

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW JERSEY DID NOT SUSPEND
MEDICAID PAYMENTS TO SOME
PROVIDERS WITH CREDIBLE
ALLEGATIONS OF FRAUD IN
ACCORDANCE WITH THE
AFFORDABLE CARE ACT**

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General for Audit Services

May 2016
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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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EXECUTIVE SUMMARY

New Jersey did not suspend Medicaid payments to some providers with credible allegations of fraud.

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA) requires a State to suspend Medicaid payments to a provider when the State receives a credible allegation that the provider has submitted fraudulent claims. This review of New Jersey's Medicaid payment suspensions is part of the Office of Inspector General's oversight of States' compliance with requirements of the ACA.

Our objective was to determine whether the New Jersey Office of the State Comptroller, Medicaid Fraud Division (State agency) suspended Medicaid payments to providers with credible allegations of fraud in accordance with the ACA.

BACKGROUND

The ACA amended the Social Security Act (the Act) to strengthen payment safeguards over potentially fraudulent Medicaid claims. Under the Act, a State that does not suspend payments to a provider when investigation of a credible allegation of fraud is pending is not eligible for Federal reimbursement for payments to that provider unless the State shows that it has good cause not to suspend such payments. A State may use such good-cause exemptions if, for example, law enforcement officials request that a payment suspension not be imposed or other remedies more efficiently or quickly protect Medicaid funds.

Effective March 25, 2011, a State agency must suspend all Medicaid payments to a provider when it determines there is a credible allegation of fraud (42 CFR § 455.23(a)). Federal reimbursement will be withheld if a State agency has unreasonably or repeatedly failed to suspend such payments (76 Fed. Reg. 5862, 5938 (Feb. 2, 2011)). The Medicaid payment suspension is temporary and will not continue after authorities determine that there is insufficient evidence of provider fraud or legal proceedings related to alleged fraud are completed (42 CFR § 455.23(c)). A State agency must also annually report to the Secretary of Health and Human Services summary information on payment suspensions and good-cause exemptions (42 CFR § 455.23(g)(3)).

In New Jersey, the Department of Human Services, Division of Medical Assistance and Human Services (Department of Human Services) is responsible for the administration of the Medicaid program. The State agency is responsible for detecting, preventing, and investigating Medicaid fraud and abuse, recovering improperly expended Medicaid funds, and enforcing Medicaid rules and regulations. The New Jersey Office of the Attorney General, Medicaid Fraud Control Unit (Fraud Control Unit) is responsible for investigation and criminal prosecution of provider fraud in the Medicaid program.

HOW WE CONDUCTED THIS REVIEW

Our review covered 49 providers with allegations of fraud that the State agency deemed credible between April 1, 2011, and June 30, 2013.

WHAT WE FOUND

The State agency did not always suspend Medicaid payments to providers with credible allegations of fraud in accordance with the ACA. Of the 49 providers we reviewed, the State agency suspended or had good cause not to suspend Medicaid payments to 36 providers. However, it did not initiate proceedings to suspend Medicaid payments to 13 providers.

Effective September 1, 2012, the State agency implemented procedures to initiate Medicaid payment suspension proceedings when it determines there is a credible allegation of provider fraud for which an investigation is pending, unless good cause not to suspend payments exists. Additionally, an existing Memorandum of Understanding (MOU) between the State agency, the Fraud Control Unit, and the Department of Human Services, was amended to ensure that the agencies are complying with Federal regulations. The amended MOU, effective November 5, 2012, provides that the State agency should refrain from taking any action regarding cases in which there is a credible allegation of fraud, including suspending Medicaid payments for the lesser of 10 days or until the State agency receives written notice from the Fraud Control Unit indicating it will accept the case for further criminal investigation and for which the Fraud Control Unit believes a payment suspension may compromise or jeopardize its investigation.

Suspension of Medicaid payments was not initiated for 10 of the 13 providers because, when the ACA requirement became effective, the State agency did not have procedures in place for suspending payments to providers with credible allegations of fraud. The State agency subsequently implemented such procedures; therefore, we have no recommendation to address this deficiency. For the remaining three providers, the State agency had policies and procedures in place; however, it did not always follow those procedures. As a result, the State agency placed Medicaid payments at risk.

WHAT WE RECOMMEND

We recommend that the State agency follow its policies and procedures to ensure that it suspends Medicaid payments to providers when there are credible allegations of fraud.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendation. The State agency also stated that it plans to revise its MOU with the Department of Human Services and the Fraud Control Unit to remove the 10-day review period and replace it with language requiring the State agency to immediately suspend all Medicaid payments to a provider when it determines there are credible allegations of fraud.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA)¹ requires a State to suspend Medicaid payments to a provider when the State receives a credible allegation that the provider has submitted fraudulent claims. This review of New Jersey's Medicaid payment suspensions is part of the Office of Inspector General's (OIG) oversight of States' compliance with requirements of the ACA. (Appendix A lists related OIG reports on States' compliance with ACA requirements in reviewing cases of credible allegations of fraud.)

OBJECTIVE

Our objective was to determine whether the New Jersey Office of the State Comptroller, Medicaid Fraud Division (State agency) suspended Medicaid payments to providers with credible allegations of fraud in accordance with the ACA.

BACKGROUND

Federal Requirements Related to Payment Suspensions for Providers with Credible Allegations of Fraud

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The ACA amended the Act to strengthen payment safeguards over potentially fraudulent claims. Under the Act, a State that does not suspend payments to providers when investigation of a credible allegation of fraud is pending is not eligible for Federal reimbursement for payments to that provider unless the State shows that it has good cause not to suspend such payments.² A State may use such good-cause exemptions if, for example, law enforcement officials request that a payment suspension not be imposed or other remedies more efficiently or quickly protect Medicaid funds.³

Effective March 25, 2011, a State agency must suspend all Medicaid payments to a provider when it determines that there is a credible allegation of fraud (42 CFR § 455.23(a)). Federal reimbursement will be withheld if a State agency has unreasonably or repeatedly failed to suspend such payments (76 Fed. Reg. 5862, 5938 (Feb. 2, 2011)). The Medicaid payment suspension is temporary and will not continue after authorities determine that there is insufficient evidence of provider fraud or legal proceedings related to alleged fraud are completed (42 CFR § 455.23(c)). A State agency must also refer credible allegations of fraud to either a Medicaid Fraud Control Unit or an appropriate law enforcement agency in States without such a unit (42 CFR § 455.23(d)).

¹ P.L. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 (Mar. 30, 2010), collectively known as the Affordable Care Act.

² The Act § 1903(i)(2)(C) and 42 CFR § 447.90(b).

³ A list of good cause exemptions is provided at 42 CFR § 455.23(e).

New Jersey's Medicaid Payment Safeguards

In New Jersey, the Department of Human Services, Division of Medical Assistance and Human Services (Department of Human Services) administers the Medicaid program. The State agency is responsible for detecting, preventing, and investigating Medicaid fraud and abuse, recovering improperly expended Medicaid funds, and enforcing Medicaid rules and regulations. Within the New Jersey Office of the Attorney General, the Medicaid Fraud Control Unit (Fraud Control Unit) is responsible for investigation and criminal prosecution of provider fraud, waste, abuse, and neglect in programs receiving Medicaid funds.

Effective September 1, 2012, the State agency developed procedures to initiate payment suspension proceedings when it determines there is a credible allegation of provider fraud for which an investigation is pending, unless good cause not to suspend payments exists. In addition, the State agency, the Fraud Control Unit, and the Department of Human Services entered into a memorandum of understanding (MOU), effective November 5, 2012, which requires the State agency to refer credible allegations of fraud to the Fraud Control Unit. The MOU also provides that the State agency should refrain from taking any action regarding cases in which there is a credible allegation of fraud, including suspending Medicaid payments, for the lesser of 10 days or until the State agency receives written notice from the Fraud Control Unit indicating it will accept the case for further criminal investigation and for which the Fraud Control Unit believes a payment suspension may compromise or jeopardize its investigation (i.e., good cause).

HOW WE CONDUCTED THIS REVIEW

Our review covered 49 providers with allegations of fraud that the State agency deemed credible between April 1, 2011, and June 30, 2013.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains the details of our audit scope and methodology.

FINDINGS

The State agency did not always suspend Medicaid payments to providers with credible allegations of fraud in accordance with the ACA. Of the 49 providers we reviewed, the State agency suspended or had good cause not to suspend Medicaid payments to 36 providers. However, it did not initiate proceedings to suspend Medicaid payments to 13 providers. Specifically:

- The State agency did not initiate proceedings to suspend Medicaid payments for six providers with credible allegations of fraud and for which the Fraud Control Unit did not provide the State agency good cause not to suspend payments. Specifically, the State agency did not suspend Medicaid payments to three providers totaling \$1,025,900 (\$512,949 Federal share). For the remaining three providers, while the State agency did not initiate proceedings to suspend payments, the providers did not claim Medicaid reimbursement.
- The Fraud Control Unit requested that the State agency not initiate Medicaid payment suspension proceedings for five providers for good cause (i.e., not to alert the providers that they were the subject of a criminal investigation). For these providers, the Fraud Control Unit either requested that the State agency not suspend payments for 30 days or subsequently withdrew the good cause. Once the exemption ended or was withdrawn, the State agency should have suspended Medicaid payments. However, for four providers, the State agency did not suspend Medicaid payments totaling \$122,900 (\$61,605 Federal share) made to these providers after the good-cause exemption ended or was withdrawn. For the remaining provider, while the State agency did not initiate suspension of Medicaid payments after the good-cause exemption ended; the provider did not claim Medicaid reimbursement.
- The State agency made Medicaid payments totaling \$24,456 (\$13,352 Federal share) to two providers for periods of 32 and 146 days after it deemed the allegations of fraud credible and referred the providers to the Fraud Control Unit. Contrary to Federal regulations, these payments should have been suspended on the date the allegation was deemed credible and each provider was referred to the Medicaid Fraud Control Unit (42 CFR §455.23(a)).⁴

Suspension of Medicaid payments was not initiated for 10 of the 13 providers⁵ because, when the ACA requirement became effective, the State agency did not have procedures in place for suspending payments to providers with credible allegations of fraud. The State agency subsequently implemented such procedures; therefore, we have no recommendation to address this deficiency. For the remaining three providers, the State agency had policies and procedures in place; however, it did not always follow those procedures. As a result, the State agency placed Medicaid payments at risk.⁶

⁴ We took a conservative approach in identifying the amount of Medicaid payments made to these two providers. Specifically, rather than using the date the State agency referred a provider to the Fraud Control Unit for further investigation as the date payments should have been suspended, we used the timeframe agreed to in the MOU between the State agency and the Fraud Control Unit (i.e., the lesser of 10 days or until the State agency receives written notice of good cause from the Fraud Control Unit), even though the State agency deemed the allegations of fraud associated with these providers to be credible prior to the effective date of the MOU.

⁵ The ten providers were composed of three providers described in the first subcategory bulleted above, five from the second subcategory, and two from the third subcategory.

⁶ As of the end of our field work, the Fraud Control Unit's investigations for 12 of the 13 providers had been terminated or resolved. For the remaining provider, no Medicaid payments were made during the period that the State agency should have suspended the provider's payments. Thus we are not recommending that the State agency refund any monies to the Federal Government.

RECOMMENDATION

We recommend that the State agency follow its policies and procedures to ensure that it suspends Medicaid payments to providers with credible allegations of fraud.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendation. In addition, the State agency stated that it plans to revise its MOU with the Department of Human Services and the Fraud Control Unit to remove the 10-day review period and replace it with language requiring the State agency to immediately suspend all Medicaid payments to a provider when it determines there are credible allegations of fraud. The State agency's comments are included in their entirety as Appendix C.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Arkansas Complied With the Requirements of the Affordable Care Act in Its Review of Cases of Credible Allegations of Medicaid Fraud</i>	<u>A-06-15-00026</u>	9/21/2015
<i>Washington State Did Not Suspend Medicaid Payments to Some Providers With Credible Allegations of Fraud in Accordance With the Affordable Care Act</i>	<u>A-09-14-02018</u>	8/31/2015
<i>Ohio Did Not Always Comply With the Requirements of the Affordable Care Act in its Review of Cases of Credible Allegations of Medicaid Fraud</i>	<u>A-05-14-00008</u>	3/9/2015
<i>Minnesota Complied With the Requirements of the Affordable Care Act in its Review of Cases of Credible Allegations of Medicaid Fraud</i>	<u>A-05-14-00009</u>	11/21/2014
<i>Pennsylvania Complied With the Requirements of the Affordable Care Act in its Review of Cases of Credible Allegations of Medicaid Fraud</i>	<u>A-03-14-00202</u>	6/25/2014

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 49 providers with allegations of fraud that the State agency deemed credible between April 1, 2011, and June 30, 2013 (audit period).

We did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only those internal controls related to our objective. We limited our review to determining whether the State agency complied with Federal requirements when it deemed an allegation of fraud against a Medicaid provider to be credible.

We performed our fieldwork at the State agency's and the Fraud Control Unit's offices in Trenton, New Jersey.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- met with CMS Program Integrity officials to obtain an understanding of the findings identified during its 2012 review of New Jersey's Medicaid program;
- held discussions with the State agency, the Fraud Control Unit, and the Department of Human Services officials;
- obtained and reviewed the State agency's policies and procedures related to referring cases to the Fraud Control Unit and for suspending Medicaid payments to providers with credible allegations of fraud;
- obtained and reviewed the MOU between the State agency, the Fraud Control Unit, and the Department of Human Services;
- obtained from the State agency all provider referrals it made to the Fraud Control Unit during our audit period;
- obtained from the Fraud Control Unit all provider referrals and related information it received from the State agency during our audit period;
- identified 49 providers for which the State agency deemed to have credible allegations of fraud against them and for which the State agency referred to the Fraud Control Unit during our audit period;
- obtained quarterly certifications from the Fraud Control Unit of the provider referrals it accepted and determined the status of those referrals;

- determined the amount of Medicaid payments made to providers after the allegations of fraud were determined to be credible and the amount that should have been suspended; and
- summarized the results of the review and shared those results with State officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX C: STATE AGENCY COMMENTS



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State Comptroller

May 6, 2016

Ms. Brenda Tierney
Acting Regional Inspector General
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza Room 3900
New York, NY 10278

Re: Report Number A-02-13-01046

Dear Ms. Tierney:

Please accept this letter as the response of the New Jersey Office of the State Comptroller, Medicaid Fraud Division ("State") to the above-referenced draft report issued by the Department of Health and Human Services, Office of the Inspector General ("OIG").

OIG's central finding is that the State "did not always suspend Medicaid payments to providers with credible allegations of fraud in accordance with the ACA."

From the finding above, the OIG recommends "that the State agency follow its policies and procedures to ensure that it suspends Medicaid payments to providers when there are credible allegations of fraud."

The State concurs with this recommendation.

To ensure proper communication and collaboration amongst the State entities that administer the Medicaid program, address program integrity, and combat criminal fraud, the Department of Human Services, Division of Medical Assistance and Health Services, the Medicaid Fraud Division ("MFD"), and the Medicaid Fraud Control Unit ("MFCU") in the Attorney General's Office entered into a Memorandum of Understanding ("MOU"), which was most recently executed in November 2012. Among other provisions, for all cases in which the MFD believes there is a credible allegation of fraud, MFD is required to "promptly refer such cases to MFCU and track all such referrals and MFCU's responses to same." In addition, as part of this protocol, MFD is to "refrain from taking any action regarding such case, including any suspension of payments to providers, for the lesser of ten (10) business days or until MFD

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Ms. Brenda Tierney
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receives written notice from MFCU” stating that MFCU will accept such matter for further investigation and that a payment suspension may compromise or jeopardize its investigation.

As explained above, pursuant to the protocol in place for cases in which the MFD believes there are credible allegations of fraud, MFD refers such matters to MFCU and allows up to ten (10) business days for MFCU to determine whether a payment suspension should be implemented. This period was put in place to allow MFCU to determine whether (a) it wanted to pursue the case, and (b) it wanted to employ covert investigative efforts that may be thwarted were the MFD to impose a payment suspension before or while such efforts were underway.

To address OIG’s findings and recommendation, MFD will take efforts to revise the MOU with DMAHS and MFCU to remove the ten (10) day review period for MFCU and replace this language with language requiring the State immediately to suspend all Medicaid payments to a provider when MFD determines that there are credible allegations of fraud involving such provider. Implementing an immediate payment suspension when there are credible allegations of fraud would allow the State to comport with 42 CFR 455.23.

The State appreciates OIG’s recommendation to improve the State’s program integrity efforts and will strive to implement this recommendation as quickly as it can.

Very truly yours,

PHILIP JAMES DEGNAN

Philip James Degnan
State Comptroller