



**STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER**

**MEDICAID FRAUD DIVISION
WORKPLAN
Fiscal Year 2011**

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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/or 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) administer the 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 applicable federal requirements. One of these requirements is that each state maintains a Medicaid Program Integrity Unit to run utilization reviews of the billing system and investigate fraud, waste, and abuse in the varied Medicaid programs. Prior to the creation of the Medicaid Fraud Division, 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 (OMIG), now the Medicaid Fraud Division (MFD) within the Office of the State Comptroller. The Division’s Senior Team, Director, Mark Anderson, and Deputy Directors, Niki A. Trunk and Mark Moskovitz, together with a team of analysts, auditors, investigators, regulatory officers, and specialists ensure the successful daily operation and long-term functioning of the division, and by extension, the State’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 this office 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.

In addition to the Directors’ Office, the MFD has three units: Fiscal Integrity; Investigations; and Regulatory. The plans of these units for Fiscal Year 2011 are outlined in more detail below. It should be noted that MFD’s plans are subject to change based on resource allocation and unforeseen events that may shift MFD’s priorities. Finally, the plans discussed below are not exhaustive, and therefore, should not be construed to include all items that MFD intends to address in Fiscal Year 2011.

II. DIRECTORS’ INITIATIVES

The MFD Directors’ Office is implementing many new initiatives to increase monetary recoveries and cost savings and improve the integrity of the Medicaid program. It continues to increase communication with health care providers and state agencies that oversee Medicaid funding for the State, reevaluate the efficiencies of its various units, such as new data mining techniques, and market MFD as a resource to report fraud, waste and abuse in the Medicaid programs. These initiatives have already yielded fruit as MFD saw a 34% increase in recoveries and cost avoidance between 2008, when the MFD’s functions were performed through DMAHS and 2009, when MFD

became independent of DMAHS. As outlined below, the Directors' Office will continue to improve these initiatives as well as identify and implement new initiatives for fiscal year 2011.

A.

COMMUNICATIONS AND MARKETING

Establishing and maintaining channels of communication between the MFD and legislators, policymakers, other state agencies, Medicaid providers, recipients, and the public, is crucial to our success. In fiscal year 2011, the MFD will continue to maintain and foster the relationships it established in the capacity of the Office of the Medicaid Inspector General by: meeting with legislators, and state agency heads to update them on our division and discuss how legislation may impact, positively or negatively, on Medicaid fraud and abuse; speaking to and educating Medicaid providers on fraud, waste, and abuse in the Medicaid program as well as compliance with the Medicaid program; and establishing new channels for the MFD to receive fraud, waste, and/or abuse complaints and referrals.

The MFD values regular communications with providers, both directly, and through provider associations. The MFD will continue to promote its goals as part of the larger goals of the Office of State Comptroller, discuss ongoing initiatives, and obtain constructive feedback. Many providers have established best practices and the MFD is interested in learning about those, sharing them with other providers, and working with providers on audits, self-disclosure policies, and compliance initiatives, in the hope of fostering high quality care and compliance throughout the healthcare industry.

The launch of the MFD website this past year is both a new avenue of communication as well as an essential tool in marketing the Medicaid Fraud Division as

part of the State Comptroller's Office. The website, www.nj.gov/comptroller/divisions/medicaid, not only contains background information about the office, it provides information on Medicaid regulations, investigative, and audit reports, disqualified providers, presentations, provider compliance, self-disclosure policies, and a listserv subscription service to our office that enables subscribers to automatically receive alerts from the MFD as soon as they are posted on the website. Some of these alerts specifically provide an investigative tool. For example, if a physician's prescription pad is stolen, MFD will send out letters via fax to all pharmacies alerting them to potential forgeries. The website also serves as another 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, including this plan, will also be posted to the website so that our areas of focus will be readily available to all interested parties.

B.

COUNTY COOPERATIVES

We must work closely with the 21 New Jersey counties, both their welfare agencies where recipients apply for Medicaid and FamilyCare, and the Prosecutor's Offices which prosecute criminal provider and recipient fraud. We have proactively reached out to all 21 counties to coordinate with them on recipient fraud issues and to discuss the problems they face. As a result of our efforts, we have received numerous fraud and abuse referrals from the counties. We will continue to meet with these groups, including attending meetings with County Prosecutors, County Chiefs of Investigators, and County Medicaid Directors to discuss how we can work with them to crack down on Medicaid recipient fraud. In fact, one referral from the Bergen County Welfare Agency led to an MFD investigation and resulted in the arrest of a FamilyCare

recipient in fiscal year 2010. Likewise, a home health agency owner was indicted on Medicaid fraud charges as a result of a collaborative investigation of MFD, the Union County prosecutor's office and the Medicaid Fraud Control Unit within the Attorney General's office. For details about these or other past MFD investigations, please visit our website at www.nj.gov/comptroller/divisions/medicaid.

C.

COMPLIANCE GUIDANCE

While New Jersey does not currently require providers to have a compliance program or a compliance officer, Section 6401 (b)(5) of the Patient Protection and Affordable Care Act (PPACA) will require New Jersey Medicaid providers to have a compliance program. The U.S. Secretary of Health and Human Services is required to promulgate regulations by January 1, 2011; however, the law goes into effect regardless of whether new regulations have been promulgated.

Having a vigorous and effective compliance program is in the best interests of all health care providers. A successful compliance program addresses the provider's need to prevent fraud, waste and abuse as well as improves the quality of health care at lower costs. It emphasizes, to the provider's employees and the public, the provider's commitment to conducting its affairs honestly and responsibly. The MFD's guidance for an effective compliance program can be found on our website under Provider Compliance.

Additionally, the enactment of PPACA imposes additional Medicaid program integrity responsibilities on both the MFD and DMAHS. MFD will be implementing many new procedures to be in compliance with PPACA as well as ensure that DMAHS and other state departments that receive Medicaid funds are also in compliance.

1.

Compliance Recommendations

Compliance officers serve as the cornerstone of a provider's efforts to establish an environment conducive to and supportive of efforts to eliminate fraud, waste, and abuse. A diligent and experienced compliance officer is integral to preventing illegal, unethical or improper conduct on the part of providers and their staff.

The MFD appreciates the wide-ranging and vital responsibilities of compliance officers and the contributions they make to advance ethical behavior and exceptional health care by New Jersey Medicaid providers. Compliance officers should be placed in senior management positions within their organizations and be afforded the full support and assistance of the governing board, the chief executive officer, the chief legal officer, and the rest of senior management, provided adequate resources (i.e., sufficient time, staff and budget) and granted unfettered access to documents and other information necessary to effectively design, implement and monitor the provider's activities.

Where the MFD identifies significant compliance or control weaknesses, or where no compliance program exists, the MFD will meet with all relevant members of a 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 of directors requires a sanction or exclusion from the Medicaid program for failure to comply with their duties with respect to compliance and oversight.

In an effort to promote integrity and to assist providers in understanding what is required of them to mitigate fraud, waste, and abuse, during the next year the MFD

plans to publish its first compliance guidance in the adult medical day care programs designed 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.

Finally, MFD now has oversight of the Section 6032 Compliance Requirements for New Jersey. 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 applicable to the entity's employees, contractors, and agents. The MFD will review all required reporting submissions by providers to ensure they are in compliance.

2.

Self Disclosures

Because New Jersey cannot afford to always play the "pay and chase" game, we must educate providers on compliance, work with them to cure wasteful practices, encourage them to strengthen internal controls, and encourage them to submit self-disclosures to our office when they discover they have overbilled Medicaid. In fiscal year 2010, we received three self-disclosures, one for \$1 million. We will audit any information providers submit for accuracy and confirm the proper amount that is owed based on our evaluation.

The MFD recognizes that many improper payments are discovered during the course of a provider's internal review processes. While providers who identify that they have received inappropriate payments from the Medicaid program are obligated to return the overpayments, it is essential to develop and maintain a fair, reasonable process that will be mutually beneficial for both New Jersey and the provider involved. We support providers who find problems within their own organizations, reveal (self-disclose) those issues to the MFD, and return inappropriate payments.

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

Each incident must be considered on an individual basis. Factors to consider include the exact issue, the amount of overpayment, any patterns or trends that the

¹ Section 6402 of the PPACA 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 are not generally 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 seeks to disclose an issue to MFD, the provider should follow this guidance accordingly.

² Because of the complexity of some issues surrounding self-disclosures, providers may want to consider obtaining the advice of experienced healthcare legal counsel or consultants.

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) 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, an initial report should be prepared which includes gathering the following information:

- The basis for the initial disclosure, including how it 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 reoccurrence; 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 an appropriate position to speak for the organization.

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,

³ Upon review of the providers' disclosure and related information, the MFD may conclude that the disclosed matter warrants referral to the New Jersey Attorney General's Medicaid Fraud Control Unit (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 the Federal or State False Claims Act or other laws.

which may include voiding or adjusting the amounts of claims. Providers should be aware that the MFD monitors both the number of occurrences 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.

MFD will expand its audit review of a provider group 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. As a result of self-disclosures it has received over the past year, the MFD is seeking to determine whether certain health systems are systematically overbilling Medicaid for certain types of services they have provided.

D.

MANAGED CARE ORGANIZATION COORDINATION

DMAHS currently contracts with four Managed Care Organizations (MCOs) to provide a variety of health care services to Medicaid and FamilyCare recipients. In return for a monthly capitation payment, the MCOs ensure that a recipient has a primary care provider and access to quality health care and needed medical services. The MCOs enter into contracts with health care providers for delivering these services to recipients and are responsible for paying the actual service providers.

The MFD meets with these MCOs on a monthly basis to foster communications amongst the MCOs and to ensure these organizations educate each other on all current fraud, waste, and abuse schemes. The MFD will also continue to review and reevaluate the contract that the State of New Jersey has with these MCOs and suggest changes to the Commissioner of the Department of Human Services to ensure that the MCOs are doing all they can do to safeguard Medicaid dollars. MFD will also be issuing a

policies and procedures manual to assist MCOs in detecting, preventing, and reporting fraud, waste, and abuse. Finally, MFD will work with the MCOs to correct their internal control weaknesses. Some of the identified weaknesses are detailed below.

1.

Recipients With Multiple Identification Numbers

A 2009 audit conducted by New Jersey's Office of Legislative Services (OLS) identified 505 fee-for-service inpatient hospital claims totaling \$4.8 million for the period January 2007 through March 2009 for recipients who were enrolled in managed care on the date of service. The auditors tested 278 of those claims totaling \$4.3 million and found 101 claims, totaling \$1.1 million, that should have been paid by the MCOs, rather than as a fee for service claim. The auditors concluded that the claims were paid because the recipients had both a fee for service and a managed care identification number. MFD's Data Mining team will determine if this problem still exists and, if so, our auditors will determine whether claims were improperly paid. If the claims were improperly paid, MFD will recover the monies owed, and recommend edits to the billing system to eliminate this problem in the future.

A related problem exists concerning recipients who have multiple managed care identification numbers. Through data mining, the MFD will identify MCOs receiving multiple capitation payments for the same enrollee. The MFD will request that the MCO review the claim(s) in question and either reimburse the Medicaid program where the payment was not appropriate, or if the MCO believes the claim(s) was appropriate, provide supporting documentation to support the claim, which MFD auditors will verify.

2.

Payments for Newborns

The 2009 OLS audit also found that hospitals were reimbursed on a fee for service basis for infants born to mothers enrolled in managed care. The MCO receives a supplemental payment from Medicaid which reimburses the MCO for its prenatal, hospital/birthing, and postpartum costs in connection with the delivery. Additionally, Medicaid covers the baby's care for the first 60 days after birth and through the end of the month in which the 60th day occurs. During this postpartum period, the newborn is covered under the mother's recipient number. The audit uncovered \$748,000 in fee for service payments to the hospital that were for services that should have been covered by the MCO.

The MFD will conduct follow up data mining to determine if and to what extent the problem still exists, and identify any payments which should be recovered from the hospital or the MCO. The MFD will expand the review conducted by the OLS by reviewing claims to ensure that only one supplemental payment is received by the MCO.

E.

MONITORING NEW JERSEY'S ARRA MEDICAID FUNDS

In March 2009, the State of New Jersey formed an ARRA Task Force to oversee all federal American Recovery and Reinvestment Act (ARRA) funds that flow through New Jersey, both directly and indirectly. Because the ARRA provides for an increased federal subsidy of Medicaid dollars for State Medicaid programs, the MFD Director was appointed to this Task Force to assist in the oversight of all New Jersey ARRA funds in general and Medicaid funding in particular.

As part of his role on the task force and as a result of his prior experience as an auditor, Director Mark Anderson joined the Internal Controls subcommittee of the Task Force, which met with multiple levels of all State Departments and agencies that received stimulus funds to evaluate their existing internal controls in overseeing these funds and to educate them on how to improve the protections they have in place to ensure these dollars are being accounted for appropriately. The Task Force continues to meet with all Departments to ensure that all agencies continue to monitor their stimulus-funded programs closely to ensure accountability and transparency. The Director will also continue to provide guidance to all Departments who receive additional Medicaid funding through the ARRA.

III.

IMPLEMENTATION TOOLS

In order to perform its functions, the MFD has three units: Fiscal Integrity; Investigations; and Regulatory.

A.

FISCAL INTEGRITY

The Fiscal Integrity Unit is charged with a wide-range of responsibilities including, but not limited to: recovering all overpayments identified by MFD's other units; auditing Medicaid provider claims; analyzing claims data for outliers and fraudulent patterns; and overseeing all third party liability recoveries and cost-savings.

1.

Audit

The Audit team 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 those providers who contemplate committing fraud and abuse within the Medicaid program.

The MFD Audit team not only audits services for the Medicaid programs but also reviews audit work of other State agencies and/or third-party contractors. For example, in fiscal year 2011, MFD will be reviewing the pharmacy and DME audits that will be performed by a third party vendor that contracted with DMAHS.

The Medicaid program requires participating providers to maintain adequate records to support their claims. Cost-based 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. Fee-for-services 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 under the Medicaid program. 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.

Selection of Audit Subject Areas, Providers and Methods

The MFD uses a variety of analytical tools and data mining techniques to identify providers for audits. MFD's Audit unit conduct a risk assessment analysis as well as consider successful initiatives employed in other states, current academic and public policy organizational analyses of health care issues, and program ideas and directives from the federal CMS Medicaid Integrity Program, which guides and oversees our work. MFD Auditors work closely with the Departments of Human Services, Health and Senior Services, and Children and Families to identify potential vulnerabilities in the Medicaid programs they administer.

Providers are selected for audit utilizing a variety of risk factors including, but not limited to: a) Medicaid dollars billed on a yearly basis; b) provider type; c) significant change in Medicaid billings on a year-to-year basis; d) complaints from the public; e) providers subject to Corrective Action Plans or Corporate Integrity Agreements; f) CMS alerts regarding fraud and abuse taking place in other states' Medicaid and/or Medicare programs; g) program vulnerabilities identified from previous audits or investigations; h) length of time since a previous audit or investigation took place; and i) services billed which are particularly vulnerable to fraud, abuse, or waste.

Prior to the Audit team conducting an on-site audit, MFD will send a letter alerting the provider that it will be audited, the scope of the audit, the length of the audit, the authority for the audit, and the date of the entrance conference. The entrance conference consists of a meeting with each individual provider to discuss in more detail the nature and extent of the audit.

Upon completion of a field audit, MFD will conduct an exit conference with the provider to discuss preliminary findings. Afterward, the MFD will issue its draft audit

report which will identify any proposed recovery and the basis for the action, internal control weaknesses, and recommendations to address these weaknesses. The provider has 15 business days to respond to the draft audit report. If the provider fails to respond within that time frame, the report will become final within 5 business days and be issued at that time. If the provider objects to the draft audit report, the MFD will evaluate the provider's response, and any supporting documentation submitted by the provider, before issuing a final report. Under these circumstances, the final audit report will be issued within 35 days from the exit conference. MFD's next step in recovering overpayments is discussed in a subsequent section.

If the Audit team uncovers fraudulent activity during the course of its field audit, they will immediately refer their findings to the MFD's Investigation Unit for further review and investigation.

The Audit team utilizes both statistical and non-statistical sampling techniques to gather its sample population for a given audit scope. These techniques, which are discussed in more detail below, enable a reasonable conclusion to be drawn regarding the entire population based on the audit findings of the sample population.

Statistical Probability Sampling:

Probability sampling methods include: simple random sampling, systematic sampling, stratified sampling, and cluster sampling. For each of these methods, each unit within the population has a known non-zero probability of being included in the sample. The advantages of these methods give high degree of representativeness and the ability to calculate a sampling error. When a sampling error can be calculated, a confidence interval can be determined.

Simple random sampling involves using a random selection to draw a fixed number of sampling units from the data without replacement (one unit cannot be used more than once). This method ensures that each set of sampling units has the same probability of selection from any other set.

Systematic sampling requires that the population be numbered in order (from 1 to the end). A random start is used and the next unit is selected using a fixed interval (i.e., if one starts with the number 5 and uses an interval of 10, the next data to be a part of the sample is number 15, then 25, 35, etc.) until the end of the population is reached.

The stratified sampling method is done by grouping the population into non-overlapping strata. Random samples are selected from each of the strata to obtain an unbiased estimate while reducing the margin of error.

Cluster sampling involves drawing a random sample of clusters and reviewing either all units or a sample of units selected from each of the sampled clusters. Unlike strata, the clusters are groups that might not have strong similarities.

Non-statistical Probability Sampling:

Non-statistical probability sampling includes haphazard sampling, block selection, and judge selection. Using the haphazard sampling method, the auditor selects the sample items without bias to include or exclude certain items in the population. It represents the auditor's best estimate of a representative sample. Block selection is performed by applying audit procedures to items, such as claims, that occurred in the same "block" of time. Judgment sample selection is based on the auditor's judgment. It is used when only a specific area within the population is under auditor scrutiny or timely information is required.

Pursuant to Governmental Auditing Standards, an audit does not need to be based on a statistical sample to be considered valid. The Government Auditing Standards states that:

When a representative sample is needed, the use of statistical sampling techniques generally results in stronger evidence than that obtained from non-statistical techniques. When a representative sample is not needed, a targeted selection may be effective if the auditors have isolated certain risk factors or other criteria to target the selection.

(Ch. 7, Sec. 63). Non-statistical samples are appropriate when reviewing certain thresholds or criteria within the population. A non-statistical sample can be chosen if the MFD auditor is focusing on certain providers or claim amounts.

The confidence level measures the reliability of the estimates when doing statistical probability sampling. Non-statistical probability sampling does not provide a measurement of sampling risk, thus, confidence interval measurements do not pertain to this category of sampling. A confidence interval is expressed by a percentage (i.e., 90% confidence interval). For example, an auditor can be “99 percent confident” that the mean of the items within the sample fall between two values, M1 and M2, which are the upper and lower bounds of the confidence interval.

2.

Data Mining

The MFD Data Mining team reviews anomalous claim reimbursement behavior of providers, and based on a preliminary review, submits its findings to either the Audit team for further review and determination of whether a full audit should be scheduled or the Investigations Unit for a more clinical review. Additionally, the Data Mining team reviews CMS alerts to determine from a data analysis perspective, if there are similar fraud or abuse activities taking place in New Jersey. The Data Mining team

reviews Medicaid audit findings from other states as well as the results of investigations by the federal government into Medicare and Medicaid fraud and abuse to generate data analyses for review in the New Jersey Medicaid system. For example, as a result of a federal report on abusive ultrasound practices, the Data Mining team ran additional reports for New Jersey providers and found practices such as running four or more overlapping and/or duplicative ultrasounds on the same patient on the same day and billing for gynecological ultrasounds for male patients. These findings have been sent to our Investigations Unit for further review. Finally, MFD is seeking to augment its data mining capabilities by purchasing software that will enable the Data Mining team to ferret out more complicated fraud and abuse schemes by providers.

As MFD continues to grow, the Data Mining team will be the primary internal referral source for both the Audit team and Investigations Unit.

3.

Recovery and Exclusion

Our Recovery and Exclusion team recovers overpayments identified by the MFD auditors and investigators as well as decides when to exclude a Medicaid provider from the program. The primary goals of Recovery and Exclusion are twofold: 1) to take an active approach to recover overpayments from providers and recipients; and 2) ensure that only providers who adhere to Medicaid program regulations are Medicaid providers. This team has a number of tools at its disposal to achieve these goals.

Where MFD has identified an overpayment, the Recovery and Exclusion team may, under certain circumstances, withhold payments to a Medicaid provider until an overpayment is recouped. In other circumstances, the Medicaid provider may make payment arrangements with 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.

Pursuant to federal law, the MFD is obligated to repay the federal government its proportionate share of recovery within one year of properly identifying the amount of recovery. The Recovery and Exclusions Team follows the protocol outlined below in seeking recoupment.

Recoupment Protocol

If the MFD Audit team determines that the provider overbilled the Medicaid program, the team will issue a final audit report, putting the provider on notice of the amount owed. When a final audit report is issued, the case will be referred to the Recovery and Exclusions team, which will immediately issue a Notice of Claim to the provider identifying the amount owed. When a Notice of Claim is issued to an entity, the entity has 20 days to request a pre-hearing conference with the MFD Recovery and Exclusion team to resolve the amount of the claim. If the pre-hearing conference results in the proper claim amount being agreed upon by both the entity and the MFD, the MFD will recover the overpayment in a manner to be determined by the circumstances.

Similarly, where the MFD identifies an amount of money owed by a provider resulting from an investigation by the Investigation Unit, the Recovery and Exclusion team will issue a Notice of Claim to the provider identifying the amount owed. When a Notice of Claim is issued to an entity, the entity has 20 days to schedule a pre-hearing conference with the team to resolve the amount of the claim. If the pre-hearing conference results in the proper claim amount being agreed upon by both the entity and the MFD, then MFD will recover the overpayment in a manner to be determined by the circumstances.

If the pre-hearing conference process does not result in a mutually agreed upon claim amount, then within five days from the end of that process, the MFD will send a Notice of Demand to the entity. The entity has 20 days from the date of the Notice of Demand to schedule an administrative hearing with the Office of Administrative Law (OAL). If the entity does not schedule a hearing, MFD reserves the right to withhold payment up to 100 percent of the amount listed on the Notice of Demand (if a provider), or file a Certificate of Debt against the recipient's property. Additionally, the claim against the provider is considered identified and final, and MFD is obligated to reimburse the federal government its portion of the claim.

If a request for a hearing is filed, an Administrative Law Judge (ALJ) will conduct a hearing and make a determination of the proper amount of the claim. Once the OAL Judge determines the amount of the claim, DMAHS will make a Final Agency Decision (FAD) either affirming or denying the OAL determination. If the FAD affirms the amount of the claim, the Recovery and Exclusions Team will proceed with recovery and share the proportionate share with the federal government within the allotted time.

Exclusions

Being a Medicaid provider is a privilege not a right; therefore, where circumstances warrant it, providers are excluded from the Medicaid program. These circumstances include, but are not limited to: 1) the provider is excluded by the federal government 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. The Recovery and Exclusions team will review the circumstances and determine the appropriate sanction, including suspension, debarment, or disqualification. The provider will then have the same procedural rights to appeal as with a recovery.

4.

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 MFD's efforts to obtain payments from third party insurers responsible for services inappropriately reimbursed by Medicaid funds. The Third Party Liability team (TPL), working with an outside vendor, seeks to determine whether Medicaid recipients have other insurance. The TPL team also makes sure that, if the recipient has other insurance, TPL recovers money from the private insurer.

There are two main methods for determining if a recipient has third party insurance coverage: identification of insurance during the Medicaid eligibility intake process at the local county welfare agency (CWA); and a state contractor identifies the client's third party's insurance not reported during intake.

Third party insurance coverage, Medicare and/or commercial health coverage, should be identified during the CWA's intake process. Applicants for Medicaid services complete paperwork at these agencies and identify any third party health insurance coverage the applicants have, including policy information. Additionally, the state contractor routinely processes matches with CMS and commercial insurance carriers to identify third party insurance coverage. Additional third party information identified by the contractor is used to update the client eligibility file. As a result of the State's contract with its current state vendor, MFD recovered and provided cost savings to the State in the amount of \$257,996,654 in fiscal year 2010.

B.

INVESTIGATIONS

1.

Generally

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. The Investigations Unit is comprised of the Chief of Investigations, two supervising investigators and 18 investigators.

Our investigators have a wide variety of law enforcement, nursing, and Medicaid program integrity experience. This blend of experience is ideal for scrutinizing claims submissions, interviewing witnesses, and performing clinical reviews of medical charts. They serve subpoenas, testify in legal proceedings, and conduct site visits at provider locations (both announced and unannounced) to review records, documentation, and to verify the credentials of healthcare providers.

MFD investigators have identified 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 actually provided); unbundling (submitting claims for separate services which should be submitted as a unit, at 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 at assessing credibility of individuals they interview and are experienced in analyzing claims data to uncover complex health care

fraud schemes and gathering the 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, Drug Enforcement Administration, 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 refers cases to the New Jersey Medicaid Fraud Control Unit (MFCU) in the Attorney General's Office, when the evidence uncovered indicates criminal health care fraud may have been committed. We also meet on a monthly basis with the MFCU to share intelligence and to coordinate our anti-fraud efforts. Many cases are worked as a joint effort by MFD investigators and MFCU detectives. For the MFD to be truly effective, it is vital that a high level of cooperation and coordination exists between the MFCU and the MFD. Established by State law and federal regulations, MFCU is the first referral destination for all cases of suspected provider fraud, where there is potential criminal liability.

The Investigations Unit is charged with looking into both Medicaid recipients and providers including, but not limited to, physicians, hospitals, long-term care facilities, adult medical day care centers (AMDCs), pharmacies, laboratories, and durable medical equipment providers (DMEs) who participate in the Medicaid, FamilyCare and/or Charity Care programs.

Our Special Investigations Unit (SIU), within Investigations, ensures that all Medicaid providers are properly enrolled in the program, denying those providers who either do not meet the criteria to be a Medicaid provider or who submit false information to become a provider. The SIU unit strengthens the state's philosophy that becoming a Medicaid provider is a privilege, not a right.

Our Investigators receive allegations of fraud, waste, and abuse from many sources including, but not limited to: MFD's fraud hotline (1.888.937.2835); other state

and federal agencies; the New Jersey Departments of Human Services (DHS) and Health and Senior Services (DHSS); state agency websites; in-house referrals; Explanation of Medical Benefits (EOMB) responses; written correspondence; information brought to the attention of an investigator during the course of unrelated investigations; media; county welfare agencies; and Medicaid recipients.

Hotline contact information is disseminated to the public through a number of avenues including the distribution of posters and the MFD website. Calls to the hotline are reviewed by MFD staff for assignment and investigation.

The MFD's oversight over Medicaid billings includes not only ensuring the billings match the treatment but that recipients are receiving the quality of care for which the Medicaid program pays. To that end, the MFD Investigators will 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 far and above other Medicaid providers; providers who order services or goods for patients where there is no evidence of an existing physician-patient relationship. Where identified, these findings will be referred to our Recovery and Exclusions team to seek a return of monies paid and sanctions against the providers where appropriate.

In fiscal year 2011, the MFD will continue its investigations of certain Medicaid providers and expand its focus to include providers it previously has not reviewed.

2.

Providers

Unlicensed or excluded providers (providers debarred from any federally funded health care program due to professional misconduct or a criminal arrest or conviction) may not treat, order, or bill for services rendered to Medicaid recipients. The period of an exclusion may last anywhere from three to eight years, depending on the severity of the conduct that caused the exclusion. The Investigations Unit identifies these 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 them, and may, depending on the nature of the conduct involved and whether the conduct has occurred before, seek damages and false claims penalties from the excluded individual and/or the employer.

It is much easier to prevent fraud by preventing unscrupulous providers from ever entering the Medicaid program rather than investigating and trying to recover the improperly billed money after the fraud is committed, a practice known as “pay and chase.” To protect the integrity of the Medicaid program and recipients from health care professionals who pose a risk, the Special Investigations Unit examines provider applications submitted by pharmacy, durable medical equipment, adult medical day care, pediatric medical day care, and laboratory providers. Background checks are conducted, and in some cases applications are denied, based on false information provided on the applications, prior criminal arrests, indictments, or convictions, and violations of professional board regulations, or for engaging in any practice considered unacceptable by the Medicaid program (Medicaid regulations list 26 different reasons for denial of an application, N.J.A.C. 10:49-11.1(d)(1)-(26)).

An additional screening requirement has been mandated by Section 6401 of the PPACA. As of January 1, 2011, a pre-enrollment site visit will be required for new applicants. Section 6401 also requires that not less than 30 days and not more than one year during which a new provider has been enrolled in the program, the provider will be subject to enhanced oversight, such as prepayment review and payment caps.

The decision to deny a provider's application to become a Medicaid provider previously rested with DMAHS. When MFD first opened its doors, MFD's SIU would perform the background check on the provider, make the recommendation to DMAHS to either accept or deny a provider's application and DMAHS would make the decision. If DMAHS denied the application, the provider could appeal to the Office of Administrative Law. If the OAL affirmed the denial, the provider could appeal that decision to the final arbiter, the Director of DMAHS. Recognizing the need to improve both the integrity and efficiency of the process, MFD recommended that provider applications be sent directly to MFD, SIU would perform the background check and make the decision to either approve or deny the application. MFD now informs the provider of a denial decision directly. The provider can appeal denial decisions to the OAL and ultimately, to the Director of DMAHS. This new MFD responsibility was incorporated into an amended Memorandum of Understanding with DMAHS at the end of fiscal year 2010.

3.

Recipient Fraud

Eligibility fraud and medical necessity fraud are two of the many types of recipient fraud. Eligibility fraud involves individuals who defraud the Medicaid program by falsifying their income in order to qualify for Medicaid, FamilyCare or Charity Care. The MFD has countered this type of fraud by working with local social

service departments and DMAHS to obtain referrals of individuals believed to have lied about their income.

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 these individuals. If MFD investigators find that their income is greater than what they have declared or they refuse to provide supporting documentation, they are terminated from the Medicaid or FamilyCare Program and the MFD Recovery and Exclusion team will recover the money spent to provide them with medical care, including penalties and interest. The MFD has also referred cases of this nature to local prosecutors, some of which have resulted in arrests and convictions.

Medical necessity fraud involves knowingly obtaining services that are not medically necessary. Many of these cases are intertwined with provider fraud. For example, a recipient who does not need psychiatric treatment may find a psychiatrist who provides the recipient with a controlled substances 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, or in some 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 type of doctor and more than one pharmacy several times a day.

After identifying such a recipient, investigators review computer printouts of all services billed to Medicaid as a result of a 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. Additionally, the MFD will pursue recoveries from recipients and providers, and these cases can be referred to the MFCU for prosecution of the provider and the recipient.

C.

REGULATORY

In May 2010, the MFD’s Regulatory Unit was created to provide administrative, investigative, and rule-making support to other MFD units. Prior to the creation of the Regulatory Unit, the Attorney General’s Office handled MFD’s representation at OAL Hearings. In fiscal year 2011, the MFD’s Regulatory Unit will handle all aspects of these hearings. In connection with these cases, MFD Regulatory officers will also negotiate and monitor corporate integrity agreements. The Regulatory officers will also aide in investigations by advising investigators on evidentiary issues and assisting in interviews. The officers will continually review current Medicaid regulations to determine if changes need to be made, draft new regulations and/or changes to existing regulations with the assistance of and input from all other MFD units, review cases that are being appealed to the OAL by providers and recipients. The officers will also work with the Director’s Office to develop compliance programs for Medicaid providers, publish fraud alerts and provide other guidance to the health care industry concerning the anti-kickback statute.

IV.

FISCAL YEAR 2011 OBJECTIVES

Medicaid fraud is committed by both the providers and recipients of Medicaid services. The MFD is charged with civil recovery from both groups. Below are the areas where the MFD will focus on in fiscal year 2011.

A.

PROVIDERS

1.

Addiction Services

The Division of Addiction Services (DAS) within DMAHS promotes the prevention and treatment of substance abuse and supports the recovery of individuals affected by addiction.

The MFD will investigate treatment clinics by conducting clinical reviews to ensure that recipients have been admitted and continue to be treated based on medical necessity. MFD investigators will also review patient charts to determine whether they contain treatment plans, and treatment notes to ensure that services are actually being provided.

2.

Adult Medical Day Care Services

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

Because these services are essential to keeping people with special medical needs in their homes, the New Jersey Medicaid program pays these providers a daily fee for

Medicaid recipients to attend these facilities during the day. Due to the state's limited financial resources, it is crucial for the MFD to monitor these programs to ensure that the Medicaid recipients who need these services most are able to participate. As a result, MFD investigators will review whether Medicaid patients have been appropriately admitted into these programs, as well as whether recipients are receiving the care and services that were ordered and billed for and that they are receiving the appropriate quality of care for the services billed. The investigators will also compare physician orders to medical charts as well as 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 recipients are appropriately examined upon admission, all orders are medically necessary, and the providers follow through with each recipient's plan of care. An example of MFD's recent findings regarding one adult medical day care facility can be found on MFD's website.

3.

Charity Care

The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) is free or reduced charge care which is provided to patients who receive inpatient and 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 have no health coverage or have coverage that pays only for part of the bill, are ineligible for any private or governmental sponsored coverage (such as Medicaid), and meet **both** the income and assets eligibility criteria for the Medicaid program. Some services such as physician fees, anesthesiology fees,

radiology interpretation, and outpatient prescriptions are separate from hospital charges and may not be eligible for reduction.

All Charity Care applicants must be screened to determine the potential eligibility for any third party insurance benefits or medical assistance programs that might pay towards the hospital bill. Patients may not be eligible for the hospital care payment assistance program until they are determined to be ineligible for any other medical assistance programs. Patients are responsible to obtain a financial screening from the hospital in a timely manner. Usually, a patient must apply for Medicaid within three months from the date of hospital services. Based on the information provided by the patient, the hospital makes the determination as to the patient's eligibility.

If the patient fails to cooperate or does not go for 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.

Charity Care is vulnerable to patients who lie about their income and assets because hospitals do not currently have a mechanism to effectively review and verify information submitted. A 2007 report by the New Jersey State Commission of Investigation (SCI) found that numerous applicants were approved for and received Charity Care benefits for which they were not entitled. The SCI also found that audits performed by an outside vendor to review Charity Care applications simply reviewed the paperwork and not the supporting documentation. In response to this report, our auditors will spot check hospitals and review both the applications and supporting documentation of Charity Care applicants. MFD's Investigations Unit also receives allegations of Charity Care fraud from its fraud hotline and the DHSS which administers the Charity Care program.

DHSS entered into a contract with a third party vendor to do a five-year retrospective audit of Charity Care claims in order to identify whether there are third party insurers who should have paid the claims instead of Charity Care. In circumstances where the third party insurers are responsible, the State will be reimbursed. If, during the vendor's review, it finds evidence of fraud or abuse, the matter will be referred to the MFD for an expanded audit and/or investigation. The vendor has also begun a pilot project with three hospitals where the vendor provides the hospitals with access to its proprietary database of insurance coverage for an access fee. The hospitals will be able to use this database in real time to determine if patients applying for Charity Care have other health insurance and bill the insurer. The pilot program will run for six months. MFD, DHSS and the New Jersey Hospital Association will then evaluate the program to determine whether it should be expanded to all New Jersey hospitals.

4.

Child Behavioral Health Services

The Division of Child Behavioral Health Services (DCBHS) within the Department of Children and Families (DCF) serves children and adolescents with behavioral health care challenges and their families. DCBHS provides these services 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. For families in the Medicaid program who are in need of these services, Medicaid will pay the providers who perform these services for Medicaid families. Additionally, as part of its duties, DCBHS also contracts with residential treatment centers to provide services for families that need them. These centers likewise bill Medicaid for the services it provides to Medicaid eligible families.

Through audit and investigative tools, MFD will ensure that Medicaid families are receiving the services for which Medicaid is billed and the program is operating efficiently. MFD will work with DCBHS to identify trends or patterns that indicate provider fraud and abuse, and where identified, recover overpayment from providers.

5.

Durable Medical Equipment Providers

The Medicaid program contracts with a number of durable medical equipment (DME) providers who supply services such as adult diapers, prosthetics, canes, walkers, ventilators, hospital beds, and wheelchairs to Medicaid recipients in need of these medical support supplies.

MFD auditors will audit DME providers to determine if equipment and/or supplies were properly authorized, products delivered, and claims fall within Medicaid payment guidelines. Auditors will focus on items dispensed to Medicaid recipients institutionalized in long-term care facilities and the accuracy of Medicare co-insurance claims to ensure that Medicaid is the payor of last resort. The MFD will use system matches to identify claims for recipients residing in long-term care institutions such as nursing homes or assisted living facilities and for inappropriate claims for dual-eligibility (i.e., those covered by both Medicare and Medicaid) recipients. We will also review medical records of physicians who order significantly higher amounts of supplies to determine the necessity of the supplies and to determine whether the

physicians treated the recipients on the date of service or during the six months period prior to the DME date of service. We will examine purchase invoices, shipment records, physician orders, Medicaid claims, and conduct interviews of recipients, providers and staff and ordering physicians. DMAHS has contracted with its third party liability contract vendor to audit DME providers. The vendor will perform desk and onsite audits, report its findings monthly to MFD, and refer any findings that require further auditing or investigation to the MFD.

6.

False Claims Act and Qui Tam Cases

New Jersey enacted a State False Claims Act Statute, N.J.A.C. 2A:32C-1 et seq. in 2007 that closely mirrored the Federal False Claims Act Statute, 31 U.S.C. §3729 et seq. New Jersey's False Claims Act enables individuals to file a civil complaint on behalf of the State when there are allegations that a defendant or defendants knowingly present false or fraudulent claims to the state for payment, misappropriate state property, deceptively avoid binding obligations to pay the state, among other things. The Complaint, labeled a Qui Tam, is filed under seal with the Court and served upon the State Attorney General's Office. The Attorney General's Office then has 60 days to determine whether to intervene in the case, decline to intervene, or request good faith extensions from the court to keep the matter under seal while the Office continues its investigation.

The Medicaid Fraud Division receives copies of Qui Tam complaints from the Attorney General's Office where the allegations have a Medicaid nexus. The MFD will either work with the Attorney General's Office on those matters, or will review the Complaint to determine whether there are other providers similarly situated as the

defendant to determine whether an audit or investigation should be conducted of those other providers.

7.

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 supplying certain medical supplies. MFD will ensure only those services provided according to medical, nursing and other health care related needs are covered based on documented plans of care, medical necessity and the goals to be achieved and/or maintained.

MFD will audit these agencies to verify that all aides are certified and have appropriate educational background to perform the services billed for, determine if the recipient's diagnosis justifies the higher reimbursement rate for home health services or should be receiving services from a personal care agency, and review charts for adequate documentation and care plans. MFD also will review time sheets to ensure that services billed were in fact rendered.

8.

Hospice Services

Hospice services, administered through DHSS are available for terminally ill patients regardless of whether they reside in the community or 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 medical records of Medicaid recipients receiving these services to determine whether these services were properly authorized, appropriately provided and documented, and verify whether all available third-party insurance was exhausted prior to billing Medicaid for services rendered. Additionally, MFD will audit providers' records to ensure that all providers' staff who provide care meet all licensing, regulatory, educational, and experience requirements necessary to provide the care billed for as well as all recipient records to confirm that the recipients met all necessary criteria for hospice care. Finally, the MFD will review billings to identify any potential fraudulent billings such as unnecessary services or duplicate billings and in certain circumstances 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 should no longer be in the program or who did not meet the criteria when originally placed in the program. Where there was no medical necessity or the recipient's condition improved to where continued receipt of these services were no longer medically necessary, the MFD will seek reimbursement from the appropriate providers and/or recipients. MFD data mining staff will perform data match analysis, comparing different sets of billing claims to identify potential overlapping billing for duplicate services.

The Centers for Medicare and Medicaid Services (CMS) requested a third party 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. It also found minimal professional and/or educational standards to become a hospice provider. 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.

9.

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. The focus of these audits will be excess payments for direct care services, administrative payments for undocumented or unnecessary services, physician practice subsidies, physician contracts, and physician compensation which does not reflect the fair market value of the physician's services. The MFD will conduct its first hospital audits in fiscal year 2011.

DMAHS has contracted with a third-party vendor to audit hospital DRG coding and perform utilization reviews. The contractor will report its findings of individual audits to DMAHS and to the MFD. Where the audits indicate that the hospitals owe money, the MFD will initiate the recovery process. Where the audits indicate the possibility of fraud, waste, or abuse, the MFD will widen Permedion's audit sample and initiate an investigation to determine if claims were submitted fraudulently.

10.

Laboratory Services

Independent clinical laboratories test for a wide variety of services 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 bills separately for some, or all tests, analyzed simultaneously by a single piece of equipment on a single patient specimen. There are sophisticated versions of this type of false billing. In some cases, laboratories have provided an option for physicians to order customized groupings of tests (called panels and profiles) that do not exactly 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. Many physicians said they were not aware that the extra tests would be separately billed and would not have authorized them if they had known.

11.

Lock-In Program

The Special Status Unit (SSU) of the DMAHS is responsible for restricting Medicaid and/or FamilyCare recipients to a single pharmacy where 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 are:

- A recipient who receives prescriptions drugs on two or more occasions in excess of what any one prescriber would intend;
- A recipient presents a forged prescription;
- A recipient has altered a prescription;
- A recipient who uses multiple physicians and/or pharmacies; or

- A recipient who 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 notice and 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 offense and the number of 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. Examples of good causes are if 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, DMAHS is looking into the feasibility of expanding the restriction program to different provider types.

Other states have been restricting recipients to a single provider for all types of services with a great deal of success. MFD will work with DMAHS in expanding the lock-in program to all provider types. Additionally, MFD will review the lists of

locked-in recipients to ensure they were appropriately determined to be 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.

12.

Managed Care Organizations

The MFD Audit team and Investigations Unit will monitor the Special Investigations Units (SIUs) of the four Medicaid Managed Care Organizations (MCOs). The monitoring will focus on SIU performance and SIUs’ compliance with the fraud, waste, and abuse provisions of the MCOs’ contracts with DMAHS. The SIUs’ contractual obligations involve conducting investigations, prepayment monitoring, quarterly reporting, financial recoveries, referrals to the Medicaid Fraud Control Unit. Additionally, MFD will audit SIU’s staffing 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.

13.

Medi-Medi Project

Some individuals are eligible for both Medicare and Medicaid. In these instances, Medicaid remains the payor of last resort: Medicaid should only be billed once Medicare has paid its share of the patient’s costs. Providers servicing this dually eligible population may submit impermissible Medicaid claims, thereby fraudulently and illegally increasing their revenue stream. The Medi-Medi Project identifies fraud, waste, and abuse in cases where claims are filed with Medicare and Medicaid.

Because providers who service the dually eligible population and commit fraud against one program are likely to commit fraud against the other program, MFD investigators meet regularly with federal officials to discuss the latest fraud and abuse schemes they have encountered in the healthcare arena. These meetings have produced useful information for both parties. Additionally, federal officials have been able to share helpful insights on fraud schemes not just on the federal level but at the state level for other states that participate in the Medi-Medi program. The MFD will continue to be involved with the Medi-Medi Project to help mitigate fraud and abuse by providers who seek to exploit the dual-eligible population.

14.

Nursing Facilities

New Jersey residents who need help completing activities of daily living have several options as to where such services can be provided. Today, more and more individuals with disabilities and their families are choosing to receive care in their homes or in community settings; however, nursing homes continue to play a role in New Jersey's long-term care system by providing 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 causes 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

- Major health needs, such as physical rehabilitation, recuperation after hospitalization for serious illness or surgery, restorative services, tube feeding and special equipment or treatment.

Since nursing home care is the most medically intensive of the long-term care services, it is also the most expensive. Nursing homes charge a daily or monthly fee. In 2008, the average cost of a semi-private room in a nursing home was \$5,448 per month or \$65,385 per year.⁴ 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, the 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 provide us with corrective action plans demonstrating how they will prevent this practice from continuing 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, the provision of nursing services by these facilities, and sets forth a process for the calculation of nursing facility Medicaid per diem rates and for audits of nursing facilities.

⁴ New Jersey Department of Health and Senior Services, Aging and Disability Resource Connection manual p. 110.

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, which groups residents according to their status and anticipated uses of services and resources, and used by DHSS 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 provide 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.

15.

Partial Care

The purpose of Partial Care (PC) services is to assist individuals with severe mental illness to achieve community integration through valued living, learning, working, and social roles and to prevent hospitalization and relapse. The role of PC is to facilitate patient integration into the community, not to become a permanent outcome, although it is recognized that some consumers may 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, and shall be 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.

16.

Pharmacies

The Medicaid program reimburses pharmacies for a variety of prescription and over the counter medications. Significant fraud, waste, and abuse problems 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. The MFD auditors will audit pharmacies to ensure that services billed for have been provided. MFD auditors will also review purchase invoices to ensure that medication billed to the Medicaid program has been dispensed, and that purchases are from legitimate pharmaceutical wholesalers.

DMAHS has contracted with a third party liability vendor to audit pharmacies. The vendor will conduct 1100 pharmacy audits per year and 1200 DME audits/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 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 ensure that duplicative work is not being done work with the vendor to ensure that the audits are inclusive of the work that MFD would perform if it were conducting the audits, and inspect the vendor's work for accuracy and completeness.

Additionally, MFD will review pharmacy overrides. Some Medicaid recipients are covered by third party insurers, including Medicare. A database of those recipients who have third party insurance is maintained by the state's fiscal intermediary Molina. Working with Molina, the MFD has identified pharmacies who submit claims to Medicaid first rather than to the recipient's third party insurer by indicating that the third party insurer has denied a claim and overriding the pharmacy claims submission process so that they can submit claims to Medicaid first (thereby obtaining the larger dispensing fee paid by Medicaid).

MFD will audit pharmacies who override the claims submission process to identify potential recoveries and potential fraudulent conduct by pharmacies. If fraudulent conduct is identified, the MFD will seek to recover additional funds from the pharmacy under the Medical Assistance and Health Services Act, N.J.S.A. 30:4D-17(e) and refer the matter to the MFCU.

17.

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 who have contracted with managed care plans or who 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. MFD will review records of non-Medicaid referred providers to determine whether there is sufficient medical necessity for services ordered exceeding \$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 then the Medicaid recipient fills the prescription at a Medicaid pharmacy for which it is reimbursed. Under those circumstances, the physician who wrote the prescription will be liable and MFD will seek 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, audit the physicians' records

where appropriate, and seek recoveries of amounts paid and sanctions from the provider of the service and/or ordering physician if overbillings have occurred.

18.

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 personal care, 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 while nursing assessment and reassessment visits under this program are reimbursed on a per visit basis after they have been preauthorized. MFD staff will audit agencies to determine if services were pre-authorized, provided in accordance with physician orders, appropriate care plans were developed and followed, and services were performed by appropriately trained and certified and/or licensed staff, supervised by a registered nurse.

19.

Special Education Medicaid Initiative (SEMI)

New Jersey's SEMI program is a school-based health services program which is administered through three New Jersey State departments: Human Services, Education, and Treasury. DHS oversees school-based provider enrollment, provides

technical assistance to providers, and processes provider claims through Molina, the State fiscal intermediary. The Department of Education (DOE) certifies school-based providers and provides policy guidance. Treasury serves as the contract manager for the SEMI billing agent. The SEMI program provides the following: rehabilitative services including occupational, physical and speech-language therapies, audiology services, psychological counseling, psychotherapy, and nursing; evaluation services which includes identifying the need for specific services and prescribing the range and frequency of services that the student requires as well as the reevaluation or review of the current services specified in the child's plan; and specialized transportation services where a child requires transportation in a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus. The purpose of the SEMI program is to recover a portion of costs for certain Medicaid covered services provided to Medicaid-eligible students enrolled in participating New Jersey Local Education Agencies (LEAs). SEMI is different than any other Medicaid program because it is limited to services provided in an educational setting (in school, student's home or in a community setting) under the jurisdiction of the Department of Education. Prior to SEMI, these services would have been funded by state or local tax dollars. Federal Revenue is available only if Federal and State Medicaid requirements are met.

During fiscal year 2011, MFD auditors will review the program to ensure these departments continue to address deficiencies in the program identified by the federal government in a 2009 audit and confirm that additional internal controls have been added to ensure future compliance. Additionally, due to the number of departments involved and the complexity of the program, there are areas that are not monitored that could cause overpayments to occur. MFD, which is responsible for overseeing a number of the agencies involved, will monitor this program by focusing on areas that are most vulnerable to fraud, waste or abuse.

20.

Medical Transportation

In 2009, DMAHS entered into a contract with a transportation broker to provide non-emergency medical transportation services for Medicaid recipients for certain selected counties in New Jersey as well as higher level services statewide. The broker is responsible for taking care of all mobility assistance vehicle/wheelchair/livery transports. A monthly capitation payment of \$23.02 is paid to the broker for every Medicaid client regardless of whether they have ever 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 capitation to Logisticare. The 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 order.

MFD will audit ambulance providers to ensure that the use of an ambulance was medically necessary and that the ambulance had the proper equipment and personnel to provide emergency services. The audit will encompass a review of claims for recipients who were inpatients on the date of service to ensure that the recipient was actually transported. The auditors will also review claims to ensure that providers do not bill the broker for a trip and Medicare/Medicaid for the same trip.

21.

RECIPIENT PROGRAMS

The MFD will also continue its investigation and prosecution of recipient fraud cases. In these economically challenging times, it is crucial for the 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 where the conduct is criminal in nature to ensure all appropriate recovery methods and sanctions are employed. The MFD will continue to raise awareness of recipient fraud cases to both send a message of deterrence and to encourage the public to report examples of recipient fraud to MFD for further review. The MFD will also be working with the Commissioner of DHS and the DMAHS Director 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 New Jersey's uninsured children and certain low-income parents and guardians to have affordable health coverage. It is not a welfare program. New Jersey FamilyCare is for families who do not have available or affordable employer insurance, and cannot afford to pay the high cost of private health insurance.

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. The impact of this fraud is that it drains the resources of Medicaid dollars for those who truly are eligible for assistance.

To address this issue, MFD established relationships with the county welfare offices so that MFD could be a source of referrals for potentially egregious cases of eligibility fraud for our office to investigate. MFD, formerly OMIG, had numerous cases of eligibility fraud it investigated from the counties in the 2009-2010 fiscal year. Once MFD determines that an individual family has committed eligibility fraud, MFD will seek to recover the money that FamilyCare has paid for their health benefits. Since July 1, 2009, MFD has recovered over \$100,000 from FamilyCare recipients who were found ineligible to be in the program and MFD has successfully requested that county welfare offices terminate 66 recipients who were not eligible for services.

For those eligibility cases that rise to the level of criminality, 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 which 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 fiscal year 2011 workplan, please contact:

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If you suspect fraud, waste or abuse in the Medicaid, FamilyCare or Charity Care programs, please contact: 1.888.937.2835 or email: njmedicaidfraud@osc.state.nj.us, or submit a form electronically through our website www.nj.gov/comptroller/divisions/medicaid.