



**STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION**

INVESTIGATIVE REPORT

**IMPROPER MEDICAID PAYMENTS TO
ADULT MEDICAL DAY CARE FACILITIES**

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I.

INTRODUCTION

The Medicaid Fraud Division of the Office of the State Comptroller (OSC) is charged by statute with preventing and detecting fraud, waste and abuse within New Jersey's Medicaid program. In accordance with that responsibility, OSC issues this public report on five Adult Medical Day Care (AMDC) providers, which summarizes the results of a series of recent OSC investigations concerning the AMDC industry.

As set forth below, OSC's investigations revealed substantial problems at these facilities, with negative financial consequences for state taxpayers. These problems range from the state paying for services not actually provided or properly documented, to the state paying for services for individuals not clinically eligible to receive AMDC care. Based on our findings, OSC recommends a series of changes to ensure that taxpayer dollars are not wasted and that the safety of those receiving AMDC services is not compromised.

II.

BACKGROUND

The AMDC program is available to individuals over the age of 18 who have physical and/or mental impairments, but do not require 24-hour inpatient institutional care. To be eligible for the program, the individual must require medical assistance to continue to function in his or her community and/or require assistance in carrying out activities of daily living. For example, individuals attending AMDC facilities require services such as medication administration, health monitoring services, or physical or occupational therapy. AMDC facilities are required to

employ a registered professional nurse who is responsible for the administration and supervision of all nursing services including medication dispensation and monitoring of medical conditions.

The vast majority of individuals receiving AMDC services in New Jersey are participants in the state's Medicaid program. Over the last few years, the Division of Medical Assistance and Health Services (DMAHS), the state's Medicaid agency, has paid on average \$195 million per year to AMDC facilities on behalf of these individuals.

In order to operate an AMDC facility in New Jersey, the facility must be approved and licensed by the New Jersey Department of Health (DOH) in accordance with the Standards for Licensure of Adult and Pediatric Day Health Services Facilities as set forth in state regulatory law at *N.J.A.C.* § 8:43F. Currently, 134 AMDC facilities in New Jersey provide services to approximately 14,000 state residents. For ease of reference, this report frequently refers to these individuals receiving AMDC services simply as "recipients."

Prior to New Jersey's recent transition to managed care in its Medicaid programs, the AMDC program operated primarily on a "fee for service" basis, under which AMDC providers were reimbursed directly by the state Medicaid program at a flat rate per recipient per day for all services provided to the recipient for that day. Starting in 2006, under the fee-for-service system a Medicaid participant had to obtain prior authorization from DOH to enroll at an AMDC, which was predicated on the individual meeting clinical eligibility standards set forth in state law. These clinical standards detail the physical and/or mental impairments an individual must be experiencing in order to be eligible for care at an AMDC through the Medicaid program. Under certain circumstances, DOH would authorize the AMDC's staff to conduct both the initial eligibility assessment as well as annual reassessments in accordance with DOH's criteria. Pursuant to *N.J.A.C.* § 8:43F-5.4(d)(1) and *N.J.A.C.* § 8:86-1.5(b)(2)(i), if the individual was not

eligible for services based on the assessment, the AMDC center was required to discharge the individual.

Following the state's recent transition to managed care, an AMDC provider must now enroll in a Medicaid managed care network in order to accept Medicaid participants at its facilities. Each managed care organization (MCO) has its own process and criteria it uses to enroll AMDC facilities in its network. Under this system, DMAHS now simply pays the MCOs a monthly, per-person payment on behalf of each of their Medicaid participants, known as a "capitation" payment. The capitation payment by DMAHS is based on, among other things, the costs the MCOs incur in administering the state's Medicaid program, such as, for example, costs resulting from services provided to recipients at an AMDC facility.

Under both the fee-for-service system and the newer managed care approach, state payment for AMDC services (either directly to the AMDC or indirectly through an MCO) is legally dependent on the AMDC documenting that the recipient's required AMDC services have been provided. State law stipulates that Medicaid providers "shall not be entitled to reimbursement for the services rendered unless said services have been documented" and that such documentation must include, at a minimum, "the date of the service rendered" and "the nature and extent of each such service rendered." *N.J.S.A.* 30:4D-12(d), (e). State regulatory law similarly requires that all Medicaid providers, including AMDC facilities, must "keep such records as are necessary to disclose fully the extent of services provided." *N.J.A.C.* § 10:49-9.8(b)(1). "[C]urrent, complete medical record[s] shall be maintained for each participant and shall contain documentation of all services provided." *N.J.A.C.* § 8:43F-15.1(a). "[W]here such records do not document the extent of services billed, payment adjustments shall be necessary." *N.J.A.C.* § 10:49-9.8(b)(3). Thus, if a purported service has not been documented, under the law

it is deemed not to have been provided and does not qualify for payment. OSC is charged with recovering state payments made to health care providers in such circumstances.

Historically, AMDC providers repeatedly have been the subject of state enforcement actions. For example, in November 2008, DOH revoked the authority of 41 AMDCs to conduct their own Medicaid eligibility assessments because the AMDCs either were enrolling ineligible individuals or were failing to discharge individuals who were no longer in need of AMDC services. DOH further instituted a moratorium that prohibited the licensing of new AMDC facilities. That moratorium expired in November 2012.

Similarly, in 2010, the former Office of the Medicaid Inspector General (OMIG), which is now part of OSC, issued a public report on its investigative findings concerning Garden Adult Medical Day Care (Garden). OMIG had commenced the investigation after DOH cited Garden for multiple violations over a number of years, including failure to: monitor identified medical conditions; administer and supervise prescribed treatments; follow physicians' orders for treatment; correct deficiencies identified during previous inspections; communicate medical findings to treating physicians; attend to nutritional needs of recipients who required therapeutic diets; develop discharge plans for recipients; and follow the state sanitary code for meal services.

OMIG's investigative report documented a number of significant deficiencies at Garden. For example, investigators found that most of the medical files that were reviewed were missing medication administration records for the recipients at issue. Many of the recipient files also failed to appropriately document the recipient's course of treatment. Nearly all of the files for recipients requiring pain management services lacked required documentation demonstrating that pain management services actually were provided. Lastly, for recipients needing assistance with activities of daily living, none of the recipient files contained adequate documentation

demonstrating that such assistance was provided. As a result of the investigation, OSC terminated Garden's participation in the Medicaid program and obtained a settlement payment from Garden of \$1.6 million.

With this historical background, OSC undertook an expanded inquiry into AMDC services being provided in New Jersey.

III.

SCOPE OF REVIEW

OSC investigated the following five AMDC facilities:

- 1) *Oceanview Adult Medical Day Care* (Oceanview). Oceanview was located in Lakewood, New Jersey. The facility originally obtained an AMDC license under the name Riverside Manor on February 25, 2002, and subsequently changed its name to Oceanview Adult Medical Day Care in 2010. On February 22, 2011, DOH alerted OSC that Oceanview would be closing and selling its license to a facility in Mercer County.
- 2) *Home Sweet Home Adult Medical Day Care* (HSH). HSH is located in Elizabeth, New Jersey. It has been an AMDC provider since April 2005.
- 3) *Belleville Adult Medical Day Care* (Belleville). Belleville is located in Belleville, New Jersey. It has been an approved AMDC provider since April 2003.
- 4) *Golden Era Adult Medical Day Care* (Golden Era). Golden Era is located in Edison, New Jersey. It has been an approved AMDC provider since May 2008.
- 5) *Atlantic Adult Day Health Care* (Atlantic). Atlantic is located in Northfield, New Jersey. It has been an approved AMDC provider since June 2002.

OSC reviewed these facilities based in part on information received in connection with DOH's inspection program. The facilities' annual Medicaid reimbursements from the state from 2002 through 2011 were as follows:

	Oceanview	HSH	Belleville	Golden Era	Atlantic
2002	\$110,217.22	n/a	n/a	n/a	\$259,085
2003	\$323,866.11	n/a	\$380,710.07	n/a	\$787,907
2004	\$631,726.33	n/a	\$1,517,307.00	n/a	\$1,471,694
2005	\$728,363.25	\$1,217,059.16	\$2,104,178.34	n/a	\$1,923,921
2006	\$684,663.93	\$2,014,874.61	\$2,565,706.45	n/a	\$1,975,358
2007	\$762,347.62	\$2,306,861.79	\$2,446,409.52	n/a	\$2,059,108
2008	\$771,004.90	\$2,294,491.34	\$2,373,991.27	\$626,506.66	\$2,154,404
2009	\$882,848.86	\$2,387,612.47	\$2,696,653.46	\$2,045,509.76	\$1,962,996
2010	\$714,114.50	\$3,227,289.98	\$3,342,608.50	\$2,467,647.50	\$1,828,501
2011	n/a	\$2,171,231.50	\$2,101,288.00	\$1,756,673.00	\$1,823,106
Total	\$5,609,152.72	\$15,619,420.85	\$19,148,142.54	\$6,896,336.92	\$16,246,080

The primary purpose of OSC's investigations was to determine whether the required services these AMDC providers billed to the Medicaid program had been rendered and properly documented. The investigations included on-site inspections of these facilities, interviews of recipients and AMDC staff, and medical chart reviews.

Medical chart reviews may consist of either a "pre-payment review," a "post-payment review," or both. When OSC conducts a pre-payment review, the charts selected for review represent claims submitted to the Medicaid program that have not yet been paid. Any payment to the AMDC on such claims is held in abeyance until the pre-payment review is completed. If

the chart review indicates that reimbursement would be unwarranted, then payment on the claim is denied.

When OSC conducts a post-payment review, the medical charts selected for review represent claims for which the AMDC already has received payment. If the review indicates that the payment to the AMDC was inappropriate, OSC seeks to recover the overpayment as well as potential penalties and interest from the AMDC.

In accordance with *N.J.S.A. 30:4D-60*, this report sets forth the findings of these investigations. We provided a draft copy of this report to DMAHS, DOH and counsel for HSH, Belleville, Golden Era and Atlantic (the same counsel represents each of those four entities) for their review and comment. DMAHS did not have any objections to the draft report. DOH offered additional information for the report, which has been incorporated herein as appropriate. Counsel for the four facilities offered a series of suggested revisions to the report, which were incorporated into the final report as appropriate. We also sent relevant portions of the draft report to counsel for Oceanview, who confirmed that Oceanview is no longer operating an AMDC facility.

IV.

SUMMARY OF FINDINGS

OSC's investigations revealed a series of pervasive and significant deficiencies in the administration of the AMDC programs we reviewed. Those deficiencies had substantial fiscal consequences for state taxpayers and also affected the medical care provided to those attending the AMDC facilities.

Several of the facilities we reviewed received state payments on behalf of individuals who did not even attend the facilities on the dates in question. In one case, a facility billed the state for more than a month when the recipient actually was on vacation and not present at the facility. In another instance, an AMDC facility received more than \$10,000 for an individual who never even attended the program.

OSC's investigations also revealed a series of individuals receiving publicly funded AMDC services even though documentation indicated they did not need and did not appear to be medically or clinically eligible for such services. Even though these recipients' files did not reveal any medical treatment or other clinical services being received at the AMDC facility, the facility billed and was paid by the state on behalf of these individuals.

Even for those recipients who were clinically eligible for AMDC services, our investigations repeatedly found an absence of documentation demonstrating that required, prescribed services actually were provided, thus rendering the state's payments for those services improper. Where provision of services was documented, the documentation often contained striking errors, such as one facility routinely documenting that its staff administered insulin to a recipient at times when she had not yet signed into the facility for the day.

We make a series of recommendations to strengthen the oversight of the AMDC program and avoid further waste of taxpayer funds.

V.

INVESTIGATIVE RESULTS

OSC's investigative focus differed somewhat at each of the five AMDC facilities we reviewed, based on an assessment of particular risk areas as well as the content of any referrals

or allegations received concerning each particular facility. Our review of documentation at each facility typically included the following four main areas:

- 1) *Care Plans*. A care plan documents the specific goals of care for each recipient at an AMDC facility and is a requirement for all individuals receiving services at such a facility.
- 2) *Medication Administration Records (MARs)*. These records are a requirement for documenting the administration of prescribed medications at an AMDC facility.
- 3) *Activities of Daily Living (ADLs)*. ADLs are the functions or tasks involved in daily self-care, which are performed either independently or with supervision or assistance. ADLs include, for example, dressing, bathing, toilet use and eating. Provision of ADL-related services must be documented by an AMDC if the recipient is at the facility to receive such services.
- 4) *Pain Management*. When an individual's prescribed course of treatment at an AMDC facility includes provision of pain management services, the AMDC's provision of such services must be documented.

OSC has filed notices of claim against each of the facilities seeking financial recoveries and penalties. As indicated above, Oceanview ceased its operations during the course of OSC's investigation. OSC was, however, able to recover \$175,168 from Oceanview following its investigation. The other proceedings remain pending and cumulatively seek recoveries of several million dollars. The results of our investigation at each facility are set forth below. Each of the facilities will have an opportunity to dispute OSC's findings in a hearing before the Office of Administrative Law.

Oceanview

Pursuant to a referral from DMAHS, OSC conducted an investigation concerning billing practices at Oceanview. Based on preliminary investigative findings, OSC placed Oceanview on pre-payment monitoring. This monitoring consisted of a review of 50 randomly selected pending claims for the time period of December 10, 2010 to January 21, 2011. OSC's review revealed that 90 percent of those claims did not have the documentation needed to support reimbursement for the required services purportedly rendered. Specifically, there was a lack of documentation establishing that recipients' ADLs were being tracked or that related ADL services had been provided by Oceanview despite requirements to do so. OSC thus rejected payment on those claims.

OSC also conducted a post-payment review at Oceanview. That review included claims relating to 28 randomly selected Medicaid enrollees who purportedly attended the facility between January 1, 2006 and November 24, 2010. Oceanview was unable to provide 6 of the 28 charts requested. As a result, OSC sought repayment of all claims relating to those charts.

As to the remaining 22 recipient files, OSC noted a series of recipients whose MARs indicated the recipient's absence from the facility on a particular day, yet Oceanview had billed the state for services Oceanview claimed it provided on those days. Investigation further revealed that one such individual, for whom the state had paid \$11,075 to Oceanview, never attended the facility at all, although preliminary paperwork had been completed for her admission there.

OSC also noted a series of recipients who did not appear to be clinically eligible to participate in the AMDC program or did not appear to need the services provided by Oceanview. For example, one recipient was independent with respect to her own care, but used a cane for

walking due to arthritis. There was nothing in the admission information for the recipient that demonstrated any medical necessity for attending the program, and no necessary services were identified in her medical history or physical examination. There was no documentation of ADL assistance in her Oceanview file, and there was no documentation from any physician to establish that the recipient needed any ADL assistance.

Similarly, for another recipient, the admission information indicated that he was independent in his ADLs and there were no MARs or ADL documentation that indicated that Oceanview provided clinical services to this individual. Another recipient's admission information similarly indicated that he could walk independently and self-administer medication. Again, there was nothing in the file to demonstrate that Oceanview rendered any clinical services to this individual.

In some of the cases OSC reviewed, Oceanview's care plan contradicted the recipient's admission information. One recipient's care plan stated that she needed assistance with medication administration, mobility, monitoring of her blood glucose levels and monitoring of uncontrolled hypertension. The admission information, however, stated that she carried out her ADLs independently and that she was independent in monitoring her own blood glucose and blood pressure, as she performed this monitoring at home.

In other cases, there was no documentation demonstrating that Oceanview had provided care to recipients who needed it. For example, one recipient had cerebral palsy and communication difficulties, and generally was fully dependent on others for his ADLs. He also had impaired hearing and an anxiety disorder. In spite of this recipient's significant medical needs, there was no documentation demonstrating that Oceanview provided any services to him. Another recipient file stated that the recipient required assistance with showering and eating, but

there was no documentation to indicate that ADL assistance was provided. Similarly, for another recipient, the file noted that he needed assistance in taking his daily medication, but there was no documentation indicating that Oceanview provided such services. The care plan for another recipient included help with showering, medication administration and mobility. However, it appears the only service Oceanview provided to the recipient was weighing her on a weekly basis.

In sum, for the majority of recipient charts reviewed, OSC found no MARs and no documentation of tracking or recording ADLs. For the 22 charts reviewed, 75 percent of the claims billed did not have documentation to support the provision of the services authorized to be provided to those individuals.

HSH

After receiving a tip from a former HSH employee, OSC conducted a post-payment review of HSH billings submitted to the state Medicaid program. For our review, OSC randomly selected medical charts of 25 Medicaid enrollees who purportedly had received services at HSH.

All 25 charts reflected deficiencies in the provision of ADL services. Namely, HSH failed to provide adequate documentation that those recipients who required ADL services actually received them. For example, one recipient with impaired cognitive ability required assistance with ADLs such as mobility, eating and toilet use. Nonetheless, there was no daily ADL documentation in the recipient's medical record, although ADLs were mentioned in quarterly nursing notes.

Only 3 of the 25 charts included MARs. For one recipient recovering from cataract surgery there were physician orders for eye drops to be administered post-operatively, including

one medication to be given four times daily. Nonetheless, there was no indication whether the medications were actually administered at the facility, and the cataract surgery was not even mentioned either in the recipient's care plan or the nursing staff's quarterly review documentation.

Even where records existed concerning the provision and monitoring of medication, those records were incomplete. In one instance, there was no indication that HSH provided required eye medications at the facility as requested by the recipient's family. Moreover, even though the recipient was receiving insulin at HSH and needed daily monitoring of blood sugar levels, OSC found numerous dates of service with no blood sugar monitoring recorded anywhere in HSH's medical records.

Belleville

Pursuant to a referral received from DMAHS, OSC began an investigation of Belleville to determine whether required services allegedly provided to recipients at the facility were properly supported by documentation.

OSC conducted a post-payment review by randomly selecting medical charts of 25 Medicaid enrollees who were in attendance at Belleville during the period of January 2, 2010 through July 31, 2010. OSC found consistent deficiencies concerning MARs, care plans and pain management. These findings bring into question whether these individuals were receiving the required services and medical care for which the state paid.

Problems with MAR and related documentation were particularly pervasive. One recipient did not have his glucose levels monitored by the facility for several months, even though the recipient's physician had ordered that such monitoring be conducted twice each week.

Another individual was admitted to Belleville to receive daily blood pressure monitoring and medication monitoring, as well as assistance with various ADLs. Nonetheless, the recipient's medical chart contained no documentation of blood pressure monitoring and no daily ADL documentation. Another recipient at Belleville was admitted to receive blood pressure and blood sugar monitoring and assistance with ADLs. The recipient's physician also had ordered that Belleville alert the physician in the event of abnormally high glucose levels. Nonetheless, the records indicate that on one occasion when the recipient's blood sugar reached a dangerously high level, Belleville attempted to contact the recipient's physician, but when the facility did not receive a response Belleville never followed up with the doctor.

OSC also found conflicting information in Belleville's medical records. In some instances where administration of medicine was authorized, the recipient records indicate that the recipient did not actually need the authorized medication. For example, in one case there was a physician order to monitor blood sugar levels for a recipient three times per week, although there was no documentation of a diabetes diagnosis in the recipient's file. In any event, there is no documentation indicating that this service was performed as no blood sugar levels were recorded.

For another recipient there were conflicting medical records concerning whether he has the ability to self-administer medications. Such conflicting information in a medical chart presents a safety hazard for the recipient. Another recipient was initially admitted to Belleville for ADL assistance and physical therapy, and was subsequently authorized for blood pressure monitoring as well. For most of the period between the two authorizations, daily ADL assistance was not documented. Moreover, after the recipient was authorized to receive blood pressure monitoring, Belleville repeatedly failed to record her blood pressure readings.

Deficiencies in Belleville's care plans also were prevalent. In one instance, according to the nursing notes a recipient discussed suicide with a Belleville nurse in July 2010, reflecting a change in her mental health status, but this fact was never documented in the recipient's care plan. Similarly, for another recipient, there was documentation from a physician that the recipient was under psychiatric care for "major depressive disorder," yet Belleville's care plan did not address the recipient's mental health status.

For that same recipient, Belleville's MARs state that the recipient was absent on various days, yet Belleville billed the state for services allegedly rendered to this individual on 30 such days. A series of other recipient MARs had similar notations of the recipients being absent, while Belleville nonetheless billed the Medicaid program for services rendered to the recipient that day.

Golden Era

During a previous investigation conducted by DMAHS in December 2008, Golden Era was found to have enrolled ineligible individuals in its AMDC program. More recently, following receipt of several anonymous tips, OSC conducted a post-payment review to determine whether Golden Era's Medicaid billings were appropriate. OSC randomly selected for review the medical charts of 24 recipients who received services at Golden Era during the period May 1, 2008 through April 30, 2010. OSC found a series of violations and deficiencies in areas such as creation and documentation of care plans, provision of nursing services, provision of medical services, medication administration policies and procedures, and maintenance and content of medical records.

There were consistent problems with Golden Era's care plans. In one instance a care plan was simply never created for a recipient at Golden Era. Another recipient had his initial assessment conducted at the facility on March 30, 2009, yet his care plan was not developed until June 16, 2009. That delay violated *N.J.A.C. § 8:43F-5.3(b)*, which requires that a care plan be developed within five business days of the AMDC's initial assessment.

In other instances care plans were developed, but contained materially false information in a manner that raises questions about the quality of medical care being provided. For example, Golden Era's care plan for one recipient stated that the recipient had a below-the-knee amputation even though actually there had been no amputation. Upon our inquiries, Golden Era staff confirmed that the amputation entry was erroneous. The staff nurse explained to us that the error occurred because she developed the care plan by photocopying another recipient's care plan after whiting out inapplicable sections. She evidently had failed, however, to white out notations pertaining to the other individual's amputation.

The care plan for another recipient stated that she needed ADL assistance, including with her mobility and toilet use. However, the physician orders for this recipient stated that she is independent with respect to her ADLs.

Much of Golden Era's documentation also was internally inconsistent. One recipient was listed in his admission documents as being a non-smoker, despite notations in his chart requiring smoking cessation counseling. Another recipient's nursing assessment stated that the recipient had upper dentures and partial lower dentures, while a separate page of the same document stated that she did not have any dentures. Another recipient's file contained two different ADL charts for the same month for eight months in 2009. Such discrepancies make it difficult to determine the care that was actually being provided.

Deficiencies such as these resulted in inadequate monitoring of and care provided to recipients. For example, one recipient included in OSC's sample was admitted to Golden Era for daily monitoring of her blood sugar and blood pressure due to diagnoses of diabetes and hypertension. Nonetheless, records indicate that Golden Era staff failed to take the recipient's blood pressure on 76 percent of the days billed and failed to perform blood sugar monitoring on 62 percent of those days. For this same recipient, staff also failed to adequately document assistance with ADLs. In another instance, a recipient was prescribed to receive 24 physical therapy sessions, but actually received only five during the entire term of his admission. Similarly, another recipient was prescribed to receive physical therapy three times per week, for a total of 16 visits, but actually received such therapy on only three occasions.

There were similar issues with Golden Era's MARs. For example, staff routinely documented that insulin was administered to one recipient at times when she had not yet even signed into the facility for the day. For this same recipient, the MARs reflect timing of drug administration that was inconsistent with her physician's orders. In another instance, Golden Era staff transcribed the wrong dose of administered medication on the recipient's MAR. On another recipient's MAR, there are notations that the drugs benicar (used for high blood pressure) and etodolac (used for pain and arthritis) were to be administered for only two weeks and then a physician appointment was to be made. Nonetheless, Golden Era's staff continued to give these medications for a period of two months without any documentation indicating whether the staff contacted the recipient's physician, raising concerns about recipient safety and quality of care.

Another recipient at Golden Era was admitted for daily medication administration due to concerns involving cognitive impairment, blood pressure and pain management. Yet, for 23 of 40 dates of service (57 percent), no blood pressure was taken. Similarly, for another recipient

admitted to receive daily blood pressure monitoring, Golden Era did not document blood pressure monitoring for 70 percent of the days the facility billed the state over a seven-month period. Another recipient similarly was admitted for daily medication administration, blood pressure monitoring due to hypertension, and pain management. Nonetheless, there was no care plan for pain management and the documentation indicates that the recipient's blood pressure was taken on only 25 percent of the dates billed.

Golden Era also billed the state in instances where the records reflect the recipient was not even present at the facility. For example, one recipient's ADL chart reflects that he was away on vacation for more than a month, yet Golden Era billed Medicaid every day for this recipient during this time period. For another recipient the facility similarly billed the state on a day when Golden Era's progress notes stated the recipient was on vacation.

Atlantic

State regulations require that Medicaid participants sign in when they arrive at an AMDC facility, and that their arrival and departure times are documented to verify their attendance. Without supporting documentation demonstrating that the individual attended the facility for at least five hours, the facility is not eligible for payment on behalf of that individual for that day. *N.J.A.C. § 8:43F-6.1(e), (f); N.J.A.C. § 8:86-1.4.*

Pursuant to a referral received from DOH, OSC investigated Atlantic to determine whether documentation supported the purported attendance of individuals at that facility. OSC selected for review 228 separate claims that Atlantic submitted to the state for payment for the time period June 1, 2010 through May 31, 2011. Each claim represented an individual recipient who purportedly attended Atlantic on a particular day. A review of the attendance sheets found

that on 133 of the 228 dates of service, the individual's signature was not recorded at the facility. Moreover, no arrival or departure times were recorded for any of the 228 days.

In a further attempt to determine whether recipients were actually at the facility on dates for which Atlantic had been paid, OSC also reviewed a sample of Atlantic's transportation logs. Those logs are designed to document transportation of recipients to and from the AMDC facility. According to Atlantic, for all of their recipients, transportation provided by Atlantic was their only means of getting to the facility. OSC found that such information concerning recipient transportation was not consistently documented on the log and thus OSC was unable to verify the attendance of many of the recipients on the dates in question. In addition, there was no consistent documentation demonstrating pick up or drop off times, resulting in an inability to confirm that the recipients had spent the requisite five hours at the facility.

VI.

CONCLUSIONS AND RECOMMENDATIONS

AMDC programs provide an important and necessary service by allowing individuals with specialized medical needs to remain in their community rather than enter more intensive and expensive in-patient facilities. It is apparent, however, that more aggressive monitoring of AMDC facilities is needed. This series of OSC investigations has revealed repeated and substantial waste of taxpayer dollars at AMDC facilities, payment for services never rendered, payment for individuals not needing services, and recipient health apparently being placed at risk.

As a result, OSC is pursuing financial recoveries and penalties from these facilities. OSC also will implement enhanced oversight of the facilities referenced in this report to include periodic reviews of billing protocols and sample audit testing.

In addition, the state's transition to managed care in the AMDC program squarely presents an opportunity to revisit and strengthen current monitoring procedures. The fiscal consequences of failure in this regard are significant. If MCO costs in administering the AMDC program are inflated due to fraud, waste and abuse, the state bears the expense through increased capitation payments on behalf of these recipients. On the other hand, reduction of MCO costs through enhanced monitoring of AMDC providers presents the potential to reduce the amount the state pays.

Accordingly, as the transition to managed AMDC care proceeds, OSC recommends the following:

1. The MCOs institute a standard protocol through which the AMDC providers in their networks can properly assess whether prospective recipients are clinically eligible for the AMDC program.
2. The MCOs ensure that the AMDCs in their network employ appropriately certified medical personnel on-site who are active participants in the creation of care plans and the oversight of recipient care, including the daily medication given to recipients. Such personnel should be charged specifically with verifying that appropriate medical care is being provided as required and that recipients no longer requiring such care are being discharged.
3. The MCOs conduct unannounced site visits to AMDC providers, as well as random and routine audits, to determine whether services are being provided and documented

as required and whether recipients listed as receiving services are actually in attendance. Such audits should include detailed reviews of recipient charts to ensure, among other things, that AMDC facilities are providing quality medical care to these individuals.

4. The MCOs ensure that there is effective communication between AMDC facilities and recipients' primary care physicians and other health care providers.
5. The MCOs draft standardized forms to be used, for example, for MARs and care plans and for documenting the provision of pain management services, to promote appropriate AMDC practices and facilitate review by auditors.

In short, MCOs should work aggressively to fulfill their oversight role in the provision of care. OSC will continue to review the MCOs' oversight to ensure that they are performing that function adequately. OSC also will continue to investigate and audit AMDC facilities to ensure that all parties are carrying out their responsibilities in a manner that is consistent with sound fiscal and clinical practices.