



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

**MEDICAID FRAUD DIVISION
WORK PLAN
Calendar Year 2014**

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I.

THE MEDICAID FRAUD DIVISION OF THE OFFICE OF THE STATE COMPTROLLER

The mission of the Medicaid Fraud Division (MFD) of the Office of the State Comptroller is to prevent, detect, audit and investigate fraud, waste and abuse by providers and recipients enrolled in the New Jersey Medicaid program, and to recover improperly expended state funds. MFD functions independently from the state agencies it oversees. MFD has three units: Fiscal Integrity (comprising Audit, Data Mining, Third Party Liability and the Investigations Unit); Regulatory Unit; and Recovery Unit.

MFD's work plan for Calendar Year (CY) 2014 is outlined in more detail below. MFD's plans are subject to change based on resource allocation, and unforeseen events that may shift MFD's priorities, resulting in items being added or dropped. The purpose of the work plan is to serve as a roadmap for providers, managed care organizations (MCOs), policy-makers and taxpayers to follow as a guide to MFD's audit and investigative activities planned for CY 2014, for identifying fraud and abuse, and saving taxpayer dollars.

II.

Global Initiatives

OVERVIEW

The Medicaid program will have at least one new Medicaid Managed Care Organization (MCO) in 2014. Other managed care companies have applied to become providers, and so it is very possible that the state will increase the number of MCOs to well beyond the current four. New Jersey is participating in the Medicaid expansion as

part of the Affordable Care Act of 2010 (ACA). Thus MFD will have both more recipients and more providers to oversee.

As of July 1, 2014 Medicaid recipients in long-term care facilities or receiving behavioral health services will be moved to one of the MCOs, completing the switch to a managed care system of health care delivery from a fee-for-service system.

Since July 2011, contracts with the MCOs have explicitly granted MFD the ability to audit and investigate providers in the MCO networks, and to recover any and all identified overpayments. MFD's biggest priority in CY 2014 will be our efforts to investigate and audit providers and recipients within the MCO networks. MFD has been data-mining "encounter claims" to identify questionable payments to network providers and recipients who appear to be receiving services to which they are not entitled. We remain committed to working with the MCOs in the coordination of investigative and auditing initiatives to strengthen the viability and impact of the State's program integrity function.

During the last two years, MFD conducted audits of two of the managed care plans' Special Investigations Units (SIU). The units are specifically tasked with the job of finding fraud, waste and abuse in the plan's network providers and recipients. Our audits found serious deficiencies in both of the SIUs' operations we reviewed. In 2014, we will audit our third managed care plan. As detailed below, the audit will be expanded to include areas of the MCO's operations beyond the SIU.

The ACA required each state to incorporate a Medicaid Recovery Audit Contractor (RAC) into its state plan. Health Management Systems (HMS) serves as New Jersey's RAC. MFD is responsible for coordinating the RAC's activities with other agencies conducting audits and, to the extent possible, preventing providers from being

overburdened by overlapping or simultaneous audits. MFD also coordinates the RAC's efforts with state and federal law enforcement.

To facilitate MFD's coordination activities, the RAC submits a list of proposed audit projects to MFD and DMAHS for approval. Once approved, the RAC audits providers to identify overpayments and underpayments. In fiscal year (FY) 2013, the RAC recovered over \$8 million for the state.

The Centers for Medicare and Medicaid Services (CMS) supervise the Audit Medicaid Integrity Contractor program. During FY 2012, CMS offered MFD the assistance of the Audit Medicaid Integrity Contractor for New Jersey, the Island Peer Review Organization (IPRO). MFD has been working with IPRO on audits and clinical reviews involving hospitals and long-term care providers. During FY 2013, IPRO completed 3 audits with potential recoveries of over \$400,000. We plan to expand our partnership with IPRO in FY 2014, resulting in IPRO conducting more audits and identifying more overpayments.

III.

CALENDAR YEAR 2014 OBJECTIVES

MFD is charged with, among other things, recovering improperly expended Medicaid dollars from both providers and recipients. Below are the areas where MFD will concentrate its efforts to recover such dollars in CY 2014.

A.

PROVIDERS

Managed Care

During 2013, MFD completed its second audit of a Special Investigations Unit (SIU) of an MCO contracted with the State. As in the first audit, we found several performance issues, including inadequate staffing, failure to report monetary recoveries accurately to the State and undertaking too few investigations and audits. Additionally we found that MCO's subcontractors and vendors had not reported any potential fraud and abuse issues to the SIU for investigation.

MFD is auditing a third MCO during CY 2014. However, this audit is not limited to the operations of the SIU. The audit will include a compliance review of several provisions of the MCO contract. (For example, we will review the MCO's compliance plan, and its audit functions.) We will also examine the plan's medical loss ratio. (By law, a managed care plan must spend at least 80 percent of the money it receives from the state on medical care. The rest would be spent on administrative costs.) We will issue a report on our findings.

Since New Jersey is paying more than in the past in MCO capitation rates, MFD's oversight role extends to examining capitation rate calculations. As such, MFD is reviewing the documentation submitted by the MCO to calculate its capitation rates. MFD is examining the MCO's quarterly income statements, including but not limited to the appropriateness of costs reported by the MCO. The review includes but is not be limited to:

- Identifying questionable encounter data: MFD is analyzing encounter data to identify patterns and trends that may reflect fraudulent claiming by

providers. MFD will work with and assist SIUs to identify and report false billings by providers within each MCO's network.

- Auditing the credentialing process for providers applying to be in the MCO's network, including whether appropriate licensing, background and exclusion checks are being performed.
- Review of the MCO's clinical data to determine if the cost of preventable health care, such as for hospital-acquired conditions, is properly excluded in the MCO's rate setting process.
- Provision of medically unnecessary care, services, and supplies: Working in concert with the Division of Medical Assistance and Health Services (DMAHS) MFD is reviewing utilization data to determine whether payments included unnecessary costs incurred by the MCO. MFD will also work with MCOs to assess the fraud containment procedures in place to prevent MCOs from incurring unnecessary expenses.
- Supplemental Maternity and Newborn Capitation Payments: MFD is reviewing supplemental maternity/newborn capitation payments and associated inpatient delivery costs for duplicative payments.
- Review of capitation payments to determine if there are any enrollees with multiple recipient identification numbers.

Adult Medical Day Care Services

The Adult Medical Day Care (AMDC) program was transitioned into managed care in 2012. During 2013 MFD completed eight investigations at AMDC facilities. We are currently pursuing recoveries from these providers, two of whom we also referred to the Medicaid Fraud Control Unit for possible criminal prosecution.

MFD continues to monitor these programs to ensure that the Medicaid recipients who need these services most are medically qualified to participate; that recipients are receiving the care and services that were ordered and appropriately billed; that these individuals are receiving the appropriate quality of care; and that providers follow each recipient's plan of care. We will also focus on the facilities' census figures, to ascertain if AMDC facilities have exceeded the billing maximum of 200 recipients per day.

Federally Qualified Health Centers

MFD is in the process of completing our first two audits of Federally Qualified Health Centers (FQHCs). MFD plans to release both audit reports in CY 2014, and conduct another FQHC audit during 2014. MFD's review encompassed the adequacy of policy and procedure manuals, staffing composition, employee licenses, relevant employment contracts, patient medical records, quarterly reports, quarterly wrap-around reports and all applicable managed care contracts and remittance advice documentation. MFD will test the appropriateness of claims billed to the State for reimbursement.

Home Health Services

Home Health Agencies (HHAs) provide skilled nursing services, home health aide services and medical supplies and equipment to Medicaid recipients. HHAs submit claims to the State to receive compensation for the services they provide. Currently MFD is investigating two home-health providers, and a third investigation resulted in a referral to our recovery unit to collect an overpayment. We found that services were billed that were not provided or not documented.

MFD will expand its efforts to ensure that reimbursement for these services is provided in accordance with the treatment plan (relating to the medical needs of

recipients), and that services are provided and documented in compliance with all applicable staffing, licensing and documentation regulations and related industry policy and procedures.

MFD will audit or investigate these agencies to, among other things, verify that the recipient's diagnosis justifies the higher reimbursement rate for home health services; that charts contain adequate documentation and care plans; and that services billed were in fact rendered.

Laboratory Services

MFD's Data Mining Unit will focus on whether independent clinical laboratories improperly submitted claims for services for laboratory tests already covered by another provider's billing. We will also examine claims for tests that the laboratory "unbundled," meaning that the laboratory submitted claims for separate services which should be submitted as a unit, at a lower reimbursement rate, resulting in a higher cost to the state.

Medical Transportation

In 2009, DMAHS entered into a contract with a transportation broker to provide non-emergency medical transportation services for Medicaid recipients in selected counties in New Jersey as well as a higher level of services throughout the state. The broker is responsible for providing all mobility-assistance vehicle, wheelchair or livery transports in exchange for a monthly capitation payment for every Medicaid client, regardless of whether they have used the transportation services.

In CY 2013, MFD began an audit to determine if the broker is in compliance with contract provisions in a number of areas, including, but not limited to: its credentialing

process; its reporting of provider deficiencies; its licensing and exclusion checks, including subcontractor exclusion checks; subcontractors' vehicle maintenance, driver supervision and driver requirements; use of ambulances for non-emergency transportation; recipient eligibility for transportation, including medical necessity; verification of transportation; transportation to non-medical appointments; and verification of physician orders. This audit will be completed in CY 2014.

Partial Care

The Partial Care (PC) Program was established to provide outpatient services to individuals with severe mental illnesses. The goal of PC is to eventually integrate patients into the community.

MFD will review and audit claims submitted by PC providers to ensure that services were rendered in accordance with the patient's plan of care, that the provider has sufficient documentation to substantiate billed services, that appropriate documentation was maintained in patient and personnel related records, that supervision was provided as required and that claims reflect services provided at least five days per week for up to five hours.

Pharmacies

The Medicaid program reimburses pharmacies for a variety of prescription and over-the-counter medications. Risk areas in the pharmacy industry include automated refills, including the failure to return unclaimed medication to stock and the failure to reverse or void the claims for unclaimed medication; 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.

During CY 2013, MFD began a series of inventory audits of pharmacies. Ten audits were completed, all of which identified shortages of medications which the pharmacies billed and were paid by Medicaid. During CY 2014, MFD will continue to conduct audits to ensure that billed services have been provided, review purchase invoices to ensure that medication billed to the Medicaid program have been dispensed, and verify whether purchases are from legitimate pharmaceutical wholesalers.

Additionally, MFD will perform the following tests to ensure that claims are paid properly.

- **Prescriptions:** Identify prescription utilization patterns that are inconsistent with medical necessity. MFD will recommend that recipients be placed in the Lock-In Program (which restricts the recipient to using one pharmacy) in cases where fee for service payments are involved; and will work cooperatively to assist the MCOs in placing managed care enrollees who abuse prescriptions into the respective MCO's Lock-In program.
- **Inventory Reviews:** As mentioned earlier, payments made for prescriptions or claims will be compared with pharmacy inventory purchases to determine whether the pharmacy had ordered at least the volume of drugs necessary to fill the prescriptions that were claimed.
- **Drug Diversion:** Drug diversion can take many forms, such as a prescriber who is over-prescribing, an act which allows an enrollee to sell excessive medication, or the forging of prescriptions by an enrollee with the intent to sell. MFD will identify high users of potentially diverted medications as well as pharmacists, prescribers and other providers or enrollees who participate in drug diversion.

MFD will also investigate pharmacies referred from the State's pharmacy audit contractor for suspected fraud or abuse.

Primary Care Physicians

To ensure these providers are fulfilling their obligations, MFD will determine whether physicians: are properly licensed, have been excluded at the time treatment was provided or goods and services were ordered, have 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 medical providers who are not enrolled in the Medicaid program but who have referred services paid for by Medicaid, to determine whether there is sufficient medical necessity for any services ordered that exceed \$50,000 per year, such as pharmaceuticals, laboratory tests and durable medical equipment. In those cases, if a non-Medicaid provider causes the Medicaid program to pay for a prescription which was not medically necessary, that provider will be liable to the State for reimbursement.

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

Personal Care Services

MFD staff will audit agencies to determine if services were pre-authorized and provided in accordance with a physician order. We will also review whether

appropriate care plans were developed and followed and whether services were performed by appropriately trained and certified or licensed staff.

B.

RECIPIENT PROGRAMS

MFD will continue to investigate recipient fraud cases. In these economically challenging times, it is crucial for MFD to evaluate eligibility determinations and confirm that only those who are in need of Medicaid assistance receive it. MFD will continue to work with county prosecutors when conduct appears criminal in nature to ensure that all appropriate recovery methods and sanctions are employed. MFD will also continue to raise awareness of recipient fraud cases to send a message of deterrence and to encourage the public to report examples of recipient fraud to MFD.

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

During FY 2013, MFD referred 16 investigations to county prosecutors' offices that resulted in arrests and further prosecution of the individuals involved.

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

C.

THIRD PARTY LIABILITY

Under federal law, if a Medicaid recipient has other insurance coverage then Medicaid is responsible for paying medical benefits only in cases where the other coverage does not cover the service issue. Thus 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 that were inappropriately paid for with Medicaid funds. MFD's Third Party Liability (TPL) group, working with an outside vendor, seeks to determine whether Medicaid recipients have other insurance and recovers money from these private insurers in cases where Medicaid has paid claims for which the insurer was responsible. In addition, MFD's TPL group manages a daily hotline where calls are accepted from the public and providers to update Third Party Commercial Insurance information for Medicaid recipients.

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The Medicaid Fraud Division looks forward to a successful year of combating Medicaid fraud, waste and abuse. If you have any questions about the Medicaid Fraud Division's FY 2013 work plan, 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.