THE NEW JERSEY EXPERIENCE IN COMBATTING MEDICAID FRAUD

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The distressing problem of Medicaid fraud has recently become the focus of intense concern on the part of federal and state officials. Theft from the public treasury under any circumstances demands prompt remedial action by government. When such depredation diverts funds from the elderly and others in need of medical assistance, however, preventive measures are even more imperative.

While the integrity of the vast majority of members of the medical and related professions is beyond reproach, a few unscrupulous and avaricious individuals have engaged in massive plunder of the Medicaid system. The relative ease with which these funds have been misappropriated yields the inescapable conclusion that more stringent controls are a matter of the utmost urgency. Moreover, the sophistication and ingenuity of many of the fraudulent schemes employed require a multi-disciplinary approach to detection and prevention of such abuses.

In New Jersey, a coordinated effort to eradicate this blight has met with a large measure of success. Through the joint action of the New Jersey Department of Human Resources and the Office of the Attorney General, a strategy has been formulated[1] which has been lauded as one of the most effective yet devised.[1a]

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[1] The agreement between the Department of Human Resources and the Attorney General has been formalized and appears in the attached appendix. Appendix B.

[1a] Report of the Senate Special Committee on Aging; Statement of former HEW secretary David Matthews, March 26, 1976.

In recognition of the multi-faceted nature of the problem, the expertise of several agencies has been invoked. Through the Office of the Attorney General, significant resources have been brought to bear against fraudulent Medicaid practices. Armed with recently enacted legislation authorizing treble damages, interest, and other civil penalties, staff attorneys may fully recoup losses from the culprits involved.[2] Additionally, the offending practitioner may find his professional license in jeopardy since the State's licensing boards are also under the supervision of the Attorney General.[3] Finally, a uniquely qualified group of attorneys, accountants and investigators has been assembled and charged with the responsibility of investigating and criminally prosecuting Medicaid fraud cases.[4]

Direct responsibility for administering the Medicaid Program in New Jersey has been legislatively conferred upon the Division of Medical Assistance within the Department of Human Resources. This agency, which currently has 26 auditors on its staff, utilizes the services of Prudential Insurance Company and Blue Cross of New Jersey as fiscal intermediaries for disbursing funds.[5] A sophisticated screening procedure has been developed by these insurance carriers in cooperation

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[2] N.J.S.A. 30:4D-17, enacted by L. 1976, ch. 89, sec. 2, effective September 15, 1976.

[3] N.J.S.A. 52:17B-126, 137; N.J.S.A. 52:17B-4.

[4] N.J.S.A. 30:4D-4.

[5] N.J.A.C. 10:49-1.6(c).

with the Division of Medical Assistance which will shortly be described in greater detail.

A balanced effort by these agencies has proven highly effective in ferreting out abuses and identifying individuals engaged in fraudulent activity. By imposing appropriate sanctions upon offenders and continually refining administrative regulations, the coordinated action of these components has produced gratifying results in New Jersey.

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In order to fully appreciate the problems confronting governmental agencies in insuring proper enforcement of the law, reference should be made to several typical artifices utilized in defrauding the Medicaid Program. Simply stated, Medicaid abuses are carried on cautiously and furtively and in as many different ways and by as many conceivable methods as human ingenuity can devise. The most obvious, of course, is the submission of a claim for services not actually rendered. This may be plausibly accomplished simply by having a patient sign several blank forms which the "provider" can subsequently complete at his leisure with a fictitious description of the patient's diagnosis and treatment.

Another increasingly prevalent scheme is to inflate nursing home costs through fictitious or exaggerated invoices. The vendors of these hypothetical or overpriced items are inevitably expected to kickback a portion of the windfall profits to the nursing home operator. A variant of this fraudulent theme involves what is known as a "leaseback" arrangement. Pursuant to this device, a Medicaid nursing home operator may legitimately sell the home's furnishings

and fixtures to a "leaseback" corporation and lease the necessary items from the purchaser. The Medicaid Program then pays the rental required by the lease.[6] Fraud occurs under this scheme through the sale and subsequent leasing of nonexistent items. Not infrequently, the "leaseback" corporation never confirms the existence of the rented property since the lease is promptly discounted to a financial institution. The public is thus bilked into supplying funds for completely fictitious expenses.

Through yet another guise, a nursing home may misuse Medicaid funds to absorb operating costs of other ineligible facilities. Because the New Jersey Medicaid Program reimburses nursing homes for the actual costs of operation rather than at a fixed rate, owners of a number of institutions may seek to shift the financial burden of less profitable health care facilities to the public through inflated Medicaid billings.

Circumvention of the prohibition against factoring, or rebating, among providers has also been unearthed.[7] In an effort to avoid this regulation, arrangements have been made with physicians whereby laboratories, or other service-oriented providers, have paid "rent" to a physician for closets to store papers, laboratory forms and other materials. "Rentals" of up to $1,200 per month for a closet have been discovered. Such agreements are obviously illegal rebates or kickbacks to the physician.

Finally, manipulation of certain "fixed rate"

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[6] N.J.A.C. 10:63-3.7.

[7] N.J.A.C. 10:49-1.18(b)(9); 10:49-1.22; 10:61-1.6.

reimbursements has resulted in excessive payments to some providers. A unitary series of laboratory tests, for example, will produce a larger reimbursement if each individual component of the analysis is separately billed to Medicaid.[8]

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It is evident from this discussion that unscrupulous operators have devised a formidable array of fraudulent arrangements. Correspondingly, these complexities demand a coordinated effort on the part of all law enforcement agencies to cope with the dirty realities of criminal conduct. The governmental response must be forceful and swift, and all available resources must be utilized. Clearly, we may no longer hope, as did the creators of the Medicaid program, to avoid the interposition of fiscal safeguards. The original expectation of uniform professional responsibility by the health care industry has unfortunately proved to be overly optimistic.

The sanction of criminal prosecution has been adapted to the exigencies of the problem of Medicaid fraud. The Office of the Attorney General has assembled a well-trained team of attorneys, accountants, and investigators to devote its energies exclusively to the prosecution of Medicaid cases. Each of the individuals in this group, the Medicaid Investigation Unit, has had considerable experience

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[8] See N.J.A.C. 10:61-1.5.

in dealing with sophisticated financial crimes.

The effect this Unit has had on the investigation and prosecution of Medicaid fraud has been dramatic. Prior to the existence of the Unit, three providers were prosecuted for Medicaid fraud over a two-year period. Since April of 1975, when the Unit was formed, a total of 24 individuals and six corporations have been indicted. There have been fifteen convictions to date, with the remaining cases awaiting trial. Among those indicted are six doctors, eight nursing home owners, three pharmacists, one public official (for misconduct in office), two laboratory owners, two accountants, two employees of nursing homes and six corporations.

Detection of criminal behavior following its occurrence is plainly not enough, however. Our system of law must seek to deter Medicaid abuses, not merely to rectify a wrong already done. In short, we must discourage those who might otherwise be inclined to embark upon a course of misconduct concomitant with our responsibility to pursue and punish those who deliberately disobey our laws.

In this context, one of the foremost tools in combatting fraud is the periodic audit of institutional providers. As previously noted, the Division of Medical Assistance currently employs 26 auditors to examine the operations of New Jersey's 221 participating nursing homes. During the fiscal year of 1975, a return of $7.70 was

realized for every dollar invested in auditing procedures. This impressive achievement is rendered even more gratifying when it is considered that many operators may have been deterred from filing improper claims by the existence of this auditing staff. Many of the abuses outlined above may be detected by such conventional accounting procedures.

Another highly effective measure has saved the public an estimated forty million dollars over the past three years. The New Jersey Medicaid Program has coordinated with their fiscal intermediaries, Prudential and Blue Cross, a sophisticated and computerized "front end screening program" which is the first interception point of questionable claims. "Front end screening" is particularly important because it identifies the questionable claims prior to payment. The computer at Prudential, the fiscal intermediary for payment of physicians and medical laboratories, is programmed to review all claims pertaining to the number of billings by physician per month, eligibility of provider and recipient, concurrent care by other similar providers, amount of fees for specific services to determine that they are under scheduled ceilings and not above customary fees of the specific provider, cross referencing by recipient and date to screen for duplicate billings, cross referencing by date of providers in medical groups to screen for duplicate billings or over-utilization,

post-operative visits to determine whether eligible for separate payment, and combinations of the basic screening components. The computer at Blue Cross, fiscal intermediary for payment of hospitals, pharmacists, and home health services, is programmed to review all hospital claims for medical necessity of number of days of hospitalization in relation to diagnosis and date of surgery, and amount of fees to determine that they are under ceiling schedules. In addition, the computer at Blue Cross screens pharmacy claims to detect duplicate billings, eligibility of recipient and provider, concurrent care by other providers, compliance with Medicaid regulations pertaining to length of supply and other requirements, and combinations of the basic screening components. In addition to computerized screening and cross referencing, "front end screening" also incorporates clerical staff to review all claims for signatures and entry of required data. Claims rejected by the computer are reviewed by a trained reconciliation staff and when necessary, by medical specialists to determine their validity. This combination of computerized and clerical screening, plus desk review of billing patterns of potentially abusive providers, is highly effective in identifying invalid claims. Blue Cross has declined payment on hospital claims in the amount of $600,000 per month determined by front end screening to be medically unnecessary. Obviously, screening claims prior to payments is better than later resorting to litigation to recover monies paid out.

Of course, despite even the most stringent preventive program, resort to legal action will nonetheless be required in certain cases. In New Jersey, remedies are available in the civil, criminal, and administrative arenas. In evaluating the situation and determining what action to take, it is advantageous to have the collective judgment and experience of all disciplines involved in the administration of the program.

Consequently, New Jersey has created a Legal Action Committee comprised of representatives of the agencies responsible for criminal prosecution, civil litigation, and professional licensing, as well as a member of the Division of Medical Assistance. The purpose of this Committee is to provide the mechanism for efficient and effective investigation and prosecution of providers involved in Medicaid fraud from both the civil and criminal point of view.

Currently, individual cases are brought to the attention of the Committee by investigators working with the Medicaid Program.[9] In general, any matter potentially involving a fraud is brought to the attention of the Committee. Members of the Committee question the individual investigator about the case, and ultimately decide whether the matter warrants further criminal investigation. At the same time, alternative remedies which can be administered through the other agencies represented on the Committee are also discussed. In addition to the criminal remedy available, it is possible to

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[9] See N.J.A.C. 10:49-1.14; Appendix A.

effect money damages or recoupment, suspension or revocation of an individual provider's license, suspension of Medicaid payments to that provider[10] and possibly further inspection of the facility involved.

Once the appropriate course of action has been determined, a formidable array of remedies may be invoked. New Jersey's enforcement efforts in this regard have recently been enhanced by the enactment of L. 1976, ch. 89, §2.[11] This act drastically increases the criminal penalties for Medicaid fraud by authorizing a fine of up to $10,000. Additionally, interest upon any excess payments is to be assessed from the date of payment to the provider until the funds are recovered by the state. Moreover, an exaction of treble damages may be imposed as well as a civil penalty of $2,000 for each excessive claim for reimbursement filed.

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[10] N.J.A.C. 10:49-1.18; 10:49-6.3.

[11] This statute provides for the following penalties:

> (a) It shall be unlawful for any person, firm, corporation, partnership or other entity to willfully, by means of a false statement or representation, or by deliberate concealment of any material fact, or other fraudulent scheme or device on behalf of himself or others, obtain or attempt to obtain medical assistance or other benefits or payments

The severe economic penalties provided by this act supply a powerful deterrent to those motivated by greed. Assessment of treble damages is particularly efficacious since some fraudulent dealings in excess of $250,000 have

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> under this act to which he is not entitled, or in a greater amount than to which he is entitled, and, further, it shall be unlawful for any provider to willfully receive medical assistance payments to which he is not entitled, or in a greater amount than to which he is entitled, or to falsify any report or document required under this act.
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> (b) Any person, firm, corporation, partnership or other legal entity who violates the provisions of subsection (a) of this section shall be guilty of a misdemeanor and shall be liable to a penalty of not more than $10,000.00 for the first and each subsequent offense, or to imprisonment for not more than 3 years or both.
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> (c) Any person, firm, corporation, partnership, or other legal entity who violates the provisions of subsection (a) of this section shall, in addition to any other penalties provided by law, be liable to civil penalties of (1) payment of interest on the amount of the excess benefits or payments at the maximum legal rate in effect on the date the payment was made to said person, firm, corporation, partnership or other legal entity for the period from the date upon which payment was made to the date upon which payment is made to the State, (2) payment of an amount not to exceed three-fold the amount of such excess benefits or payments, and (3) payment in the sum of $2,000.00 for each excessive claim for assistance, benefits or payments.

been detected. Likewise, exaction of $2,000 for each excessive Medicaid claim will undoubtedly inhibit avaricious providers who have been known to submit hundreds of false billings.

An additional sanction with significant potential for controlling Medicaid fraud is the power of the various professional boards, such as the Board of Medical Examiners

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> (d) Any person, firm, corporation, partnership or other legal entity other than an individual recipient of medical services reimbursable by the Division of Medical Assistance and Health Services, who, without intent to violate this act, obtains medical assistance or other benefits or payments under this act in excess of the amount to which he is entitled, shall be liable to a civil penalty of payment of interest on the amount of the excess benefits or payments at the maximum legal rate in effect on the date the benefit or payment was made to said person, firm, corporation, partnership, or other legal entity for the period from the date upon which payment was made to the date upon which repayment is made to the State, provided, however, that no such person, firm, corporation, partnership or other legal entity shall be liable to such civil penalty when excess medical assistance or other benefits or payments under this act are obtained by such person, firm, corporation, partnership or other legal entity as a result of error made by the Division of Medical Assistance and Health Services, as determined by said division.
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> (e) All interest and penalties provided for in this act and all medical assistance and other benefits to which a person, firm, corporation, partnership, or other legal entity was not entitled shall be recovered in an administrative procedure held pursuant to the "Administrative Procedure Act," P.L. 1968, c. 410 (C. 52:14B-1, et seq.).

and the Board of Pharmacy, to suspend or revoke professional licenses. The threat to a provider of losing his license to practice is a substantial one.

New Jersey has been in the forefront in this area. Last year over 50% of the license revocations in the country were a result of actions taken by the New Jersey professional boards. By dramatically increasing the legal staff of these agencies, greater activity in this direction has been experienced. This aggressive enforcement of professional responsibility has made a large contribution in the State's comprehensive anti-fraud program.

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These improvements in the prevention and detection of Medicaid fraud as well as those in other areas, are largely attributable to the cooperative efforts of those

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> (f) Upon the failure of any person, firm, corporation, partnership or other legal entity to comply within 10 days after service of any order of the Attorney General or his designee directing payment of any amount found to be due pursuant to subsection (e) of this section, the Attorney General may issue a certificate to the Clerk of the Superior Court that such person, firm, corporation, partnership or other legal entity is indebted to the State for the payment of such amount. A copy of such certificate shall be served upon the person, firm, corporation, partnership or other legal entity against whom the order was entered. Thereupon the clerk shall immediately enter upon his record of docketed judgments the name of the person, firm, corporation,

involved in every phase of the New Jersey Medicaid Program. Manifestly, a coordinated attack encompassing all aspects of the problem must necessarily deploy a wide spectrum of professional expertise. Civil litigation, license revocation proceedings, administrative hearings,and criminal prosecutions are integral parts of any effective anti-fraud strategy. Only by such a combined inter-agency endeavor will the present deplorable duplicity in the Medicaid Program be eradicated.

Vital to this effort is the infusion of federal funds. In recognition of the urgency of coordinated action, the Department of Health, Education and Welfare has ruled that New Jersey's Medicaid Investigation Unit does not contravene the policy against a multiplicity of Medicaid agencies. Thus, both the auditing staff of the Division of Medical Assistance and the separate prosecutorial unit currently receive fifty percent of their funding from the federal government. This candid acknowledgement of the necessity for a multi-disciplinary remedy has proven to

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> partnership or other legal entity so indebted, and of the State, a designation of the statute under which such amount is found to be due, the amount due, and the date of the certification. Such entry shall have the same force and effect as the entry of a docketed judgment in the Superior Court. Such entry however, shall be without prejudice to the right of appeal to the Appellate Division of the Superior Court from the final order of the Attorney General or his designee.

be correct. Obviously, the favorable results in New Jersey could not have been possible if funding had been denied through hypertechnical interpretation of the "single agency" rule.

Accordingly, it is evident that the shared investment of the federal and state government should not be curtailed. On the contrary, an expansion of the current program could result in further improvements in the integrity of the Medicaid system. Additional auditors could accomplish the projected goal of a yearly audit of all of the State's nursing homes. Likewise, an expansion of the Medicaid Investigation Unit would also be beneficial.

Consequently, while enormous strides have been taken, considerable improvement still lies ahead. Nevertheless, it may be confidently asserted that the ultimate solution to the problem of Medicaid fraud lies within our grasp. We in New Jersey believe that our experience in preventing and detecting Medicaid abuses might well serve as a model for an effective national anti-fraud strategy.

APPENDIX A

GUIDELINES FOR EVALUATION OF POTENTIAL MEDICAID FRAUD REFERRALS TO DIVISION OF CRIMINAL JUSTICE

Joseph Piazza, as Assistant Director, shall review all potential Medicaid abuse cases with the understanding that cases meeting the following criteria shall be referred to the Medicaid Investigation Unit, Division of Criminal Justice for follow-up action.

I. Non-Institutional Providers

A. Any case where there has been documented at least $1,000 of overbilling and there is any indication of fraudulent intent.

B. Any case where there is the potential of proving $1,000 of overbilling, utilizing not more than 30 witnesses, where there are clear indications of fraudulent intent and a fraud ratio of over 50%.

II. Institutional Providers

A. Any case where there is documented at least $10,000 of overbilling, where there is any indication of a fraudulent intent.

B. Any case in which any Cost Study reveals personal expenditures over $500 in any one year.

C. Any case where the Cost Study reveals fictitious persons on the payroll or persons related to the owner or administrator who appear not to be performing their stated function at the facility.

D. Any case in which there are unusual lease arrangements or excessive payments to particular vendors or particular categories of goods or services. (Ex. Unusually large rental payments or unusually large payments for laundry, etc.) These cases should include a vendor list.

III. Indications of Fraudulent Intent include but are not limited to the following:

A. Incriminating conversations or admissions made by provider or staff.

B. Prior warnings to the provider pertaining to the matter under investigation.

C. Criminal record.

D. Billing for services not performed at all.

E. Information that patients were asked to sign multiple claim forms per visit.

F. Attempts to contact potential witnesses for the purpose of influencing their statements to investigative personnel.

G. Any indication whatsoever that the provider or others on his behalf have offered gratuities to either Medicaid personnel or other potential witnesses.

H. Any indication that the provider has committed any other crime, such as forgery.

IV. Legal Action Committee Presentations

A. Any case, regardless of documented overbilling, which does not meet the criteria for direct referral to Criminal Justice but where there are any indications of criminal intent shall be presented to the Legal Action Committee.

B. Any case involving a non-institutional provider where there is documented $5,000 or more of overbilling without indications of criminal intent shall be presented to the Legal Action Committee.

C. Any case involving an institutional provider where there is documented at least $20,000 of overbilling but where there is no criminal intent shall be presented to the Legal Action Committee.

V. Cases which shall not be referred to the Division of Criminal Justice or presented to the Legal Action Committee:

A. Those cases not heretofore described shall not be referred to the Division of Criminal Justice or to Legal Action, however, it shall be the responsibility of Assistant Director Piazza to send written memoranda

to the Division of Criminal Justice indicating relevant information including the names of owners and administrators, the nature of the case, the nature and amount of irregular billing, the percentage of irregular billing, the number of irregular billings per patient, the amount of provable overbillings per patient, the number of patients interviewed, the nature and scope of the irregularity, and the total annual earnings of the provider. In addition, the contents of any conversations with the provider pertaining to the irregularity.

B. For all institutional providers, the report shall contain a list of all vendors doing at least $1,000 annual business with the facility or commonly owned facilities.

pob 6-8-76

A G R E E M E N T

between the

DEPARTMENT OF INSTITUTIONS AND AGENCIES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

and the

DEPARTMENT OF LAW AND PUBLIC SAFETY
OFFICE OF THE ATTORNEY GENERAL

This Agreement entered on May 20, 1976, between the Department of Institutions and Agencies, Division of Medical Assistance and Health Services, hereinafter referred to as "Agency," and the Department of Law and Public Safety, Office of the Attorney General, hereinafter referred to as "Department."

WITNESSETH:

WHEREAS, Agency and Department are desirous of protecting and preserving the integrity of the Medicaid Program in its expenditures of public funds; and

WHEREAS, Agency is desirous of utilizing the expertise of Department in the investigation of abusive and potentially fraudulent conduct of providers and recipients participating in the Medicaid Program; and

WHEREAS, Department is desirous of assisting Agency in its efforts to uncover and abate abusive or fraudulent activities in the Medicaid Program; and

WHEREAS, Department has established a Medicaid Investigation Unit within the Bureau of Enforcement, Division of Criminal Justice, to investigate potentially fraudulent activities in the Medicaid Program.

NOW THEREFORE, in consideration of the mutual promises herein contained,

Agency Agrees:

1. To utilize its available resources to ascertain abusive and potentially fraudulent activities in the Medicaid Program;

2. To refer appropriate cases to Department for further review, analysis, and investigation of potentially fraudulent activity of providers and recipients of Medicaid services under criteria established by Agency and Department;

3. To cooperate with Department in its review and investigatory process;

4. To meet with representatives of Department to review potentially fraudulent cases.

Department Agrees:

5. To utilize its available resources to ascertain abusive and potentially fraudulent activities in the Medicaid Program;

6. To accept referral of cases forwarded by Agency and expeditiously review same for abusive and potentially fraudulent activity;

7. To return to Agency as soon as possible all cases determined not to be prosecuted;

8. To advise Agency of those cases under its review which shall have no administrative action taken pending completion of review and investigation;

9. To inform Agency periodically of the progress of cases accepted by it for investigation.

Agency and Department Jointly Agree:

10. To establish procedures and appropriate liaison to facilitate and expedite the cooperative purposes of this agreement;

11. To develop methods and procedures to evaluate the effectiveness of the efforts of the parties hereto;

12. This agreement shall be effective on the date first stated above and shall continue in effect until mutually terminated by the parties hereto.

William F. Hyland
Attorney General

Ann Klein, Commissioner
Department of Institutions
and Agencies

Robert J. DelTufo, Director
Division of Criminal Justice

Gerald J. Reilly, Director
Division of Medical Assistance
and Health Services