

The MCOs are required to reassess a beneficiary's clinical eligibility annually. When MLTSS began, OCCO reviewed 100 percent of MCO reassessments, however, beginning in February 2017 it implemented a process to review only a sample of MCO reassessments for which the MCO reports no change in a beneficiary's condition. When a change in condition is reported by the MCO, OCCO reviews those assessments.

Home-Based Beneficiaries Not Receiving Any MLTSS Service

Enhanced capitation totaling $76.2 million was paid to MCOs for those MLTSS home-based beneficiaries who opted not to utilize MLTSS services.

The DMAHS does not require beneficiaries to utilize any MLTSS service on a regular basis. Beneficiaries are only required to receive care management, which is not considered an MLTSS service. Our analysis of MCO encounter claims (payments made by the MCOs to service providers) for 17,465 MLTSS beneficiaries in a home-based setting as of February 2017 disclosed 2,777 (16 percent) opted not to receive any long-term care services at a level requiring MLTSS enrollment from March 2016 through February 2017. Our result was conservative in that it included only beneficiaries enrolled in MLTSS for the entire year. We also excluded beneficiaries from our result if they had even one claim for an MLTSS service during the year.

We estimated that continued enrollment of the beneficiaries who opted not to receive any services requiring MLTSS enrollment for a period of one year resulted in $76.2 million in enhanced capitation paid to the MCOs. While shifting these beneficiaries to a non-MLTSS benefit plan could result in increases to the capitation rates paid to the MCOs for non-MLTSS beneficiaries, enhanced capitation payments for those MLTSS home-based beneficiaries who opt not to utilize MLTSS services should be avoided. In calculating the $76.2 million, we included only those beneficiaries receiving 40 hours or less of personal care assistant (PCA) services per week, as this level of service can be provided to any non-MLTSS beneficiary per regulations.

Our analysis disclosed 2,524 of the 2,777 home-based beneficiaries received PCA and/or medical day care (MDC) services during the period analyzed. These are state plan services that do not require enrollment in MLTSS, but may be beneficial to the support of a home-based MLTSS beneficiary. PCA involves hands-on personal care with health related tasks in a beneficiary's home under the supervision of a registered nurse, while MDC provides medically necessary and social services in an ambulatory setting to meet the needs of beneficiaries and to support their living in the community. When home-based beneficiaries do not receive any MLTSS services, enhanced capitation payments to MCOs result. The 2,777 beneficiaries who did not receive an MLTSS service for the year included 1,696 who received only PCA services and 239 who received only MDC services.

Non-MLTSS beneficiaries who receive PCA services have a care management component similar in some aspects to MLTSS beneficiaries. Regulations require that a registered professional nurse assess the beneficiary, develop a plan of care, and provide direct supervision of the personal care assistant at least once every 60 days. In addition, a nurse must reassess the beneficiary's need for continued care at least every six months or more frequently if the beneficiary's condition warrants. MDC services are the same regardless of whether a beneficiary is enrolled in MLTSS or a non-MLTSS benefit plan.

The 2,777 beneficiaries included 253 who did not receive any long-term care services at all during the year analyzed. These beneficiaries received only care management services. Enhanced

MLTSS capitation totaling $11.2 million was paid to the MCOs for these beneficiaries for the year. We estimated non-MLTSS capitation would have totaled $1.9 million for the same period.

Our further analysis of encounter claim data disclosed PCA and MDC accounted for 78 percent of the cost of long-term care services utilized by MLTSS home-based beneficiaries for fiscal year 2017 as illustrated by the following chart.

FY 2017 MLTSS Home-Based Beneficiaries' LTC Encounter Claims

Service	Dollars	% of Total Dollars	
Personal Care Assistance	$ 214,582,253	62.6%	} 78%
Medical Day Services	$ 53,292,239	15.5%	
Private Duty Nursing	$ 32,707,193	9.5%	
Community Residential Services	$ 9,609,641	2.8%	
Home-Delivered Meals	$ 8,121,645	2.4%	
Home-Based Supportive Care	$ 6,275,738	1.8%	
Cognitive Therapy	$ 3,542,990	1.0%	
Structured Day Program	$ 2,923,639	0.9%	
Personal Emergency Response System	$ 2,543,302	0.7%	
Respite	$ 2,075,286	0.6%	
Occupational Therapy	$ 1,582,656	0.5%	
Physical Therapy	$ 1,574,298	0.5%	
Residential Modifications	$ 1,083,053	0.3%	
Speech, Language and Hearing Therapy	$ 1,006,927	0.3%	
Other	$ 1,913,192	0.6%	
Total	$ 342,834,051		

To determine if beneficiaries were receiving more than the maximum 40 hours of PCA services per week allowed to non-MLTSS beneficiaries per regulations, we reviewed encounter claims for 160 of the 1,696 beneficiaries who received only PCA services from March 2016 through February 2017. We found only 10 percent were receiving more than 40 PCA hours per week as shown by the following chart.

Summary of test results of hours per week of PCA services 3/1/16 through 2/28/17

	10 or less	**11 - 20**	**21 - 30**	**31 - 40**	**More than 40**	**Totals**
MCO # 1	3	5	8	9	0	25
MCO # 2	1	5	4	8	8	26
MCO # 3	5	9	17	16	3	50
MCO # 4	1	12	8	7	1	29
MCO # 5	0	6	11	10	3	30
Totals	**10**	**37**	**48**	**50**	**15**	**160**
Percentage	6%	23%	30%	31%	10%	100%

These levels of utilization of PCA services could have been provided to the majority of the home-based beneficiaries tested through non-MLTSS Medicaid at a much lower capitation rate. The following are examples of cases we reviewed of home-based beneficiaries receiving minimal weekly PCA hours.

- A beneficiary received only nine PCA hours per week from November 2015 through May 2018 at an encounter claim cost of $15,700. Enhanced capitation totaling $98,700 was paid to the MCO. Non-MLTSS capitation would have totaled approximately $14,500 for the same period.

- A beneficiary received only six hours of PCA per week from July 2014 through May 2018 at an encounter claim cost of $12,400. Enhanced capitation totaling $142,400 was paid to the MCO. Non-MLTSS capitation would have totaled approximately $22,200 for the same period.

Home-Based MLTSS Beneficiaries Receiving only Care Management Services

The following are examples of the 253 MLTSS home-based beneficiaries who did not receive any long-term care services.

- A beneficiary in a home-based setting since July 2014 whose only clinical assessment completed January 2015 indicated the beneficiary "reports to be independent with bathing, grooming, meal preparation, dressing, and toileting" and "ambulates and transfers independently without an assistive device or assistance". A review of the MCO's case file disclosed the beneficiary refused services and had no plan of care. Enhanced capitation totaling $132,600 was paid from July 2014 through February 2018 for this beneficiary. Non-

MLTSS capitation payments would have totaled approximately $20,800 for the same period. Following our inquiries, the beneficiary's MLTSS coverage was terminated.

- A beneficiary in a home-based setting since December 2015 received no long-term care services for two years until December 2017 when a personal emergency response system was installed in his home at a total cost to the MCO of $334 as of June 2018. Enhanced capitation totaling $94,000 was paid to the MCO from December 2015 through June 2018 for this beneficiary. Non-MLTSS capitation would have totaled approximately $14,500 for the same period.

Our review of MCO case files for 86 of the 253 beneficiaries noted MCOs were not able to provide a plan of care for 39 of the beneficiaries for the year tested. Of the 47 beneficiaries for whom we were able to obtain a plan of care, 31 had plans of care that did not include a long-term care service. We found no encounter claims indicating any service was provided for the remaining 16 beneficiaries whose plans of care included a long-term service.

As part of its quality monitoring activities, DMAHS has developed various MLTSS performance measures. Our review of the following three MCO reported performance measures related to services received by MLTSS beneficiaries supported our findings that beneficiaries are not receiving an MLTSS service.

- MCOs reported an average of 25 percent of MLTSS beneficiaries did not receive an MLTSS service in each of the first three quarters of fiscal 2017.

- MCOs reported an average of 15 percent of MLTSS beneficiaries in a home and community-based setting received only PCA services in each of the first three quarters of fiscal 2017.

- MCOs reported an average of 4 percent of MLTSS beneficiaries in a home and community-based setting received only MDC services in each of the first three quarters of fiscal 2017. One MCO reported an average of 13 percent.

Impact of MLTSS Enrollment on Capitation Payments

For fiscal years 2015 through 2017, MCOs received an average MLTSS capitation rate of $2,712 per month for a home-based beneficiary with Medicare and $7,921 per month for a home-based beneficiary without Medicare. For the same period, MCOs received an average capitation rate of $6,416 per month for a non-specialized care nursing home beneficiary with Medicare and $9,212 per month for a non-specialized care nursing home beneficiary without Medicare.

Beginning in fiscal year 2018, a blended statewide nursing home/home and community-based rate was implemented to incentivize MCOs to keep beneficiaries in a less expensive home-based setting. For fiscal year 2018, MCOs were paid a blended monthly capitation rate of $4,133 for a home-based or non-skilled nursing home beneficiary with Medicare and $8,414 per month for a home-based or non-skilled nursing home beneficiary without Medicare.

By comparison, monthly capitation rates for non-MLTSS beneficiaries were significantly less. For fiscal years 2015 through 2018, non-MLTSS capitation rates averaged $473 per month for a beneficiary with Medicare and $1,315 per month for a beneficiary without Medicare.

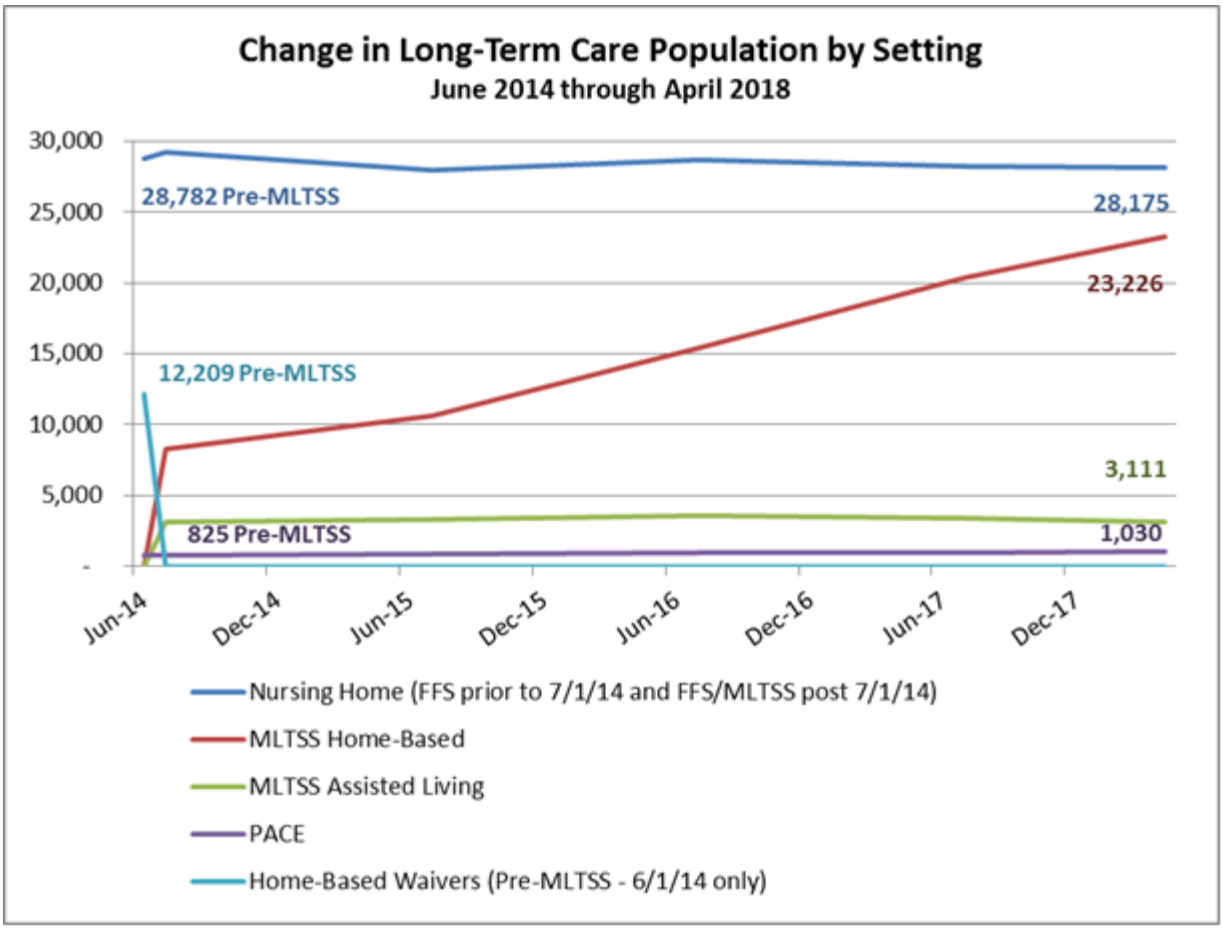
Home-based beneficiaries receiving only PCA or MDC services or only care management services could be enrolled in a non-MLTSS benefit plan at a significantly lower monthly capitation rate. Enrollment of such beneficiaries in MLTSS results in enhanced capitation payments. The following chart demonstrates the impact MLTSS enrollment has on annual capitation paid for a home-based MLTSS beneficiary versus a non-MLTSS beneficiary.

Annual MLTSS Capitation vs. Non-MLTSS Capitation per Beneficiary for Fiscal Year 2018

	Annual Capitation Paid	
MLTSS Home-Based beneficiary (with Medicare)	$	49,596
Non-MLTSS beneficiary (with Medicare)	$	5,652
Additional annual capitation paid per beneficiary due to MLTSS enrollment	$	43,944
MLTSS Home-Based beneficiary (without Medicare)	$	100,968
Non-MLTSS beneficiary (without Medicare)	$	15,948
Additional annual capitation paid per beneficiary due to MLTSS enrollment	$	85,020

Impact of MLTSS on the Long-Term Care Population

The long-term care population has increased significantly since the implementation of MLTSS. In June 2014, the month preceding the implementation of MLTSS, a total of 41,816 beneficiaries were receiving long-term care services via a FFS payment methodology in a nursing home (28,782), community waiver (12,209), or PACE (825). As of April 2018, the long-term care population increased by 33 percent to 55,542 beneficiaries. The increase can be attributed to the substantial increase in the home-based population as demonstrated by the following chart.



The community-based population which is comprised of home-based and assisted living beneficiaries more than doubled from the June 2014 waiver population of 12,209 to 26,337 as of April 2018. This is attributed to the increase in home-based beneficiaries because the assisted living population has remained relatively stable. During the same period, the nursing home population decreased by only 607 beneficiaries. The increase in the home-based population can be partially attributed to beneficiaries in a home-based setting who are not receiving an MLTSS service.

Recommendation

We recommend DMAHS implement procedures to identify home-based beneficiaries not receiving an MLTSS service and determine if their continued enrollment in MLTSS is appropriate. DMAHS should monitor encounter claims and adjust beneficiaries' status accordingly, thereby avoiding enhanced capitation payments for those MLTSS home-based beneficiaries who opt not to utilize MLTSS services.

Clinical Termination of MLTSS Coverage

Beneficiaries were not removed in a timely manner from MLTSS coverage.

When beneficiaries' clinical eligibility is not authorized based on an MCO conducted clinical assessment, OCCO will conduct a face-to-face clinical assessment within 14 days to determine clinical eligibility. If clinical eligibility is denied by OCCO, the case is referred to the Aging & Disability Resource Connection (ADRC) to identify non-Medicaid funded community-based wraparound long-term services and supports.

We noted a high percentage of MLTSS coverage terminations occurred during September 2015 as well as during February 2016. When OCCO first began denying MLTSS clinical eligibility, it was unware that a "D" in the New Jersey Medicaid Management Information System (NJMMIS) Pre-Admission Inquiry Screen did not terminate MLTSS coverage. This coding error resulted in beneficiaries remaining enrolled in MLTSS and MCOs receiving MLTSS capitation despite beneficiaries being denied clinical eligibility. The agency recognized the coding error in August 2015 and corrected it accordingly.

We judgmentally selected testing populations from September 2015, February 2016, and January through September 2017. Despite the NJMMIS Pre-Admission Inquiry Screen coding error being corrected, we determined the division was still not terminating beneficiaries in a timely manner.

	Population	**Beneficiaries Tested***
2015 September	156	20
2016 February	139	20
2017 January - September	416	40
Totals	**711**	**80**

**Not all beneficiaries were enrolled in MLTSS due to beneficiaries not needing to be enrolled in managed care to be clinically assessed for MLTSS. We selected beneficiaries who were enrolled in MLTSS for testing.*

We reviewed a total of 80 beneficiaries whose clinical eligibility was not authorized based on the MCO conducted clinical assessment and found OCCO did not complete a face-to-face assessment, at all, for 11 (13.8 percent) beneficiaries to determine clinical eligibility. Of the remaining 69, OCCO did not complete a timely face-to-face assessment for 57 (82.6 percent) beneficiaries to determine clinical eligibility. We were conservative in our testing and gave OCCO 30 days, instead of the mandated 14, to complete all face-to-face clinical assessments for beneficiaries for whom clinical eligibility was not authorized based on the MCO conducted clinical assessment. For the time periods tested, beneficiaries had the right to appeal clinical eligibility denials within 20 days of the denial notification, but OCCO allowed 30 days for mailing purposes. OCCO did not terminate 65 (81.3 percent) of the total 80 beneficiaries tested from MLTSS coverage in a timely manner resulting in $1.7 million in improper capitation payments. Overall, we allowed 60 calendar days before MLTSS capitation payments were

considered improper. It should be noted, if the 60-day mark fell on or after the 22nd of the month, the improper capitation payment start date would not begin until the 1st of the second following month.

Recommendation

We recommend OCCO conduct timely face-to-face clinical assessments for beneficiaries for whom clinical eligibility is not authorized based on the MCO conducted clinical assessment. OCCO should ensure all beneficiaries are properly terminated from MLTSS coverage in a timely manner.

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Clinical Eligibility

Beneficiaries are automatically enrolled in MLTSS based on outdated clinical eligibility determinations, and MCOs are not clinically assessing those beneficiaries timely.

The NJMMIS contains a system edit which automatically enrolls beneficiaries who have both financial and clinical eligibility present in the system, regardless of whether those beneficiaries are actually seeking or needing long-term care services. Beneficiaries automatically enrolled in MLTSS are not notified of their enrollment until the MCO receives notification. The MCO then initiates the proper MLTSS procedures, such as completing a clinical assessment and plan of care. Despite OCCO's policy that a clinical assessment is valid for one year, prior to January 2018, the system recognized any approved clinical assessment determination from July 2014 forward, as valid.

The MCOs are responsible for obtaining a copy of an existing clinical assessment or conducting a clinical assessment themselves, completing the initial face-to-face beneficiary visit, and completing the beneficiary plan of care within 45 calendar days of MLTSS enrollment notification. Upon request from OCCO, MCOs shall receive a completed clinical assessment and interim plan of care for non-managed care individuals newly enrolled in MLTSS for whom the assessment was conducted and OCCO considers current. An unwritten OCCO internal policy considers a four-month old OCCO conducted clinical assessment for non-managed care individuals current.

We reviewed MLTSS enrollment as of January 2018 (41,028 beneficiaries), including the PACE population (which also requires clinical eligibility), and identified 677 (1.7 percent) beneficiaries who were enrolled based on a clinical assessment determination greater than 13 months before their MLTSS enrollment date. Of the 677 beneficiaries, MCOs did not complete timely clinical assessments or beneficiary plans of care within 45 calendar days of enrollment notification for 208 (30.7 percent) beneficiaries.

One non-managed care individual, enrolled in MLTSS based on an outdated 21-month clinical assessment determination, was clinically approved on October 27, 2015. This individual was

enrolled in NJ FamilyCare for the first time on April 1, 2016 and automatically enrolled in MLTSS on August 1, 2017 based on the October 27, 2015 clinical assessment determination, which was then 21 months old. The MCO was first notified of the beneficiary living outside of the country on August 1, 2017, and notified OCCO of this on August 7, 2017. OCCO was notified by the MCO again on October 5, 2017 and again on February 9, 2018. The MCO never completed a clinical assessment or any plan of care. The beneficiary was clinically terminated on April 18, 2018 and MLTSS enrollment ended accordingly on April 30, 2018. Enhanced capitation totaling $34,700 was paid to the MCO.

In January 2018, the division implemented an NJMMIS edit requiring a clinical assessment determination date of January 2016 or newer to initiate automatic enrollment in MLTSS. With no current plan to adjust the January 2016 date, the system will allow automatic MLTSS enrollment based on outdated clinical assessment determinations.

As of May 4, 2018, only 9 of the 677 beneficiaries were clinically terminated from MLTSS coverage. These terminations occurred due to beneficiaries being unable to be contacted, voluntarily withdrawing, or no longer meeting clinical eligibility. While the number of clinical terminations appears low, this number could increase due to allowing increasingly outdated clinical assessment determinations to initiate automatic MLTSS enrollment. The low number of clinical terminations may also be attributed to MCOs not assessing beneficiaries within the required 45 calendar days, OCCO not monitoring MCOs assessing beneficiaries within 45 calendar days, and untimely clinical terminations noted in our previous finding (page 11).

Recommendation

We recommend OCCO monitor that MCOs are completing timely clinical assessments and plans of care within 45 calendar days of MLTSS enrollment. In addition, OCCO should revise the NJMMIS edit so that it is in compliance with their policy that clinical assessment determinations older than one year are not valid for automatic MLTSS enrollment.

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Observation

MLTSS Rebalancing

DMAHS' assertion regarding the extent to which MLTSS has shifted the long-term care population away from nursing home care and into home and community-based care is impacted by the MLTSS home-based beneficiaries not receiving MLTSS services.

A key objective of MLTSS was to rebalance the state's long-term care system away from its traditional reliance on nursing home care towards home and community-based care; to which DMAHS asserts has been successful. The following chart compares the January 2014 and January 2018 long-term care populations by setting, and illustrates the division's method for reporting on the status of this objective.

Setting	January 2014 % of LTC Population	January 2018 % of LTC Population
Nursing Home	68.6%	51.6%
Home and Community-Based	29.5%	46.7%
PACE *	1.9%	1.8%

**Although excluded from our audit scope, PACE is included in this chart for a complete representation of the long-term care population.*

The analysis demonstrates a shift from nursing home care to home and community-based care. From January 2014 to January 2018, the percentage of the long-term care population in a nursing home decreased from 68.6 percent to 51.6 percent, while the percentage in the home and community increased from 29.5 percent to 46.7 percent. However, when analyzing beneficiary enrollment by setting, the shift in percentages can be attributed to the increase in the number of home and community-based beneficiaries as demonstrated by the following chart.

	January 2014		January 2018			
Setting	Beneficiaries	% of Beneficiaries in Setting	Beneficiaries	% of Beneficiaries in Setting	Change in Beneficiaries	% Change in Beneficiaries
Nursing Home	28,783	68.6%	28,143	51.6%	(640)	-2.2%
Home and Community-Based	12,377	29.5%	25,461	46.7%	13,084	105.7%
PACE *	779	1.9%	969	1.8%	190	24.4%
Total	41,939		54,573		12,634	

**Although excluded from our audit scope, PACE is included in this chart for a complete representation of the long-term care population.*

Home-based beneficiaries who opted not to utilize MLTSS services, as noted in our finding on page 5, have impacted the extent of the shift in the long-term care population away from nursing home care into home and community-based care since a portion of the increase in the MLTSS home-based population can be attributed to beneficiaries who could have received the same services without enrollment in MLTSS. Thus, the home and community-based portion of MLTSS reflected in the chart above would be significantly reduced.

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Sheila Y. Oliver
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Commissioner

November 7, 2018

John J. Termyna
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Trenton, NJ 08625

Dear Mr. Termyna:

The Department of Human Services (the Department) is in receipt of a draft audit report issued by your office entitled ***"Department of Human Services' Division of Medical Assistance and Health Services and Division of Aging Services, Managed Long-Term Services and Supports"*** for the period of July 1, 2014 through June 30, 2018. The objectives of the audit were to determine if Managed Long-Term Services and Supports (MLTSS) home and community-based beneficiaries were receiving MLTSS services and to determine if the Division of Aging Service (DoAS) was timely terminating MLTSS coverage for beneficiaries who no longer met clinical eligibility. Thank you for the opportunity to comment on the draft report.

Please accept the following responses to the draft audit findings:

OSA Recommendation

"We recommend DMAHS implement procedures to identify home-based beneficiaries not receiving an MLTSS service and determine if their continued enrollment in MLTSS is appropriate. DMAHS should monitor encounter claims and adjust beneficiaries' status accordingly, thereby avoiding enhanced capitation payments for those MLTSS home-based beneficiaries who opt not to utilize MLTSS services."

Response

OSA identified 2,777 MLTSS beneficiaries who did not receive a service requiring MLTSS enrollment from March 2016 through February 2017, although 2,524 of these enrollees received personal care assistant services or medical day care services. OSA suggests the enrollment of these individuals in MLTSS caused $76.2 million in capitation payments beyond what would have been paid under the existing capitation rate for the Medicaid Age, Blind and Disabled (ABD) program and further suggests that the State could realize savings by moving these beneficiaries to other programs. However, OSA acknowledges that "shifting these beneficiaries to a non-MLTSS benefit plan could result in increases to the capitation rates made to Medicaid's managed care organizations for non-MLTSS beneficiaries." DMAHS and its actuarial consulting firm, Mercer Government Human Services (Mercer), analyzed whether shifting the MLTSS beneficiaries identified in the audit to the ABD program would result in cost

savings. DMAHS and Mercer confirmed that the State would not realize appreciable savings because the capitation rates of both programs would fluctuate according to the needs of the members insured. As the medical needs of these MLTSS beneficiaries are greater than the average needs of current ABD users, the cost of the ABD program would increase by adding these beneficiaries. Likewise, by removing these beneficiaries from MLTSS, the remaining MLTSS beneficiaries would have greater medical needs on average, resulting in a higher capitation rate. Blending low and high utilization beneficiaries allows for more socialized risk, and shifting beneficiaries between programs does not net meaningful savings.

In developing its draft audit report, OSA reviewed encounter data for a sample of 160 beneficiaries (specifically those who received only PCA services from March 2016 through February 2017). DMAHS estimated the average monthly medical costs for these MLTSS beneficiaries based on OSA's sample. As illustrated in Table 1 below, DMAHS used an average PCA rate of $15.50 per hour for this time period and estimated the number of hours for each group to be the midpoint of the range (e.g., 11-20 hours equals 15 hours). DMAHS estimated the total monthly PCA costs for these beneficiaries to be $284,113, or $1,775.71 per individual. The average PCA costs alone of these MLTSS beneficiaries are approximately four times greater than the medical component of the capitation rate for the existing ABD population.

Table 1

Average Cost of PCA Services for MLTSS Beneficiaries Identified in OSA Audit

						Totals
Average Number of Hours Per Week	5	15	25	35	45	
Cost per hour	$15.50	$15.50	$15.50	$15.50	$15.50	
Weeks per month	4.3333	4.3333	4.3333	4.3333	4.3333	
Beneficiaries	10	37	48	50	15	160
Total Monthly Cost	$3,358	$37,277	$80,599	$117,541	$45,337	$284,113
Average Monthly Cost per Individual	$335.83	$1,007.49	$1,679.15	$2,350.82	$3,022.50	$1,775.71

As indicated in Table 2 below, based on Mercer's calculations of revised capitation rates, incorporating the 2,777 MLTSS beneficiaries identified by OSA into the ABD program would result in an increase in ABD costs of approximately $67,760,000 per year.

Table 2

Effect of Shifting the 2,777 MLTSS Beneficiaries identified by OSA to the ABD Program

	Average Enrollment Mar '16 to Feb '17	Monthly Capitation	Total Cost	Average cost per person
Existing ABD with Medicare Beneficiaries	123,453	$479.70	$710,644,849	$5,756
New ABD w/Medicare group (Existing ABD + 2,777 Group)	126,230	$513.88	$778,404,868	$6,167

Moreover, as demonstrated in Table 3 below, the per person cost of the remaining MLTSS population would be greater. Because the total population in MLTSS would decrease, there would be an estimated $70 million in cost decrease but it would be substantially offset by the estimated nearly $70 million increase in ABD costs. As a result, the State would not realize any appreciable savings by shifting these MLTSS beneficiaries to the ABD program.

Table 3

Effect of Shifting 2,777 MLTSS Beneficiaries identified by OSA on the MLTSS Program

	Average Enrollment Mar '16 to Feb '17	Monthly Capitation	Total Cost	Average Cost Per Person
Existing MLTSS with Medicare Beneficiaries	16,428	$2,516.08	$496,009,946	$30,192
New MLTSS with Medicare (Existing MLTSS – 2,777 Group)	13,651	$2,594.83	$425,063,696	$31,137

As indicated in Table 4 below, DMAHS would only realize minor costs savings to the total program costs by shifting the identified beneficiaries to the ABD program from the MLTSS program.

Table 4

Comparison of Programs Following Shift of 2,777 MLTSS Beneficiaries identified by OSA

	Total Annual Costs
Existing MLTSS and ABD Programs Combined	$1,206,654,796
ABD Program with 2,777 Group	$778,404,868
MLTSS Program without 2,777 Group	$425,063,696
Combined MLTSS and ABD Costs After Shift	$1,203,468,564

DMAHS finds that there would be limited financial savings as well as the strong likelihood that individuals will lose benefits. As the financial criteria for ABD is different than MLTSS, some individuals are likely to lose Medicaid eligibility and not be able to access home and community-based services under OSA's proposed shift. Loss of services would subject these individuals to a risk of institutionalization, the prevention of which is a primary purpose of MLTSS.

The administrative processes associated with making a shift as well as the potential for enrollees to lose Medicaid coverage would outweigh any potential modest cost savings. These processes include amending the Section 1115 waiver and State regulations, requesting and receiving approval from the Centers for Medicare & Medicaid Services, educating providers and beneficiaries, and managing the transition. For these reasons, DMAHS does not believe that it is in the best interests of the State or its Medicaid beneficiaries to adjust MLTSS eligibility criteria at this time. DMAHS will continue to monitor the financial impact of MLTSS eligibility criteria and make informed policy decisions moving forward.

In addition to its finding regarding capitation rates, OSA identified 253 members who received no services other than care management. The Office of MLTSS Quality Monitoring analyzed this group and

found that beneficiaries did not utilize services other than care management for a variety of reasons. For example, certain individuals had significant informal supports, some received PCA services through the Personal Preference Program and some received hospice care. DMAHS introduced a new performance measure on July 1, 2018, for MCOs to track beneficiaries not receiving any MLTSS services, PCA services or MDC Services. DMAHS will ensure that MCOs counsel beneficiaries on all available benefits under MLTSS. DMAHS will also ensure that the MCOs will take any appropriate action based on these findings. Other existing performance measures track MLTSS beneficiaries receiving MLTSS services, PCA services only, MDC services only, and PCA and MDC services only. MCOs report all performance measures on a quarterly and annual basis, which will allow the State enhanced oversight and monitoring. These measures will ensure that members are receiving services as authorized. The Office of MLTSS Quality Monitoring will follow up with MCOs, the DoAS Office of Community Choice Options (OCCO), or Medicaid enrollment to take any required actions. This information will also be shared with the DMAHS Fiscal Office.

OSA Recommendation

"We recommend OCCO conduct timely face-to-face clinical assessments for beneficiaries for whom clinical eligibility is not authorized based on the MCO conducted clinical assessment. OCCO should ensure all beneficiaries are properly terminated from MLTSS coverage in a timely manner."

Response

The Department agrees that OCCO should conduct timely clinical assessments for MLTSS beneficiaries. During the audit period between 2015 and 2017, OCCO was not staffed to meet workload demands as the MLTSS home and community-based program grew from approximately 12,000 to 25,000 beneficiaries. Under the new administration, the Department is committed to ensuring that MLTSS applicants and beneficiaries receive timely assessments and eligibility determinations. To that end, the Department is in the process of hiring up to 20 additional registered nurses at OCCO to conduct assessments. We expect that the additional staff will alleviate the issues identified in OSA's report. The Department will continue to monitor staffing needs and make any necessary adjustments.

OSA Recommendation

"We recommend OCCO monitor that MCOs are completing timely clinical assessments and plans of care within 45 calendar days of MLTSS enrollment. In addition, OCCO should revise the NJMMIS edit so that it is in compliance with their policy that clinical assessment determinations older than one year are not valid for automatic MLTSS enrollment."

Response

DMAHS added provisions to its contract with the MCOs in July 2018 to strengthen oversight of performance standards. The contract requires MCOs to maintain a compliance standard of 86% for MLTSS care management performance measures, including timely clinical assessments, timely plans of care, outreach, and face-to-face visits. DMAHS requires MCOs which fail to achieve these standards to develop a corrective action plan, and failure to provide a timely and satisfactory plan may lead to sanctions. Moreover, an MCO's failure to complete timely corrective action as set forth in the plan subjects the MCO to sanctions and liquidated damages.

DMAHS monitors compliance with these standards through audits by its External Quality Review Organization (EQRO). Deficiencies found by the EQRO result in corrective action. Moreover, MCOs self-report performance measures to DMAHS on an ongoing basis. DMAHS tracks compliance and holds monthly calls with each MCO. Through this oversight, DMAHS aims to deliver timely and appropriate

health care to all Medicaid beneficiaries, including individuals in MLTSS. DMAHS and the EQRO will continue to make the timeliness of MCO assessments and plans of care a focus of future oversight.

The NJMMIS edit recommended by OSA has occurred. Effective August 2018, the system revises the clinical eligibility date on a rolling basis every six months. This edit will ensure that clinical eligibility for new enrollees will be based on a timely assessment not older than 13 months.

OSA Observation:

"DMAHS' assertion regarding the extent to which MLTSS has shifted the long-term care population away from nursing home care and into home and community-based care is impacted by the MLTSS home-based beneficiaries not receiving MLTSS services."

Response

The MLTSS program has been enormously successful in preventing unnecessary nursing home admissions. The decrease in the nursing home population since the onset of MLTSS indicates that the State is effectively rebalancing its long-term care system towards home and community-based care, as New Jersey's population is aging and institutional care would have significantly increased without MLTSS. The New Jersey Department of Labor projects a 48% increase in people over age 65 and a 50% increase in people over age 85 between 2014 and 2034. Based on these projections, the nursing home population would have increased by thousands since 2014 but for MLTSS. Instead, this population has decreased, while community-based beneficiaries have increased.

OSA suggests that some of this increase is due to MLTSS beneficiaries who do not receive MLTSS-specific services. However, these beneficiaries meet nursing home level of care requirements and would be at risk for institutionalization without services, regardless of whether these services fall under the MLTSS or ABD programs.

Additionally, MLTSS, as well as other home and community-based programs, have allowed the State to realize increased federal funding under the Affordable Care Act's Balancing Incentive Program. As a financial incentive to promote community care, this program awarded the State an extra 2% federal match on all home and community-based services. New Jersey received over $100 million in additional federal funding as a result of its rebalancing efforts.

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

Sincerely,

Carole Johnson
Commissioner

c: Meghan Davey
Richard Hurd
Daniel Prupis
Mark Talbot
Sarah Adelman