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

FINAL ANNUAL REPORT
FOR THE FORMER OFFICE OF THE MEDICAID INSPECTOR GENERAL

FISCAL YEAR 2010

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INTRODUCTION

The Medicaid Program Integrity and Protection Act (the Act), N.J.S.A. §30:4D-53 et seq., created the Office of the Medicaid Inspector General (OMIG) to serve as the independent "watchdog" over the State's Medicaid programs. The practical result of the legislation separated the program *administration* functions from the program *integrity* functions while still preserving the single state Medicaid agency structure required by federal law. On June 29, 2010, Governor Chris Christie signed P.L. 2010, Chapter 33, which transferred the functions, powers, and duties of the Office of the Medicaid Inspector General to the Office of the State Comptroller.

The Office of the State Comptroller created the Medicaid Fraud Division (MFD) to continue to carry out the functions of the Act. The MFD focuses its oversight on Medicaid providers, managed care organizations, and recipients. Specifically, the MFD is charged with detecting, preventing, and investigating fraud and abuse in the Medicaid, New Jersey FamilyCare, and Charity Care programs. To accomplish these goals, the MFD conducts audits and investigations, performs background checks on Medicaid provider applicants, and coordinates oversight efforts among all State agencies which administer Medicaid services. The Division also recovers improperly expended Medicaid funds, enforces Medicaid rules and regulations, reviews the quality of care given to Medicaid recipients, issues recommendations for corrective or remedial actions, and pursues civil and administrative enforcement actions against those who engage in fraud, waste, or abuse within the Medicaid program. Additionally, the MFD excludes or terminates providers from the Medicaid program where necessary, and refers criminal prosecutions to the Attorney General's office. Finally, the MFD conducts educational programs for Medicaid providers, vendors, contractors, and recipients.

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The MFD staff of 49 full-time employees is comprised of auditors, claim reviewers, investigators, physician specialists and nurses. MFD staff are dedicated and committed to ferreting out fraud, waste, and abuse in the Medicaid system. The MFD is currently in the process of drafting regulations and creating compliance guidelines to assist providers in the development and implementation of their own compliance programs. MFD is seeking input from key stakeholders to provide guidance that will be sufficiently comprehensive and useful.

FISCAL YEAR 2010 HIGHLIGHTS

As the functions, duties and powers of the OMIG transferred to the Office of the State Comptroller as of June 29, 2010, the highlights discussed below for fiscal year 2010 will be reflected as the MFD, the current Division within the Office of the State Comptroller with oversight responsibility of New Jersey's Medicaid, FamilyCare, and Charity Care programs. The Division ended the fiscal year having identified numerous new strategies to control and prevent fraud, waste, and abuse in the Medicaid program and through the efforts of its Fiscal Integrity, Investigations, and Regulatory Units, obtained recoveries and cost savings of $278,622,194. These significant results came as a result of a number of initiatives. For example, the MFD staff met with numerous county welfare agencies and prosecutor's offices throughout New Jersey in an effort to coordinate with them on recipient fraud issues. The MFD's efforts resulted in many fraud and abuse referrals from the counties to the MFD staff.

The MFD also focused on marketing its presence through various tools, including its website which includes additional ways to report fraud, waste, and abuse to the Division, a Medicaid fraud poster for providers to download and display in their offices, and a listserv so that the public can track the Division's efforts and providers can receive fraud alerts. The website includes a section for provider alerts so that the MFD can disseminate important information to Medicaid providers so they can help combat Medicaid fraud. For example, in an effort to assist Medicaid pharmacies in

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determining whether prescriptions are stolen, the MFD alerts pharmacies to potential thefts and forgeries through transmittal letters identifying the stolen or forged providers' prescription pads. While we send letters to all pharmacies in the region, the MFD also posts these letters to its website and encourages all providers to check for updates. These tools, which remain as part of the MFD's section on the State Comptroller's website, are essential to send a message to providers and recipients that the focus on combating Medicaid fraud, waste, and abuse is a priority.

The MFD also meets regularly with the Departments of Human Services, and Health and Senior Services, and Children and Families to discuss case referrals and proposed regulations affecting both recipients and providers and recent fraud and abuse trends in the Medicaid, FamilyCare, and Charity Care programs. MFD's goal is to work closely with these Departments as an independent partner in ferreting out Medicaid fraud and abuse. In some instances, these Departments assist the MFD in audits and investigations of providers where appropriate.

The MFD has met and will continue to meet with provider groups across the state in order to educate them about MFD functions, with the hope that these meetings will facilitate effective communication about Medicaid fraud and abuse and give providers an opportunity to refer potential fraud and abuse cases in their industry to the MFD.

MFD regularly communicates with the Attorney General's office regarding whistleblower cases involving Medicaid fraud filed under the federal and New Jersey False Claims Acts. In fiscal year 2010, the MFD saw recoveries due to these types of cases in the amount of $16,910,829. The MFD coordinates with the U.S. Attorney's office on cases that may have both federal and state implications. Lastly, the MFD meets with other states' Medicaid Program Integrity Groups and Offices of Medicaid Inspector Generals to share information on Medicaid fraud and abuse, in the hopes of

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being less reactive and more proactive and to ensure that, especially in these difficult financial times, the State's Medicaid program dollars are being spent appropriately, not wastefully, and that the people who need the program most are benefitting.

I. FISCAL INTEGRITY

The Fiscal Integrity Unit consists of four sub-units: Audit; Data Mining; Recovery and Exclusions; and Third Party Liability.

Audit

The Audit group started operation at the end of fiscal year 2010. Its purpose is to conduct audits, ensure Medicaid providers comply with program requirements, identify improper billings made by Medicaid providers, and provides deterrence for fraud, waste, and abuse in the Medicaid program. The Audit group also oversees and reviews audit work done by other entities who have contracted with the State to audit certain types of providers.

The ability to now conduct these audits will be an entirely new source of recoveries and cost-savings through deterrence in fiscal year 2011 that has never before been realized by the State. In its short period of time of operation, the Audit group has begun to create an audit workplan which will include a risk assessment of current provider types so as to create a prioritization schedule of what provider types and providers MFD will audit in fiscal year 2011. The auditors have already completed audits of various durable medical equipment providers, identified overpayments that MFD is currently recovering, and identified weaknesses in current Medicaid regulations. The audit group will work with the Regulatory Unit in 2011 to propose changes to these, and other, regulations to address the weaknesses found.

Data Mining

The Data Mining group reviews anomalous claim reimbursement behavior of providers, and based on a preliminary review, submits its findings to either the Audit

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group for further review and determination of whether a full audit should be scheduled or the Investigation Unit for further clinical review and/or investigation. This group also meets with other states' program integrity data mining units' staff to identify new means to generate data reports and potentially identify different fraud and abuse patterns.

The Data Mining group also reviews alerts from the Centers for Medicare and Medicaid Services (CMS), the federal agency tasked with, among other things, oversight of all States' Medicaid programs, to determine if there are similar fraud or abuse activities taking place in New Jersey that should be analyzed. For example, as a result of a federal report on abusive ultrasound practices, the Data Mining group ran additional reports for New Jersey providers and found practices such as overlapping and/or duplicative ultrasounds 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 obtaining software that will enable the Data Mining group to ferret out more complicated fraud and abuse schemes by providers. Our data miners review 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 analysis for review in the New Jersey Medicaid system.

As required by the federal government, the data miners also perform Surveillance and Utilization Review System (SURS) functions, including monitoring the claims processing system for indications of fraud and abuse, looking for duplicate, inconsistent and excessive claims, and reviewing other suspicious claims and circumstances. For example, one quarterly SURS case revealed that one durable medical equipment provider was billing more than 8000 units of diapers per recipient for a period of July 1, 2008 through June 30, 2009, or 22 diapers per person, per day. This case has been referred to our Audit group for further review.

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Our data mining efforts also help us capture recipient fraud. For example, after examining billing data from January 1, 2009 to March 31, 2009, our data miners found one recipient filled 19 prescriptions, 11 of which were for narcotic drugs, at seven different pharmacies. This case was referred to the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) Recipient Lock-In Unit which "locked" in this recipient to one pharmacy to prevent this conduct in the future. The Data Mining group also obtained lock-in reports from the state's fiscal agent who identified recipients who had used multiple pharmacies and/or were doctor shopping to obtain prescriptions.

MFD also works with state, local, and federal entities to acquire non-Medicaid data, such as vital statistics, and Medicare data from additional sources to maximize the utility of these tools and improve our ability to expose anomalous behavior.

Recovery and Exclusions

Our Recovery and Exclusions group (R&E) recovers overpayments and penalties identified by MFD auditors and investigators. The group also determines when to exclude a Medicaid provider from the program.

When MFD identifies overpayments that it needs to recover, R&E sends out Notices of Claims and Notices of Demands, works with federal authorities to ensure that the federal government receives its monetary share of a recovery once a recovery is identified and/or received, works with DMAHS to ensure fraudulent providers are terminated, and recovers the money from providers and recipients on behalf of the State of New Jersey. Where the R&E group cannot resolve an overpayment or exclusion with a provider, it will proceed with the case through administrative action. For example, one provider had been excluded by the federal government from the Medicaid program for eight years due to a federal conviction. An MFD investigation revealed that the provider worked for four different Medicaid providers during the period she was

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federally excluded in direct violation of her exclusion. The R&E group excluded her from the New Jersey State Medicaid program. She appealed, and on May 19, 2010, an administrative law judge dismissed the provider's appeal to be reinstated based on MFD's findings.

Third Party Liability

Medicaid is the payor of last resort. As such, Medicaid should only cover medical benefits where there is no other insurance coverage. However, providers often do not bill the responsible third party insurer. A significant amount of the State's Medicaid recoveries are the result of the MFD's efforts to obtain payments from third party insurers responsible for services inappropriately reimbursed by Medicaid funds. The Third Party Liability group (TPL), working with an outside vendor, seeks to determine whether Medicaid recipients have other insurance and if so, 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); or the state contractor identifies the recipient's third party's insurance not reported during intake. Applicants for Medicaid services complete paperwork at the county welfare agencies and identify any third party health insurance coverage they have, including policy information. Additionally, the state's 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. In 2010, the third party vendor also began to identify third party liability for Charity Care claims which resulted in an additional $739,993 not previously recovered. As a result of this contract, we recovered and provided cost savings to the State in the amount of $257,996,654 in fiscal year 2010.

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II. INVESTIGATIONS

The Investigations Unit is charged with investigating Medicaid, FamilyCare, and Charity Care providers and recipients. Specifically, it investigates medical providers including, but not limited to, adult medical daycare centers, pharmacies, laboratories, and durable medical equipment providers. When fraud is identified, the MFD initiates administrative action against the provider or recipient and/or refers it to the state Attorney General for criminal prosecution. In both coordination with, and independent of, the Departments of Human Services and Health and Senior Services, our Investigations Unit has conducted extensive investigations of numerous providers and recipients.

Case Sources

In fiscal year 2010, the Investigations Unit opened 374 cases, closed 227, and referred 47 cases to other agencies. MFD Investigators receive allegations of fraud, waste, and abuse from many sources including, but not limited to: the New Jersey Medicaid fraud hotline (1.888.937.2835); other state and federal agencies such as the New Jersey Departments of Human Services and Health and Senior Services, the Medicaid Fraud Control Unit of the Attorney General's Office, and the Office of Legislative Services; in-house referrals; Explanation of Medical Benefits responses; written correspondence; information brought to the attention of an investigator during the course of unrelated investigations; media; county welfare agencies; and Medicaid recipients. It received 48 cases from MFD's hotline, 21 from the Medicaid Fraud Control Unit (MFCU), six from managed care organizations, seven from County prosecutor offices and other agencies, and the rest from a variety of other sources including state vendors who assist in administering Medicaid programs. The cases included 13 recipient fraud cases, 61 eligibility cases, 15 pharmacy cases, 12 physician cases, seven adult medical day care cases, and numerous other provider fraud cases. We referred 17

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cases to county boards of social services and three to the MFCU. The Investigations Unit also generated its own cases. For example, the Unit re-implemented the Operation X Project. Operation X is an ongoing project where MFD investigators cross reference the Federal exclusion list with New Jersey Wage and Labor data to identify excluded individuals who are working and receiving wages through the State Medicaid program in violation of the federal and state Medicare and Medicaid exclusion. Once the investigator identifies an offender, the investigator sends the case to the R&E group to recover the funds paid by Medicaid during the period the provider was excluded. Operation X generated 12 cases in 2010.

Provider Enrollment

The Medicaid program is for the benefit of its recipients, not its providers; becoming a Medicaid provider is a privilege, not a right. Therefore, it is important to ensure that only those medical providers who maintain the highest integrity are allowed to service a vulnerable population and be reimbursed for their services. Our Special Investigations Unit (SIU), a sub-unit within the Investigations Unit, is charged with ensuring that this occurs.

The SIU conducts background checks to ensure the integrity of the enrollment process into the Medicaid Program. In fiscal year 2010, the SIU received 168 applications from entities requesting to become Medicaid providers. We received 130 pharmacy provider applications, 24 durable medical equipment provider applications, six adult medical daycare applications, three partial care provider applications, and five laboratory applications. Based on its investigations, the SIU approved 138 or 82% of the applications, denied 27 or 16% of the applications, and 3 or 2% were still pending investigation. Since March, our SIU staff has denied 14 pharmacies from enrolling in the Medicaid program because of various concerns including: pending licensing actions by the Board of Pharmacy; failing to disclose required information on

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applications; pending criminal investigations or actions; and filing applications on behalf of non-operational pharmacies. By preventing these pharmacies from becoming Medicaid providers, we have avoided potential fraud, waste and abuse.

For example, one pharmacy, Springfield Pharmacy, failed to disclose in its application that one of its owners submitted false information regarding a prior conviction and licensure action. SIU's background check revealed this additional information. DMAHS denied the new application and on appeal, the Office of Administrative Law Judge affirmed this decision on December 18, 2009. Cagans Pharmacy was also denied a Medicaid provider number because it submitted false information on its Medicaid application. This decision was also affirmed by the OAL. New Lucy's Pharmacy was denied a Medicaid provider number due to its failure to report a criminal history and licensure action taken against the pharmacist in charge. This decision was affirmed by the OAL on August 17, 2009. CVS Pharmacy #356 was also investigated by the Special Investigations Unit which discovered a federally excluded provider working as a pharmacist at the pharmacy. The R&E group sent out a Notice of Claim and Withholding in 2010 and has recovered $378,738.69 to date.

SIU's background checks are not confined to pharmacies. For example, on June 2, 2010 the OAL affirmed a denial of Xanadu Adult Medical Day Care Center's Medicaid application based on SIU's investigation revealing that Xanadu failed to reveal a prior conviction of one of its owners on the provider application.

Investigation Results

MFD is currently in the process of seeking recovery from seven opiate treatment centers for fraudulent billings and false claims which total in the millions. MFD also issued a report of its findings from an investigation of Garden Adult Medical Day Care Center, which identified billings for services not rendered as well as various needed

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language changes in the Department of Health's adult medical day care center regulations.

MFD has also collaborated with state and local law enforcement agencies over this past year. As a result of an investigation originating from MFD, the New Jersey Attorney General's Office indicted an owner of a counseling center for defrauding the State's Medicaid program in May 2010. In April 2010, a home health agency owner was also arrested on Medicaid fraud charges as a result of a joint investigation between these two agencies.

MFD also collaborates with the counties on recipient fraud. Upon a referral from the Bergen County Welfare Agency, the MFD investigated a FamilyCare recipient fraudulently receiving Medicaid benefits and referred the case to the Bergen County Prosecutor's Office for further investigation and arrest. In another case a Middlesex County resident pled guilty in May 2010 to theft by deception after a joint investigation with the Union County Prosecutor's Office.

Provider issues that could result in criminal prosecution are referred to the New Jersey Office of the Attorney General's MFCU for possible criminal prosecution. In order 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.

In fiscal year 2010, our Investigations Unit brought recoveries of $3,714,711 back to the State.

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III. REGULATORY

In May 2010, the MFD's Regulatory Unit was created to provide administrative, investigative, and legislative support to the other MFD units. The Regulatory Unit will work closely with the Attorney General's Office on cases that go to litigation as well as the various departments that administer Medicaid programs to recommend proposed regulatory changes to strengthen the integrity of the programs. The Unit has also begun to aid in investigations by advising investigators on evidentiary issues and assisting in interviews. The Unit has also started to review Medicaid regulations to determine if changes need to be made and propose new regulations and/or changes to existing regulations to the Departments of Human Services and Health and Senior Services. Additionally, the Regulatory Unit has begun to review provider and recipient appeals from both exclusions and Notices of Claim. The Unit will also work with the MFD Director and Deputy Directors to develop compliance programs for Medicaid providers.

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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, please contact:

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