STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER

MEDICAID FRAUD DIVISION
WORK PLAN
Fiscal Year 2012

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I.

INTRODUCTION TO THE MEDICAID FRAUD DIVISION

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to certain low income and disabled individuals. The federal and state governments jointly fund and administer the Medicaid program. At the federal level, the Centers for Medicare and Medicaid Services (CMS) monitors each state's Medicaid program. Each state administers its Medicaid program in accordance with a CMS-approved state plan. In New Jersey, the Division of Medical Assistance and Health Services (DMAHS), within the Department of Human Services (DHS), is the single-state agency responsible for operating the Medicaid program. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with federal requirements. One of these requirements is that each state maintains a Medicaid Program Integrity Unit to run utilization reviews of its billing system and investigate fraud, waste, and abuse in the varied Medicaid programs. Prior to the creation of the Office of the State Comptroller's Medicaid Fraud Division (formerly the Office of the Medicaid Inspector General), staff within DMAHS conducted these functions.

Signed into law on March 16, 2007, the "Medicaid Program Integrity and Protection Act" (the Act), N.J.S.A. §30:4D-53 et al., established the Office of the Medicaid Inspector General, now the Medicaid Fraud Division (MFD) within the Office of the State Comptroller. Comprised of a team of analysts, auditors, investigators, and regulatory officers, the MFD provides rigorous oversight of New Jersey's Medicaid program.

The Act provides that the MFD be independent from DMAHS so that it can function as a "watchdog" over the State's Medicaid programs. Efforts were undertaken by creating the MFD to separate the administrative functions and program integrity functions of the Medicaid program while still preserving the single state agency structure required by federal law; therefore, while the MFD still makes recommendations to DMAHS regarding program administration and regulations, MFD is independent of DMAHS.

The MFD has three units: Fiscal Integrity; Investigations; and Regulatory. The plans of these units for fiscal year (FY) 2012 are outlined in more detail below. The MFD's plans are subject to change based on resource allocation and unforeseen events that may shift the MFD's priorities. Additionally, the plans discussed below are not exhaustive, and therefore should not be construed to include all items that the MFD intends to address in FY 2012.

II.

GLOBAL INITIATIVES

OVERVIEW

The biggest challenge facing the MFD in 2012 is the shift in its focus from fee-for-service programs to managed care. Prior to FY 2012, the MFD focused its efforts on investigating and auditing fee-for-service providers and overseeing the investigative efforts of the Medicaid Managed Care Organizations (MCOs). The State of New Jersey's FY 2012 budget transferred the fee-for-service programs, with a few limited exceptions, into the Medicaid Managed Care program. Consequently, the MFD's

biggest priority in FY 2012 is enhancing its efforts to investigate and audit providers and recipients in the MCO networks as well as continuing to audit and investigate the remaining fee-for-service programs. To facilitate this transition, the MFD has been working closely with the MCOs to coordinate its efforts and to revise the MCOs' contract with the State to ensure that program integrity responsibilities are carefully delineated and the State's program integrity functions remain strong.

Another new challenge facing the MFD is its oversight of the efforts of the State's Recovery Audit Contractor (RAC). Since 2005, the federal government has successfully used RACs to prevent fraud and abuse in the Medicare program. As a result, the Affordability Care Act of 2010 (ACA) requires each state to incorporate a Medicaid RAC component into its state plan. DMAHS, with input from the MFD, selected the third party contractor that will serve as New Jersey's RAC. The RAC audits both fee-for-service and managed care providers to identify overpayments and it collects either 9.03% or 12.5% of the money recovered, depending on the complexity of the audit, returning the remaining recoveries to the State.

The MFD is coordinating the RAC's activities in an attempt to avoid providers undergoing multiple audits at any one time. The MFD also provides guidance to the RAC on the types of audits that it should conduct. The MFD will review the results of the audits to determine if the audits should be expanded, investigations opened, or referrals to the Medicaid Fraud Control Unit are warranted.

Outlined below are general initiatives that the MFD will seek to continue in FY 2012.

INITIATIVES

Communications and Marketing

In FY 2012, the MFD will maintain and foster its stakeholder relationships by: meeting with legislators and state agency heads to update them on our efforts and discuss how legislation may impact Medicaid fraud and abuse; educating Medicaid providers on Medicaid fraud, waste, and abuse as well as compliance issues; and establishing new channels through which the MFD may receive fraud, waste, and/or abuse complaints and referrals.

The MFD values regular communications with providers, both directly and through provider associations. Many providers have established best practices and the MFD is interested in learning about those practices and sharing them with other providers. Additionally, the MFD will work with providers on audits, self-disclosure policies, and compliance initiatives to improve provider compliance with Medicaid rules and regulations.

The MFD's website is another essential marketing tool. The website, www.nj.gov/comptroller/divisions/medicaid, not only contains background information about the division, it provides information on Medicaid regulations, investigative and audit reports, disqualified providers, presentations, provider compliance, self-disclosure policies, and a listserv subscription service that enables subscribers to receive alerts from the MFD as soon as they are posted on the website. Some of these alerts themselves serve as an investigative tool. For example, if a physician's prescription pad is stolen, MFD will post an alert on its website in order to prevent the pad from being used. The website also serves as a way to file a complaint about suspected fraud, waste, and abuse within the Medicaid program, or for a

provider to download a fraud poster to display in the provider's office. All workplans are also posted to the website so that our areas of focus are readily available to all interested parties. Finally, the website contains useful links such as a link to the State's disbarment list so providers can determine whether a new employee has been excluded from participation in the Medicaid program.

ACA Compliance

The ACA imposed new responsibilities on providers and on the MFD to address Medicaid fraud and abuse prevention and detection, as well as the recovery of overpayments.

Section 6401 (b)(1) of the ACA places all provider categories into three risk levels based on their vulnerability to fraud, waste, or abuse: limited, moderate, and high. States may only increase the risk level for a provider, not lower it. The risk level determines the level of scrutiny applied to an applicant seeking to become a Medicaid provider.

The MFD, in consultation with DMAHS and the Department of Health and Senior Services (DHSS), who also administers Medicaid programs, determined the appropriate risk category for each provider type. Our collective evaluation resulted in the high risk category comprising of: newly enrolling durable medical equipment providers; pharmacies; prosthetic and orthotic providers; adult and pediatric medical day care providers; and newly enrolling home health providers. The moderate risk category is comprised of: ambulance providers; community mental health centers; comprehensive outpatient rehabilitation facilities; hospice providers; independent diagnostic testing facilities; independent clinical laboratories; physical therapists; portable x-ray providers; and re-enrolling home health providers.

The MFD is also now required to conduct unannounced pre-enrollment site visits of providers who fall into the moderate and high risk categories, and perform a criminal background check for each person with an ownership or control interest or who is an agent or managing employee of a provider in the moderate or high risk categories. Part of New Jersey's transition to managed care includes the elimination of applying to become a Medicaid provider if the provider is part of the MCO's network. The MFD will work with the MCOs to determine how best to comply with this federal requirement.

ACA Section 6402 (d) requires providers to return overpayments by the later of 60 days after the date on which the overpayment was identified or the due date of any corresponding cost report. Failure to return the overpayment within this period subjects the provider to potential penalties under the False Claims Act ($1,500 to $11,000 per claim; see also Footnote 1 infra). Similarly, Section 6402 (h) requires the MFD to suspend payments, in whole or in part, to a provider against whom there is a pending investigation based upon a credible allegation of fraud. A credible allegation of fraud is defined as "an allegation, which has been verified by the State…. Allegations are considered credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis." 42 C.F.R. § 455.23. When payments are suspended based upon a credible allegation of fraud, the MFD must make a fraud referral to the Medicaid Fraud Control Unit (MFCU) in the State Attorney General's Office. If there is good cause not to suspend the payments, the MFD has the discretion not to suspend payments, or to suspend them in part. 42 C.F.R. § 455.23 (e) and (f). While a provider must be notified within five days of a suspension of payment, this section permits the MFCU or other law enforcement agency to request that the notification be delayed 30 days (renewable twice up to 90 days), and/or to request that payments not be suspended if it would

compromise or jeopardize the investigation. If requested by the MFCU or other law enforcement agency, the suspension may continue until the conclusion of the investigation.

Section 6501 requires a state to terminate individuals or entities from their Medicaid program if the individual or entities were terminated from another state's Medicaid program. The federal government is establishing a portal for states to check on each other's terminations, which the MFD will continually monitor.

Section 6401 (b)(5) of the ACA also requires New Jersey Medicaid providers to have a compliance program. Having a vigorous and effective compliance program is in the best interests of all health care providers as it strengthens a provider's ability to control fraud, waste, and abuse and consequently improves the quality of health care and lowers costs. It emphasizes, to the provider's employees and the public, the provider's commitment to conducting its affairs honestly and responsibly. In an effort to assist providers in developing and/or strengthening their compliance protocol, the MFD has issued guidance, which can be found on the MFD's website under Provider Compliance.

Where the MFD identifies significant compliance or control weaknesses, or where no compliance program exists, the MFD will meet with the provider's senior management and board of directors to identify the reasons for the compliance program's failure or why no compliance program existed. The MFD will consider if the conduct of senior management or the board requires a sanction or exclusion from the Medicaid program for failure to comply with compliance and oversight obligations.

To further the goals of compliance, the MFD plans to publish compliance guidance in the adult medical day care program to address problems that the MFD has

uncovered in the course of its investigations of this provider type. Additionally, the MFD plans to work in conjunction with the State's Medicaid billing vendor to conduct provider training to correct abusive and wasteful billing practices.

DRA § 6032 Compliance

The MFD also oversees Section 6032 Compliance Requirements for New Jersey. The Federal Deficit Reduction Act of 2005 requires entities that receive annual Medicaid payments of $5 million or more to certify that they have written policies which detail information about the False Claims Act, state laws that pertain to civil or criminal penalties for making false claims and statements, and whistleblower protection. These policies must be accessible to the entity's employees, contractors, and agents. The MFD reviews all such reporting submissions by providers.

Self Disclosures

Because New Jersey cannot afford to "pay and chase," we must educate providers on compliance, guide them to cure wasteful practices, instruct them how to strengthen internal controls, and encourage them to submit self-disclosures to our office when they discover they have overbilled Medicaid.

Once a provider discovers that it has overbilled Medicaid, it should contact MFD as early in the process as possible to maximize the potential benefits of self-disclosure.[1]

[1] Section 6402 of the ACA amends the Social Security Act by inserting a new Section 1128J. This section requires a provider who identifies an overpayment to report and return the overpayment to, among others, the state, within 60 days of the identification of the overpayment. If the provider is paid on the basis of cost report submissions, the provider must return the payment to the state on the date the cost report is due. Failure to report the overpayment within these time frames subjects the provider to False Claims Act penalties. Matters related to an on-going audit/investigation of the provider generally are not eligible for resolution under the self-disclosure protocol. Unrelated matters disclosed during an on-going audit may be eligible for processing under the self-disclosure protocol assuming the matter has received timely attention. If MFD is already auditing or investigating the provider and the provider wishes to disclose an issue, in addition to submitting a disclosure under this protocol the provider should bring the matter to the attention of the on-site audit staff. If another outside agency is auditing or investigating the provider and the provider

Because of the wide variance in the nature, amount and frequency of overpayments that may occur over a wide spectrum of provider types, it is difficult to present a comprehensive set of criteria by which to judge whether disclosure is appropriate. Providers must determine whether the repayment warrants self-disclosure or whether it would be better handled through administrative billing processes.[2]

The MFD will audit any information providers submit for accuracy and confirm the proper amount that is owed based on our evaluation. Each incident will be considered on an individual basis. Factors to consider include the exact issue, the amount of overpayment, any patterns or trends that the problem may demonstrate within the provider's system, the period of non-compliance, the circumstances that led to the non-compliance problem, the organization's history, and whether the organization has a corporate integrity agreement (CIA) or corrective action plan (CAP) in place. Issues appropriate for disclosure may include, but are not limited to: substantial routine errors; systematic errors; patterns of errors; and potential violation of fraud and abuse laws.[3]

Once a provider determines to disclose a problem, the disclosure should include the following information:

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seeks to disclose an issue to MFD, the provider should follow this guidance accordingly. If a provider seeks to self disclose an overpayment after the RAC has begun its audit, the provider will not automatically avoid False Claims penalties.

[2] Because of the complexity of some issues surrounding self-disclosures, providers should consider obtaining the advice of experienced healthcare legal counsel or consultants.

[3] Upon review of the provider's disclosure and related information, the MFD may conclude that the disclosed matter warrants referral to the MFCU. Alternatively, the provider may request the participation of a representative of the MFCU, HHS-OIG, the Department of Justice or a local United States Attorney's Office in settlement discussions in order to resolve potential liability under federal or State False Claims Act or other laws.

- The basis for the initial disclosure, including how the problem was discovered, the approximate time period covered, and an assessment of the potential financial impact;
- The Medicaid program rules potentially implicated;
- Any corrective action taken to address the problem leading to the disclosure, the date the correction occurred and the process for monitoring the issue to prevent recurrence; and
- The name and telephone number(s) of the individual making the report on behalf of the provider. The individual may be a senior official within the organization or an outside consultant or counsel but should, in any event, be in a position to speak for the organization.

The MFD's goal is not to alter the day-to-day business processes of organizations for minor or insignificant matters. Consequently, the repayment of simple, more routine occurrences of overpayment should continue through typical methods of resolution, which may include voiding or adjusting the amounts of claims. Providers should be aware that the MFD monitors both the number and dollar amounts of voids and/or adjustments, as well as any patterns of voids and/or adjustments. The MFD highly discourages providers from attempting to avoid the self-disclosure process when circumstances in fact warrant its use.

If there appears to be a pattern of self-disclosure in a particular area, or if a self-disclosure reveals a practice that may be endemic to the provider group, the MFD will expand its audit review accordingly.

III.

IMPLEMENTATION TOOLS

The MFD's three units, Fiscal Integrity, Investigations, and Regulatory, carry out the Division's mission of improving both the efficiency and integrity of New Jersey's Medicaid programs.

A.

FISCAL INTEGRITY

The Fiscal Integrity Unit 's wide-range of responsibilities include, but are not limited to: recovering all Medicaid overpayments identified by the MFD's other units; auditing Medicaid provider claims; analyzing claims data for fraudulent patterns; and overseeing all third party recoveries. These responsibilities are carried out by Fiscal Integrity's four sub-units: Audit; Data Mining; Recovery and Exclusion; and Third Party Liability.

Audit

The Audit Unit audits Medicaid providers to ensure compliance with program requirements and identifies overpayments. These audits allow the MFD to monitor the cost-effectiveness of Medicaid services, as well as providers committing fraud and abuse within the Medicaid program. The Audit Unit also coordinates, oversees, and reviews the audit work of other State agencies, third-party contractors, and the RAC.

The Medicaid program requires participating providers to maintain adequate records to support their billings. For example, providers must maintain financial and statistical records which are used for the purpose of establishing reimbursement rates. Providers who participate through MCOs must maintain records in accordance with the

contract language between the MCOs and DMAHS, and abide by all applicable state and federal laws and regulations, regardless of whether they are actually Medicaid providers. Fee-for-service providers, who are paid in accordance with DMAHS-established rates, fees, and schedules, must prepare and maintain contemporaneous records demonstrating their right to receive payment. The provider must maintain all records necessary to disclose the nature and extent of services or equipment furnished and its medical necessity, including any prescription or fiscal order for the service or equipment, for a period of five years from the date the care, services, or supplies were furnished or billed, whichever is later. MFD auditors review provider records to ensure compliance with these requirements. For more information on the MFD audit process, please refer to the MFD Audit Guidebook posted on our website under Medicaid Fraud Division Audit Reports.

Data Mining

The Data Mining Unit reviews providers' anomalous claim reimbursement behavior, and based on a preliminary review, submits its findings to either the Audit Unit for determination of whether a full audit should be scheduled or the Investigations Unit for a more clinical review. The Data Mining Unit reviews Medicaid audit findings from other states, CMS alerts, as well as the results of federal investigations into Medicare and Medicaid fraud and abuse to generate data analyses for review in the New Jersey Medicaid system.

With New Jersey's move to managed care, the Data Mining Unit will expand its reviews beyond fee-for-service claims into encounter data supplied by the MCOs and ultimately will review paid claims data to identify potential fraud and abuse issues. As MFD continues to grow, the Data Mining Unit will be the primary internal referral source for both the Audit team and Investigations Unit.

Recovery and Exclusion

Our Recovery and Exclusion team recovers overpayments identified by MFD auditors and investigators. Additionally, the team determines when to exclude a Medicaid provider from the program. The primary goals of the Recovery and Exclusion team are twofold: 1) promptly recover overpayments from providers and recipients; and 2) exclude providers who fail to adhere to the regulations of New Jersey's Medicaid program.

Where MFD has identified an overpayment, the Recovery and Exclusion team may, under certain circumstances, withhold payments to a Medicaid provider until that overpayment is recouped. In other circumstances, the Medicaid provider may make payment arrangements with the MFD. For a recipient who received Medicaid benefits when not entitled to them, the team may file a Certificate of Debt on the recipient's property so that the state can receive its share of monies should the recipient sell his or her property.

Where circumstances warrant it, the Recovery and Exclusion team will also exclude providers from the Medicaid program. The Recovery and Exclusion team will review the circumstances and determine the appropriate sanction, including suspension, debarment, or disqualification. Such circumstances include, but are not limited to: 1) the provider is excluded by the federal government or another state from participating in the Medicaid program; 2) the applicable licensing board has taken action against the provider's license; or 3) the provider has been arrested, indicted, and/or convicted of a criminal act, especially health care fraud.

Third Party Liability

Medicaid is the payor of last resort, but providers often do not bill the responsible third party insurer. A significant amount of the State's Medicaid recoveries are the result of the MFD's efforts to obtain payments from third party insurers responsible for services inappropriately paid by Medicaid funds. The Third Party Liability unit (TPL), working with an outside vendor, seeks to determine whether Medicaid recipients have other insurance. The TPL unit also ensures that if the recipient has other insurance which should have paid for medical services any money paid will be recovered from the private insurer.

B.

INVESTIGATIONS

The Investigations Unit investigates providers and recipients to determine whether they have committed fraud, waste, or abuse in the Medicaid, FamilyCare, and Charity Care programs. Our investigators have a wide variety of law enforcement, nursing, and Medicaid program experience that is ideal for scrutinizing claims submissions, interviewing witnesses, and performing clinical reviews of medical charts. Our investigators serve subpoenas, testify in legal proceedings, and conduct both announced and unannounced site visits of provider locations to review records and documentation, and to verify the credentials of healthcare providers.

MFD investigators identify many types of fraudulent provider billing practices including but not limited to: billing for services not rendered; providing medically unnecessary services; submitting duplicate claims for reimbursement; upcoding (billing for treatment that is more acute and costly than the treatment, actually provided); unbundling (submitting claims for separate services which should be submitted as a

unit for a lower reimbursement rate); buying back and re-dispensing medication; providing generic medication when name brand medication was prescribed; and drug diversion.

MFD Investigators are trained to assess the credibility of individuals they interview and are experienced in analyzing claims data to uncover complex health care fraud schemes and gathering evidence to prove the existence of the schemes in court. They work with a variety of federal, state, and local law enforcement agencies, such as the Federal Bureau of Investigation, the Drug Enforcement Administration, the Federal Drug Administration, the Office of the Inspector General of the United States' Department of Health and Human Services, and other states' Medicaid Program Integrity departments. The MFD also refers cases of suspected criminal health care fraud to the New Jersey Medicaid Fraud Control Unit (MFCU) in the Attorney General's Office. For the MFD to be truly effective, it is vital that a high level of cooperation and coordination exist between the MFCU and the MFD. Consequently, the MFD meets with the MFCU on a monthly basis to share intelligence and coordinate investigative efforts.

The Investigations Unit determines the validity of reported allegations of fraud, waste, and abuse in the Medicaid program. Sources of investigations include, but are not limited to, recipients, physicians, hospitals, long term care facilities, adult medical day care centers (AMDCs), pharmacies, laboratories and durable medical equipment (DMEs) providers.

MFD determines whether billings match the treatment provided and whether recipients are receiving the appropriate quality of care. MFD Investigators review relationships between ordering physicians and providers of ordered goods and services, ensure physicians are properly licensed and not excluded from the Medicaid program at the time goods and services are ordered, review claims for services that are

denied because of systems edits, identify organizations that use the services of excluded providers, and examine providers who bill Medicaid excessively or order services and goods for individuals who do not appear to be patients. Findings are then referred to MFD's Recovery and Exclusions team to seek a return of monies paid and sanctions against the providers where appropriate.

MFD investigators also ensure that providers who are unlicensed or excluded, (providers debarred from any federally funded health care program due to professional misconduct or a criminal arrest or conviction) are not treating, ordering, or billing for services rendered to Medicaid recipients. Exclusions may last anywhere from three to eight years, depending on the severity of the conduct warranting exclusion. The Investigations Unit identifies excluded providers by sharing information with other state and federal agencies and by checking employment databases. When an excluded or unlicensed provider is found treating Medicaid recipients, the MFD seeks to recoup Medicaid funds paid for services rendered by that provider, and in some instances may seek damages and false claims penalties from the excluded individual and/or the employer.

Investigators also handle recipient fraud, including fraud surrounding issues of eligibility and medical necessity. Eligibility fraud involves individuals who defraud or attempt to defraud the Medicaid program by falsifying their income in order to qualify for Medicaid, FamilyCare, or Charity Care benefits. A particular problem exists with self-employed individuals who falsify their tax returns by not declaring all the income derived from their business. When there is a reason to question self-employment income, MFD investigators will request additional verification from suspected individuals. If MFD investigators find the individual's income is greater than what he/she declared or if the individual refuses to provide supporting documentation, the

individual is terminated from the Medicaid or FamilyCare Program. The MFD Recovery and Exclusion team will then recover the money spent to provide the individual with medical care, including penalties and interest. MFD has also referred eligibility cases to local prosecutors, sometimes leading to arrests and convictions.

Medical necessity fraud, (also known as doctor shopping), involves knowingly obtaining services that are not medically necessary. These cases are often intertwined with provider fraud. For example, a recipient who does not need psychiatric treatment may find a psychiatrist to provide the recipient with a controlled substance prescription. The doctor, in turn, bills the Medicaid program for a 45-minute therapy visit that did not take place. The recipient then takes the prescription to a pharmacy, which fills the prescription and sells all or a portion of the medication on the street. In other cases the recipient sells the medication back to the pharmacy in return for other items in the pharmacy. The recipient may do this with more than one doctor or more than one pharmacy several times a day.

After identifying such a recipient, MFD investigators review computer printouts of all services billed to Medicaid as a result of the recipient's visits to doctors or clinics. All of the prescriptions billed for treatment of the recipient are reviewed and all of the pharmacies submitting the claims for the recipient are identified. Recipients who engage in this type of activity can be "locked in" to one pharmacy where they are restricted to obtaining prescriptions. Additionally, the MFD may pursue recoveries from recipients and providers, and make referrals to the MFCU for prosecution.

C.

REGULATORY

The MFD's Regulatory Unit provides administrative, investigative, and rule-making support to other MFD units. MFD's Regulatory Unit appears on behalf of MFD at all OAL hearings. MFD regulatory officers also negotiate and monitor corporate integrity agreements, aide in investigations by advising investigators on evidentiary issues and assisting in interviews, and review Medicaid regulations to determine if changes need to be made. The officers will also work with other MFD staff to develop compliance programs for Medicaid providers, publish fraud alerts and provide other guidance to the health care industry concerning anti-kickback and false claims statutes.

IV.

FISCAL YEAR 2012 OBJECTIVES

The MFD is charged with recovering Medicaid dollars from both providers and recipients. Below are the areas where the MFD will focus its efforts to recover such dollars in FY 2012.

A.

PROVIDERS

Adult Medical Day Care Services

The Adult Medical Day Care Services (AMDC) program, administered by DHSS, licenses adult medical day care centers. The centers provide daily, medically necessary services in a non-residential ambulatory care setting to eligible individuals. Due to

physical and/or mental impairment, these individuals require health maintenance, rehabilitation and restorative services to enable them to continue to live in their community. The program is designed for adults over the age of eighteen who do not require 24-hour inpatient institutional care.

The AMDC program was a fee-for-service program that was moved into managed care for FY 2012. Since AMDC is new to the MCOs, MFD and DHSS conducted an educational session on fraud and abuse in the MCO program. MFD will continue to monitor these programs to ensure that the Medicaid recipients who need these services most are medically qualified to participate, that Medicaid patients have been appropriately admitted into these programs, and that recipients are receiving the care and services that were ordered, which services were billed, and that these individuals are receiving the appropriate quality of care. The investigators will compare physician orders to medical charts and review prior authorizations, care plans, facility policies and procedures, statements of deficiencies, and plans of correction. Additionally, the investigators will interview patients, staff, and primary care physicians to ensure that recipients are appropriately examined upon admission, that all orders are medically necessary, and that providers follow each recipient's plan of care.

Charity Care

The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) provides free medical care or reduced charge care to patients who receive either inpatient or outpatient services at acute care hospitals throughout the state of New Jersey. Hospital assistance and reduced charge care are available only for necessary hospital care and only to New Jersey residents who either have no health coverage or partial coverage, are ineligible for any private or governmental sponsored

coverage (such as Medicaid), and meet **both** the income and assets eligibility criteria established by DHSS. Some services, such as physician fees, anesthesiology fees, radiology interpretation, and outpatient prescriptions are separate from hospital charges and may not be eligible for reductions.

All Charity Care applicants must be screened to determine the potential eligibility for any third party insurance benefits or medical assistance programs that might be paid towards the hospital bill. Patients are not eligible for the hospital care payment assistance program until they are determined to be ineligible for all other medical assistance programs. Patients are responsible for obtaining a financial screening from the hospital in a timely manner. Usually, a patient must apply for Medicaid within three months of receiving hospital services. Based on the information provided by the patient, the hospital will determine whether the patient is eligible. If the patient fails to cooperate with the hospital or does not receive screening in a timely manner, the hospital has the option to bill the patient and pursue collection efforts, regardless of eligibility for hospital care payment assistance.

Currently, hospitals do not have a mechanism to review and verify information submitted in Charity Care claims, leaving the process vulnerable to those who lie about their income and assets. A 2007 report by the New Jersey State Commission of Investigation (SCI) found that numerous applicants received Charity Care benefits for which they were not entitled. The SCI also found that an outside vendor hired to audit Charity Care applications simply reviewed the paperwork and not the supporting documentation. In response to the SCI's report, our auditors spot check hospital records and review both the applications and supporting documentation of Charity Care applicants. The MFD's Investigations Unit also follows up on allegations of

Charity Care fraud that it receives from both its fraud hotline and the DHSS, which administers the Charity Care program.

DHSS entered into a contract with a third party vendor to conduct a five-year retrospective audit of Charity Care claims in order to identify whether third party insurers should have paid the claims instead of Charity Care. In circumstances where the third party insurers are responsible, the State will be reimbursed. If the vendor finds evidence of fraud or abuse during its review, the matter will be referred to the MFD for an expanded audit and/or investigation.

Child Behavioral Health Services

The Division of Child Behavioral Health Services (DCBHS) within the Department of Children and Families (DCF) serves children and adolescents and their families with behavioral health care challenges. DCBHS provides these services, which are covered by Medicaid, based on the needs of the child and the family in a family-centered, community based environment.

DCBHS contracts with a contract services administrator (CSA), which provides a single point of contact for families requiring these services. The CSA's responsibilities include tracking, registering and coordinating care for children who are screened – at any level – into its Children's Behavioral Health System of Care. Qualified providers are listed with the CSA, and when contacted by a family, the CSA connects an appropriate provider with the family. Additionally, as part of its duties, DCBHS contracts with residential treatment centers to provide services for families that need them. The treatment centers likewise bill Medicaid for the services they provide.

Through audit and investigative tools, the MFD will ensure that Medicaid families are receiving the services for which Medicaid is billed and the program is

operating efficiently. The MFD will work with DCBHS to identify trends or patterns that indicate provider fraud and abuse, and where identified, recover overpayment from providers.

False Claims Act and Qui Tam Cases

New Jersey's False Claims Act Statute, N.J.A.C. 2A:32C-1 et seq., which closely mirrors the Federal False Claims Act Statute, 31 U.S.C. §3729 et seq., enables individuals to file a civil complaint on behalf of the State when there are allegations that providers knowingly present false or fraudulent claims to the state for payment, misappropriate state property, or deceptively avoid binding obligations to pay the state, among other things. The Complaint, labeled a Qui Tam, is filed under seal (is not initially made public) with the court and served upon the State Attorney General's Office. The Attorney General's Office has 60 days to determine whether to intervene in the case, or to request good faith extensions from the court to keep the matter under seal while the Office continues its investigation.

The MFD receives copies of Qui Tam complaints with a Medicaid nexus from the Attorney General's Office. The MFD will continue to work with the Attorney General's Office on those matters and review the complaints to determine whether further investigations or an audit are warranted.

Federally Qualified Health Centers

Federally Qualified Health Centers (FQHCs) are independent clinics that receive funding from a direct grant under Section 330 of the Public Health Service Act, or meet the eligibility requirements to receive funding under a contract with the recipient of a Section 330 grant.

FQHCs are safety net providers such as community health centers, public housing centers, outpatient health programs and programs serving migrants and the homeless. The main purpose of the FQHC program is to enhance the provision of primary care services in underserved communities. FQHCs are mandated by law to provide medical services to patients regardless of their ability to pay.

FQHCs are reimbursed using the Prospective Payment System (PPS), which is based on a payment rate per encounter. The rate is determined in accordance with 42 U.S.C. §1396a(a) and adjusted annually by the Medicare Economic Index (MEI) applicable to primary care services. FQHC services are services provided by physicians, physician assistants, advanced practice nurses, nurse midwives, psychologists, dentists, and clinical social workers.

To provide oversight of FQHC's, MFD auditors will verify that licensing and permit documentation at these agencies in accordance with federal and state regulations. The MFD will also review the adequacy of their policies and procedures manual, staffing composition, employee licenses, relevant employment contracts, patient medical records, quarterly reports, quarterly wrap around reports and all applicable managed care contracts and remittance advice documentation. The MFD will also test the medical necessity and appropriateness of claims billed to the State for reimbursement.

Home Health Services

The Medicaid program reimburses home health agencies for medical services rendered to recipients in their homes, including: professional nursing care by a public health nurse, registered professional nurse or licensed practical nurse; homemaker home health aide services; physical therapy; speech-language pathology services;

occupational therapy; social services; nutritional services; and the supplying of certain medical supplies. The MFD will ensure that reimbursement for these services is provided according to medical, nursing and other health care related needs of the recipient, and are based on documented plans of care, medical necessity and the goals to be achieved and/or maintained.

The MFD will audit these agencies to verify that all aides are certified and have appropriate educational background to perform the services billed for; that the recipient's diagnosis justifies the higher reimbursement rate for home health services; that charts contain adequate documentation and care plans; and that services billed were in fact rendered.

Hospice Services

Hospice services, administered through DHSS, are available for terminally ill patients regardless of whether they reside in the community or in an institution. In order to qualify for these services, a recipient must be diagnosed with a terminal illness which is defined as a medical prognosis of a life expectancy of six months or less, as certified or recertified in writing by a licensed physician.

MFD investigators will review the medical records of recipients of these services to determine whether these services were properly authorized, appropriately provided and documented, and whether all available third-party insurance was exhausted prior to billing Medicaid for services rendered. Additionally, MFD, with the assistance of a third party vendor, will audit provider records to ensure that their staff meet all licensing, regulatory, educational, and experience requirements. MFD will also audit recipient records to confirm that all necessary criteria for hospice care have been met. Finally, the MFD will identify any potential fraudulent billings such as unnecessary

services or duplicate billings and interview providers, staff, ordering physicians, or home care workers when there are billing concerns that necessitate further review.

The MFD data mining staff has already identified Medicaid recipients who have been in the hospice program for more than six months. Our audits will identify those recipients who no longer meet the criteria for the program. In cases where there was no medical necessity from the start or the recipient's condition improves to the point that continued receipt of these services is no longer medically necessary, the MFD will seek reimbursement.

The MFD data mining staff will also perform data match analysis, comparing different sets of billing claims to identify potential overlapping billing for duplicate services.

For example, the Centers for Medicare and Medicaid Services (CMS) requested a third party vendor to develop algorithms identifying New Jersey hospice providers with questionable billing practices. The vendor, in its report, found significant control weaknesses in billings for Medicaid hospice patients, as well as minimal professional and/or educational standards to become a hospice provider. The MFD will work with CMS to address these weaknesses and to recommend regulation changes to DHSS regarding standards to become a Medicaid hospice service provider.

Hospitals

The MFD will review hospital cost reports with respect to physician payments for direct patient care, administrative services and rental of hospital space for private offices to identify inflated costs. The audits will seek to determine if there are excess or unnecessary payments for direct care services, administrative payments for undocumented or unnecessary services, physician practice subsidies, physician

contracts, and physician compensation which do not reflect the fair market value of the physician's services. The MFD will conduct its first hospital audits in FY 2012.

DMAHS has contracted with a third-party vendor to audit hospital DRG coding and perform utilization reviews. Where the audits indicate that the hospitals owe money, the MFD will initiate the recovery process. If the audit indicates a weakness in the provider's internal controls, the MFD auditor will conduct a follow-up review to determine if corrective action has been taken to rectify those weaknesses. Where the audits indicate the possibility of fraud, waste, or abuse, the MFD will expand its audit and initiate an investigation to determine if claims were submitted fraudulently.

Laboratory Services

Independent clinical laboratories conduct a wide variety of medical tests ordered by physicians for Medicaid recipients. The MFD will audit samples of claims and review the underlying documentation, such as physician orders and test results, to ensure compliance with Medicaid regulations. Specifically, these audits will focus on whether the laboratories submitted claims for residents of facilities where the laboratory tests are included in the facility rate or if laboratories submitted claims that unbundled laboratory services.

Unbundling occurs when a laboratory submits claims for separate services which should be submitted as a unit, at a lower reimbursement rate. In some cases, laboratories have provided an option for physicians to order customized groupings of tests (called panels and profiles) that do not correspond to the coding principles used by Medicare or Medicaid. The physicians are led to believe that the additional tests included in the panels and profiles they order are either performed free (as part of the

panel/profile) or at very low cost. The laboratories then bill Medicare for the Medicare covered panel *plus* the additional tests.

Lock-In Program

The Special Status Unit (SSU) of DMAHS is responsible for restricting Medicaid and/or FamilyCare recipients to a single pharmacy whenever there is misuse, abuse or overutilization of Medicaid benefits pursuant to N.J.A.C. 10:49-14.2. The criteria for "locking in" a recipient to one pharmacy are:

- A recipient, on two or more occasions, receives prescriptions drugs in excess of what any one prescriber would intend;
- A recipient presents a forged prescription;
- A recipient has altered a prescription;
- A recipient uses an unusually high number of physicians and/or pharmacies; or
- A recipient is referred to the SSU by an investigative unit for possible abuse.

SSU can impose restrictions only if the following conditions are met:

- The agency gives the recipient the opportunity for a fair hearing before the restrictions are imposed;
- The agency ensures that the recipient has reasonable access to Medicaid services of adequate quality; and
- The restrictions do not apply to emergency services furnished to the recipient.

A recipient can be locked into a pharmacy from four years to life depending on the quantity and the level of the offenses. In an emergency, the recipient can receive up to a 72-hour supply of any medication from one pharmacy (they must relinquish any remaining days on the prescription). The recipient may request a change of pharmacy

for good cause only when the recipient moves out of the area, the pharmacy closes, or the pharmacy does not carry a needed medication.

New Jersey regulations do not specify what Medicaid services a recipient can be locked into. In the past the lock-in program has been used to restrict a recipient to a particular pharmacy due to systems limitations. Since the Medicaid Fiscal Intermediary now has the capability to restrict a recipient to multiple provider types, and because other states have been restricting recipients to a single provider for all types of services with a great deal of success, the MFD will work with DMAHS to expand the lock-in program to all provider types. Additionally, MFD will review the lists of locked-in recipients to ensure they were appropriately locked-in and to prevent pharmacies from "recruiting" recipients for the lock-in program, thereby granting these pharmacies an unfair advantage over other Medicaid pharmacy providers. Recipients enrolled in managed care plans can also be locked-in to particular providers.

Managed Care Organizations

The shift to managed care imposes a twofold obligation on the MFD. It must: 1) audit and investigate providers in the MCOs' networks to identify fraud, waste, and abuse; (provider and recipient investigations and audits may be conducted solely by the MFD, solely by the MCO or jointly) and 2) ensure the MCOs' compliance with their contract with DMAHS. The MFD Audit and Investigations Units will monitor the Special Investigation Units of the four MCOs for performance and compliance with the fraud, waste, and abuse provisions of the MCOs' contracts with DMAHS. The MCO's contractual obligations involve conducting investigations, prepayment monitoring, quarterly reporting, financial recoveries, and referrals to the MFD and the Medicaid Fraud Control Unit. Additionally, MFD will audit the staffing of MCO's Special Investigations Unit to ensure compliance with contract requirements. MFD's

monitoring will also provide an opportunity to identify "best practices" which will be shared with DMAHS and the MCOs.

Medical Transportation

In 2009, DMAHS entered into a contract with a transportation broker to provide non-emergency medical transportation services for Medicaid recipients in selected counties in New Jersey as well as higher level services statewide. The broker is responsible for providing all mobility assistance vehicle/wheelchair/livery transports in exchange for a monthly capitation payment of $23.02 for every Medicaid client regardless of whether they have used the transportation services. Ambulance services, whether non-emergency or basic life support, are paid as a Medicare/Medicaid crossover claim in addition to paying the broker's capitation.

MFD will audit the broker for contract compliance, including, but not limited to: its credentialing process; its reporting of provider deficiencies; its fraud and abuse checks, including subcontractor exclusion checks; subcontractors' vehicle maintenance and driver supervision such as driver requirements; use of ambulances for non-emergency transportation; recipient eligibility for transportation, including medical necessity; verification of transportation; transportation to non-medical appointment; and verification of physician orders.

The MFD will audit ambulance providers to ensure that ambulances are only used when medically necessary and that the ambulance had the proper equipment and personnel to provide emergency services. The audit will also include a review of claims for recipients to ensure that the recipient was actually transported and that providers did not bill both the broker and Medicare/Medicaid for the same trip.

Medi-Medi Investigations

Medi-Medi is a joint effort between CMS and the MFD to identify fraud and abuse by providers who render services to Medicare and Medicaid dual eligible recipients. Providers servicing recipients eligible for both Medicare and Medicaid are required to bill Medicare prior to submitting claims to Medicaid. After Medicare pays its share, the provider then submits a crossover claim to Medicaid indicating the amount approved and paid by Medicare. Some providers submit inconsistent and fraudulent claims to increase their reimbursement amounts.

Nursing Facilities

Nursing homes provide long-term care for those in need of intensive and ongoing medical and nursing assistance. Nursing homes may be appropriate for people who fit one or more of the following categories established by New Jersey's Medicaid program:

- Catastrophic illness or accident that requires major changes in lifestyle and needs;
- Debilitation or chronic changes in physical or mental status that cause deterioration of self-care skills;
- Multiple hospital admissions within the most recent six-month period;
- Previous nursing home admission within the past two years; and
- Other major health needs, such as physical rehabilitation, recuperation after hospitalization for serious illness or surgery, restorative services, tube feeding and special equipment or treatment.

For those who meet clinical and financial qualifications, both the Medicare and Medicaid programs pay for nursing home services, although Medicare coverage for

nursing home care is limited to short-term nursing care within 30 days of a hospitalization of three or more days and is medically certified.

Because some participants are eligible for both Medicare and Medicaid, MFD is currently reviewing whether nursing homes have been submitting claims to Medicaid for patients who are dual eligibles without first submitting claims to Medicare to ensure that Medicaid is the payor of last resort. If nursing homes are found to have improperly billed Medicaid, the MFD will recover the appropriate amounts from the facilities and require them to submit corrective action plans demonstrating how they will prevent this practice from occurring in the future.

As of July 1, 2010, DHSS switched nursing facility compensation from a cost report basis and has proposed new rules for nursing facility compensation. The Division of Senior Benefits and Utilization Management proposed to readopt N.J.A.C. 8:85 with amendments, repeals of certain regulations and new rules. N.J.A.C. 8:85 establishes standards for the operation of nursing facilities and the provision of nursing services while also setting forth a process for the calculation of nursing facility Medicaid per diem rates and for audits of nursing facilities.

The proposed rules would establish a prospective case mix reimbursement system designed to calculate nursing facility-specific rates based on the resident care needs of Medicaid-eligible residents in each facility. The proposed rules would also require nursing facilities to assess and identify residents' nursing and care needs using the minimum data set (MDS) established by CMS and to file the MDS data electronically. The MDS data would be adjusted by the DHSS according to the CMS resource utilization group (RUG), which groups residents according to their status and anticipated uses of services and resources. DHSS would use the data to determine a nursing facility's direct care rate component. Under the new rate-setting formula, a

nursing facility's rate would be comprised of the facility's direct care case mix and direct care non-case mix costs, the operating and administrative price, the facility-specific fair rental value allowance, and the provider tax pass-through per diem provided by N.J.S.A. 26:2H-92 et seq.

The MFD auditors and investigators will be working closely with DHSS' outside nursing auditors and conduct further clinical or financial audits where the outside vendor's work indicates that fraud, waste or abuse has occurred. The MFD also receives both clinical and financial referrals from DHSS, based on the outside auditors work, and is currently pursuing those referrals.

Partial Care

The purpose of Partial Care (PC) services is to assist individuals with severe mental illness in achieving community integration through valued living, learning, working, and social roles and to prevent hospitalization and relapse. Through PC, patients are eventually integrated into the community, though some patients need the support of PC for long periods of time. This balance between recovery and clinical services is accomplished through the provision of individualized, comprehensive, non-residential, structured programming which provides, but is not limited to, counseling, case management, psychoeducation (educating the patient and in some cases the family about the mental illness that the patient has so the patient will be better able to cope with it), pre-vocational services, social and leisure services, and psychiatric services. These services are available to eligible individuals on an hourly basis for up to five hours per day at least five times per week.

The MFD will audit claims for PC patients to ensure that services were rendered in accordance with the patient's plan of care, the provider has sufficient documentation

to substantiate billed services, appropriate documentation was maintained in patient and personnel related records, supervision was provided as required, and claims reflect services provided at least five days per week for up to five hours.

Pharmacies

The Medicaid program reimburses pharmacies for a variety of prescription and over the counter medications. Significant fraud, waste, and abuse exist in the pharmacy industry, such as drug diversion (the transfer of a prescription drug from lawful to an unlawful channel of distribution or use), buying back and reselling medication, and knowingly participating in illegal narcotics transactions. MFD will audit pharmacies to ensure that billed services have been provided, review purchase invoices to ensure that medication billed to the Medicaid program has been dispensed, and verify whether purchases are from legitimate pharmaceutical wholesalers.

DMAHS has contracted with a third party liability vendor to conduct 1100 pharmacy audits per year and 1200 DME audits per year for the next three years. The vendor will perform both desk and onsite audits, meet on a monthly basis with MFD to report its findings, and refer to MFD any findings that require either an investigation or an expanded MFD audit. The majority of these audits will be desk audits. MFD will coordinate the audit process with the vendor to avoid duplication of work and to ensure that the audits are inclusive of the work that MFD would perform if it were conducting the audit. Additionally, MFD will inspect the vendor's work for accuracy and completeness and follow-up on any audit findings that it deems significant.

Primary Care Physicians

Primary care physicians in the Medicaid program are the bedrock of health care for New Jersey's most vulnerable residents. They are involved in all aspects of an

individual's care from examination and testing, to diagnosis and treatment and maintenance and preventative care. They oversee and manage the quality of health care provided and often are the ones approving and certifying whether treatment is medically necessary. These responsibilities extend to physicians who are not directly enrolled in the Medicaid program but have contracted with managed care plans or see Medicaid recipients on a cash basis.

In order to ensure these providers are fulfilling their obligations, the MFD will determine whether physicians are properly licensed, have been excluded at the time treatment was provided or goods and services were ordered, resubmitted previously denied claims under another physician's Medicaid number, or have documentation to support an existing physician-patient relationship to allow a physician order. The MFD will review records of non-Medicaid referred providers to determine whether there is sufficient medical necessity for services ordered that exceed $50,000 per year, such as pharmaceuticals, laboratory tests, and durable medical equipment. For example, if a non-Medicaid provider, listed as a referring provider, writes a prescription that is not medically necessary and the Medicaid recipient fills the prescription at a Medicaid pharmacy, the physician who wrote the prescription will be liable to the State for reimbursement.

MFD will send letters to high-ordering physicians (i.e., physicians who exceed their peer group average in the amount or cost of services) alerting them to their ranking compared to other physicians in their peer group. The records for those physicians will be audited where appropriate. MFD will also seek recoveries of amounts paid and impose sanctions on the provider of the service and/or ordering physician if overbillings have occurred.

Personal Care Services

Personal care assistant services are provided by certified licensed home health agencies and proprietary or voluntary non-profit accredited home-maker agencies. Personal care assistant services include household duties and health-related tasks performed by a qualified individual in a recipient's residence, under the supervision of a registered professional nurse, as certified by a physician, in accordance with a written plan of care. These services, available from a home health agency or a homemaker agency, accommodate long-term chronic or maintenance health care rather than short-term skilled care required for some acute illnesses.

Personal care assistant services are reimbursed by DMAHS on a per hour, fee-for-service basis. Nursing assessment and reassessment visits under this program are reimbursed on a per visit basis only after they have been preauthorized. MFD staff will audit agencies to determine if services were pre-authorized and provided in accordance with physician orders. It will also determine whether appropriate care plans were developed and followed and whether services were performed by appropriately trained and certified and/or licensed staff, supervised by a registered nurse.

B.

RECIPIENT PROGRAMS

The MFD will also continue its investigation and prosecution of recipient fraud cases. In these economically challenging times, it is crucial for MFD to evaluate eligibility determinations and confirm that only those who are in need of Medicaid assistance receive it. The MFD will continue to work with county prosecutors when conduct is criminal in nature to ensure that all appropriate recovery methods and sanctions are employed. The MFD will also continue to raise awareness of recipient

fraud cases in order to send a message of deterrence and to encourage the public to report examples of recipient fraud to MFD. The MFD will also work with DHS to address issues that arise in eligibility criteria for Medicaid assistance.

New Jersey's FamilyCare program is a federal and state funded health insurance program created to help provide affordable health coverage to New Jersey's uninsured children and certain low-income parents and guardians. It is not a welfare program.

Many recipients of FamilyCare are self-employed. Given that eligibility for FamilyCare is based on income level, those individuals who seek to defraud the FamilyCare system will distort their true income to become eligible for FamilyCare and, consequently, avoid paying for private health insurance. This type of fraud drains the resources of Medicaid dollars for those who truly are eligible for assistance.

To address this issue, the MFD established relationships with the county welfare offices so that it could be a source of referrals for investigations of potentially egregious cases of eligibility fraud. Once MFD determines that an individual family has committed eligibility fraud, the MFD recovers the money FamilyCare paid for their health benefits. Since July 1, 2009, the MFD has recovered over $100,000 from FamilyCare recipients who were found to be ineligible for the program.

For those eligibility cases that rise to the level of criminality, the MFD will refer the cases to the appropriate prosecutor's office. Throughout the previous fiscal year, MFD coordinated several investigations with county prosecutor's offices that resulted in arrests and further prosecution.

MFD will continue in the next fiscal year to work with county prosecutors and welfare offices to mitigate eligibility fraud and send a strong message to potential fraudsters in the state.

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The Medicaid Fraud Division looks forward to a successful year of combating Medicaid fraud, waste, and abuse. If you have any questions about the Medicaid Fraud Division's FY 2012 workplan, please contact:

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