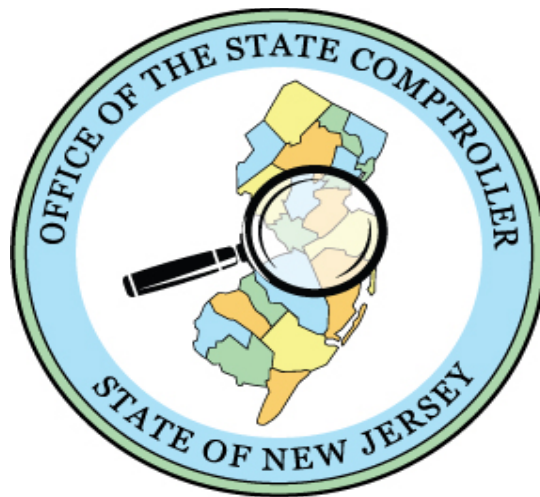


**STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION**

***OCEAN COUNTY RECIPIENT
VOLUNTARY DISCLOSURE PROGRAM***

A Summary and Discussion of the Program



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Introduction

On September 12, 2017, the Office of the New Jersey State Comptroller (OSC) launched an innovative pilot program designed to recapture improperly spent Medicaid funds and to remove from Medicaid individuals who were not entitled to participate in this state and federally funded program. The enrollment period for the Ocean County Recipient Voluntary Disclosure Program (OCRVDP or the Program), which ran for 90-days, concluded on December 12, 2017, and in large part, met or exceeded our expectations. As of October 10, 2018, which is when the final payments were received by OSC, we can report that we have achieved full compliance with all 81 settlements entered into as part of the OCRVDP. Accordingly, OSC has referred 159 individuals to be removed from the Medicaid program and recovered \$2,246,978. These totals eclipse both the total number of criminal referrals made and the total amount of money recovered for the program over the last seven years. What follows is an overview of the Program, a summary of results, and a reflection on lessons learned from the OCRVDP.

OSC/MFD

The Comptroller's Office is an independent state agency that conducts audits and investigations throughout New Jersey. The four divisions that make up OSC each have discreet functions, but all work towards the common goal of safeguarding taxpayer funds. Since 2010, OSC's Medicaid Fraud Division (MFD) has served as the state's independent watchdog for New Jersey's Medicaid, FamilyCare, and Charity Care programs and works to ensure that the state's Medicaid dollars are being spent effectively and efficiently. In so doing, OSC/MFD conducts audits and investigations to safeguard Medicaid funds. Some investigations result in referrals to criminal prosecutors or are resolved through the direct negotiation of civil settlements to recoup proceeds from conduct that violates aspects of the Medicaid program.

One area of concentration within MFD's Investigations group involves a category of conduct referred to as "recipient fraud." As the name suggests, matters generated from this group focus on individuals who have either mistakenly or intentionally defrauded the Medicaid program by accepting benefits despite the fact that they did not meet the eligibility requirements of the program. Because of the sheer number of Medicaid recipients in this state (approximately 1.75 million as of September 2018), the related difficulties in locating viable leads in this area, the complexities of the eligibility requirements, and the volume of information that must be processed to conduct an investigation in this area, this small group can conduct

only a limited number of investigations each year. When appropriate, these investigations have resulted in referrals to federal, state, and county prosecutor's offices as well as to local law enforcement. When these cases are accepted for prosecution, which is not always the case, they often and rightfully conclude with a negotiated plea deal or admission into a pretrial intervention program. And, with respect to monetary recoveries, the majority of the subjects of these matters are only marginally ineligible for the Medicaid program, resulting in recovery amounts that constitute pennies on the dollar when compared to the total value of Medicaid benefits received.

This is by no means a criticism of the process. Rather, it is intended to provide a factual backdrop to put the Ocean County Recipient Voluntary Disclosure Program into context. Historically, because these matters are referred to federal, state, and county prosecutor's office and leave our control at that point, OSC has not tracked outcomes of each criminal referral nor are we routinely notified when a criminal matter is resolved. That practice is changing, as I have directed MFD staff to track both the disposition of each recipient fraud referral going forward and to take steps to collect that information for past referrals. Our preliminary findings in that area indicate that since 2011, OSC has referred 73 recipient fraud matters to various federal, state, and county prosecutor's offices as well as to local law enforcement. While it will be very difficult to track the monetary recoveries made through those cases, we have preliminarily confirmed that over this period these entities

have recovered approximately \$500,000 from these efforts and only two of those matters resulted in a sentence involving jail time. In each of those matters, a sentence of time served of a single day was imposed.

Involvement in Ocean County

Approximately five years ago, OSC's recipient fraud investigations group began work in Ocean County, New Jersey, and the town of Lakewood in particular. After years of work, MFD referred 30 individuals to the Ocean County Prosecutor's Office (OCPO) for prosecution. Twenty-six of those matters were retained by OCPO and four were accepted by the United States Attorney's Office for the District of New Jersey. In the summer of 2017, multiple arrests took place by state and federal law enforcement officers. Almost all of those matters remain open.

Based upon our accumulated knowledge, including our belief that there were likely other instances of Medicaid fraud to be addressed in Ocean County at large, OSC began to consider alternative ways to serve our mission of safeguarding taxpayer and program funds, mindful of the difficulties of these types of investigations and the resources that we had available to deploy. From those internal discussions, OSC decided to conduct a voluntary disclosure program,¹ which to my

¹ Press reports have routinely referred to this Program as an "amnesty" program. We have not used the term "amnesty" to describe this Program for a number of reasons. First, the Comptroller does not have authority to grant amnesty. Second, while amnesty generally

knowledge has not been done in New Jersey in this context. In creating this program, OSC balanced the results that might be achieved through the traditional criminal process with the certainty of results and potential to capture a larger universe of recipients through a voluntary disclosure program. While OSC acknowledges the importance of holding individuals accountable for their criminal conduct, the realities of the criminal justice system must be considered. Simply put, the likelihood of a successful prosecution for this type of Medicaid fraud affecting meaningful change within the Medicaid system is low. OSC weighed that reality against its own ability to identify and process a far larger number of Medicaid fraud cases through the OCRVDP and recoup millions of dollars more than traditional prosecutions could. Moreover, the use of the voluntary disclosure process allowed us to open up the offer to a larger population, namely all residents of Ocean County, rather than simply continuing to focus on one municipality.

refers to a full protection from criminal prosecution, this Program does not afford that. What it affords is OSC's agreement not to refer the matter to criminal prosecutors only if the terms of a civil settlement agreement are complied with. Finally, use of the term "amnesty" in this case would have been misleading because all applicants to the voluntary disclosure program were made aware that their applications were going to be referred to both the New Jersey Division of Taxation and the federal Social Security Administration. We have no agreement in place with either of those agencies as to how these referrals will be handled. As a result, criminal prosecutions generated out of those offices are possible. There is, obviously, a subtle distinction between the concepts of amnesty and the mechanics of our voluntary disclosure program, but those distinctions are important to our effort to fairly represent the program to the public.

Program Overview

The voluntary disclosure program was structured to allow for a 90-day window during which any resident of Ocean County who had received Medicaid benefits improperly and who was not already under investigation for that conduct to self-report their receipt of those benefits and the period of time during which those benefits were improperly received. The self-reporting component eliminated several difficult and time-consuming steps from the traditional investigative route, namely the identification of targets, calculation of benefits, and verification of income levels to determine eligibility. Rather than relying on OSC investigators to perform each of these tasks, which typically involves the receipt of credible lead information and the collection and review of hundreds or thousands of pages of financial records for the subject of each investigation, each applicant was responsible for making those calculations and determining whether or not he/she was eligible to receive Medicaid funds. Indeed, the submission of the application to OSC would be taken as the applicants "admission" that he/she had performed that analysis and concluded that he/she was ineligible, but did not require each applicant to admit whether the receipt of benefits was intentional or the result of some error.

Applications were to be submitted through a secure portal opened on the OSC website and all determinations of eligibility were to be made by the applicants prior to submission of the application. Upon receipt, OSC personnel were to calculate the amount of benefits -

essentially the amount of Medicaid benefits received - and memorialize that amount in a settlement agreement, along with a civil penalty ranging from \$1,000 to \$10,000 that was to be proportional to the amount of improperly received benefits.² The OCRVDP contemplated that execution of the settlement agreement would require the participants to repay the total amount of damages no later than six months from the date of the agreement and to consent to a one-year bar from the Medicaid program, even if they later became eligible for the program. Program applicants were made aware that their settlement agreements would be referred to both the state Division of Taxation and the federal Social Security Administration for whatever additional action was deemed necessary by either or both of those agencies. In return, if the applicant satisfied the terms of the settlement agreement, OSC agreed that it would not refer an applicant's file to the OCPO for criminal prosecution of Medicaid fraud for the time period identified on the application.

² Medicaid "benefits" are made up of two components: monthly "capitation payments" from the state to the managed care organizations (MCO) that cover the health care needs of more than 95% of Medicaid enrollees (this cost is shared equally between the federal and state governments) and "claims payments" that can be made to a health care provider either directly by the Medicaid program or by an MCO. Some have argued that, in recipient fraud cases, the only true damages are the capitation payments, which reflect the amount of money that the government has spent on behalf of the Medicaid enrollee. In the aggregate, OSC's position, historically and with respect to the voluntary disclosure program, is more aggressive in that we typically seek to recover both components of the improperly received benefits (capitation and claims).

The intent of the Program was to ensure total repayment of improperly received Medicaid benefits from as many Ocean County residents as were willing to come forward and self-report their conduct, whether mistaken or intentional. We took steps to inform as many people about the program as possible, going so far as to make ourselves available to the public one evening in Toms River, New Jersey to answer questions or criticisms regarding the Program. We also met with a community group, at their request, one week prior to the launch of the Program to answer questions. In addition, we consulted with law enforcement agencies on the state and federal level to make sure they were aware of the details of the Program. Indeed, the OCPO provided OSC with a letter that was posted on OSC's website evidencing its acknowledgement of the referral restriction. Finally, we conducted numerous interviews with members of the press to detail both the availability of the Program and its requirements.

Despite our best efforts and the success that we did achieve, this pilot program was not executed without flaws and mistakes. As an agency that, in large part, examines state programs and contracts and publishes criticism of the same, we cannot be exempt from that treatment ourselves and have an obligation to disclose the areas where we fell short.

First, three days prior to the conclusion of the Program, we learned that an OSC employee had engaged in negotiations with counsel for applicants that resulted in settlements for less than the full damages amount (*i.e.*, capitation amounts and claims). We can confirm,

however, that the total amount recovered through the Program, \$2,246,978, is still above the capitation payments that were attributable to these participants for the periods identified in each of their settlement agreements. This employee circumvented the established application process and safeguards and engaged in direct communications with applicants' attorneys. This conduct was contrary to the published terms of the Program and to my public statements regarding the OCRVDP. As soon as this conduct came to light, appropriate steps were taken to end that practice. Upon conclusion of a detailed analysis of each agreement, it appears that approximately \$2.6 million of additional collections could have been pursued. This, of course, assumes that the same individuals would have executed settlement agreements and that all of them would have paid in full. Based upon our experience with this Program, however, this would likely not have been the case. Thus, despite the fact that settlement negotiations were not contemplated under the original terms of the OCRVDP,³ it is likely that the negotiated-for settlements led to increased participation and removals from the Medicaid program and possibly to increased recoveries as well.

³ It is important to note that OSC is authorized to engage in civil settlements to resolve recipient fraud matters and, as with virtually all civil settlements, negotiate settlement amounts. Thus, while the OSC employee's negotiations were not contemplated under the terms of the OCRVDP and were not authorized by the employee's chain of command, it does not appear that this employee acted beyond the authority of the OSC generally.

Second, OSC should have been more proactive in marketing the voluntary disclosure program to a larger population in Ocean County. As OSC has confirmed to the press, the Comptroller and members of OSC met with representatives of the Lakewood Vaad on two occasions. The first meeting took place at the Vaad's request, approximately one week prior to the public announcement of the voluntary disclosure program. As it was explained to OSC, members of the Vaad wanted to discuss certain aspects of their community and underscore their commitment to compliance with Medicaid rules. Given the fact that 14 members of the community that the Vaad represents had recently been arrested on Medicaid fraud charges and 12 others had been served with criminal complaints soon after, we believed that it was appropriate to take this meeting. Unbeknownst to the Vaad at the time of that meeting, the major substantive elements of the voluntary disclosure program, including its launch date, had already been settled on by this office. Because, however, we were not prepared to discuss the Program publicly, the representatives of the Vaad were not told of OSC's plans at that point. A second meeting with the Vaad was convened, at the Comptroller's request, one day prior to the public announcement of the Program to share with them the details of the Program given their interest in the issue and to address substantive insurance coverage requests that would likely be raised by those who were considering participation in the Program. Importantly, OSC did not make any changes to the framework of the Program as a result of either of these two meetings.

Despite that, OSC has been criticized for meeting with the Vaad and for not reaching out to other community groups in Ocean County to discuss the Program. This is not completely valid criticism given OSC's understanding of the issues and the fact that we did not, in the first instance, request the meeting with the Vaad. Indeed, I would have accepted meeting requests from other community groups had any been made. OSC does acknowledge, however, with the benefit of hindsight that we could have and should have done more to bring other community stakeholders into the discussion generally about the voluntary disclosure program.

Results

Notwithstanding the issues outlined above, the Ocean County Recipient Voluntary Disclosure Program largely achieved the goals that were set and far exceeded the anticipated levels of participation. To date, we have entered into 81 fully executed settlement agreements. As of October 10, 2018, the terms of all of these settlements were met, and OSC will have recouped \$2,246,978 in improperly allocated Medicaid funds that would likely not have otherwise been recovered.

Comparing these numbers to the 72 criminal referrals made through the history of the recipient fraud investigations unit (from 2011 to present), we have, with an exceptional economy of resources, achieved a tremendous benefit for the Medicaid program both in terms of direct recoveries and in terms of the cost avoidance that will

come with the removal of 159 people from the Medicaid program. Further, our referrals will result in all of these individuals undergoing additional scrutiny from the Division of Taxation and the Social Security Administration, potentially resulting in the resolution of other matters that would otherwise never have been uncovered. Thus, both directly and tangentially, the Ocean County Recipient Voluntary Disclosure Program has resulted in a tremendous benefit to Medicaid.

Notwithstanding the success of the Program, I accept the criticism or concern that, in some of these cases, intentional conduct is not being addressed through the criminal process. I continue to believe, however, that given the mission of this office, the nature of this type of Medicaid fraud generally, the reality of the criminal process, and the unique circumstances of our work in Ocean County, we have served our mission and the public interest more effectively through this innovative program than we would have by simply continuing to rely only on our traditional methods of investigations and referrals. To be clear, we will not abandon those traditional methods. Indeed, I have directed MFD to continue working in Ocean County to determine whether or not there are other viable leads to pursue. If warranted, we will investigate those leads and make referrals to the OCPO.