

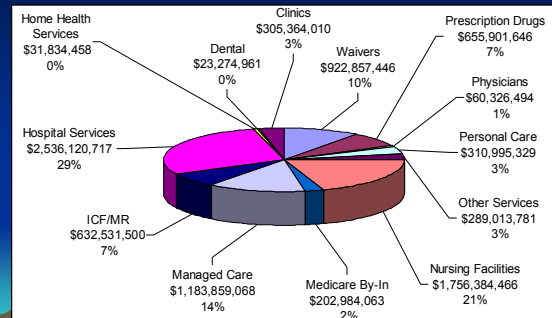
# Medicaid

## Fraud, Abuse and Inefficiencies in the NJ State Program

NJ Office of Legislative Services  
Office of the State Auditor

1

State FY 2006 Medicaid Expenditures  
Title XIX Allocation  
Total \$8.9 (billion)



## Brainstorming Considerations

- Inappropriate billing by provider
  - Up-coding
  - Ghost or phantom billing
  - Delivering more services than needed
- Provider self-referrals
- Provider misrepresentation of qualifications
- Enrolling ineligible or non-existent patients into program
- Underutilization of services by MCO's
- Falsification of cost reports

3

## OSA Medicaid Audits

1. Eligibility
2. Third Party Liability
3. Managed Care
4. Nursing Homes
5. Medical Day Care
6. Family Care and the Health Benefits Contract
7. Partial Hospitalization / Partial Care
8. Transportation
9. Personal Care Assistants (PCA) Services

4

## Eligibility

5

## Audit Findings-Eligibility

- Income & Eligibility Verification System (IEVS)
- Invalid Social Security Numbers

6

## Invalid SS Numbers

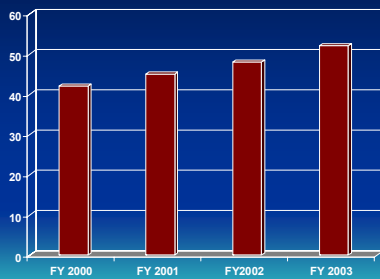
SSN	# Recipients	SSN	# Recipients
• 000000000	13,690	• 999000000	385
• 999999999	5,903	• 090909090	238
• 888888888	2,006	• 999012002	117
• 333333333	385	• 999092002	93
• 111111111	291	• 999123102	93
• 555555555	53	• 999082002	91
• 444444444	18	• 999022002	80
• 666666666	12	• 999072002	80
• 777777777	12	• 999102002	77

7

## Third Party Liability (TPL)

8

## TPL Recovery Trend (in millions of dollars)



9

## Audit Findings

- Insurance information is not being updated
- Recovered \$32 million recipients previously identified as having other insurance
- Paid vendor \$3 million to recover

10

## 2007 Follow-up Audit

Improvements in updating TPL information, however 37% of the cases were still not updated.

State Employees on Medicaid

11

## Managed Care

Insufficient Encounter Data Finding

12

### Audit Finding –Insufficient Encounter Data

Managed Care Encounter Data Number of Claims  
Comparison to Quarterly Financial Reports

	Total Claims Encounter Data	Total Claims Financial Reports	Variance
Provider A	561,737	522,757	39,980
Provider B	191,702	293,505	-101,803
Provider C	120,026	251,823	-131,797
Provider D	82,782	83,616	-834
Provider E	231,197	359,692	-128,495
Provider F	211,316	85,112	126,204
Total	1,398,760	1,596,505	-197,745

13

## Long Term Care Program

Nursing Homes

14

### Audit Findings

Audits of Nursing Homes and Cost Recoveries

- Approximately 250 of the 320 Medicaid nursing facilities were never audited by DHSS internal auditors
- An average time span of 4.5 years occurred between the end of the period being audited and the date the report was issued
- Of the \$15.9 million in overpayments, only \$1.5 million was collected
- Excess time delays resulted in \$4.5 million in overpayments that could not be recovered because of nursing facility bankruptcies

15

### Audit Findings

Dead Beneficiaries

- In 1998, our audit identified \$430,000 in overpayments for dead beneficiaries
- Since implementing our recommendation of matching claims against the Bureau of Vital Statistics, the DHSS has recovered millions in overpayments for deceased beneficiaries (Lazarus Project)

16

### Audit Findings

- 192 of the 350 nursing homes were never audited
- Average time span is 4.8 years between the end of the period being audited and the date the report is received.
- Department cannot determine the receivable because the system was abandoned in 1999
- \$1.8 million of overpayments were not recoverable due to bankruptcies

17

## Medical Day Care

Program

18

## Medical Day Care Audit

“This program has apparently evolved from providing services as an alternative to nursing home care to providing services to any participant eligible for Medicaid.”

19

## Summary of Findings

- Eligibility
- Cost Reports
- Claim Payments
- Attendance Records
- Criminal Background Checks

20

## Eligibility

- 2 sets of regulations
- “Medical condition” is not defined
- Hypertension, diabetes, and arthritis was primary diagnosis in 50% of recipients of MDC services in NJ

21

## Cost Reports

- DHSS never requested cost reports from providers until May 2002
- The Department was not aware that 78 providers were participating in federal Child and Adult Food Program and received \$6 million in reimbursements

22

## Claim Payments

- Duplicate Claims : \$170,000
- Clients in Hospital : \$66,000
- Payments in excess of 5 day per week : \$410,000
- Potential conflicts : \$1 million

23

## Attendance Records

- Do not indicate arrival and departure times
- Clients are not required to sign, acknowledging that they were at facility

24

## Criminal Background Checks

- The department relies on the provider making full disclosure on their applications
- No procedures in place to perform reviews and background checks

## Moratorium on New Facilities

Providers who filed applications prior to the moratorium were still being processed for licensure

52 new facilities with a capacity of 5400 slots were approved

Increased the program's participants by 70% and the program's expenditures by another \$60 million

## Transportation Program

Types of Services:

- Livery.
- Ambulance.
- Public transportation.
- Taxi.
- Mobility Access Vehicle (MAV).

## Mobility Assistance Vehicles (MAV)

Specialized transportation provided to those who are not ambulatory and need to obtain medical services.

## Audit Findings

- Medical justification and duration of services submitted by the transportation providers for prior authorizations are not being verified for accuracy.
- There is no validation that the prior authorization destinations agree with those MAV claims.
- Recipients are using MAV to pick up prescription drugs when pharmacies provide free delivery services.

## Department Initiatives

- Program Integrity Unit reduced expenditures by \$2 million through surveillance.
- Providers were fined and terminated.

## MAV Process

- Provider determines need.
- Prior Authorization required.
- Provider paid \$25 each way plus mileage.

31

## 2002 Audit Findings

- Electronic Claims
  - reduces control - documentation stays with provider.
  - Results in duplicate payments.
  - Results in over-billing.

32

## NJ Family Care (NJFC)

Health Benefits Coordinator Contract

33

## NJFC and Health Benefits Coordinator Contract

Purpose

- Screen and process applications
- Make eligibility determinations for NJFC
- Assess and collect premiums
- Provide outreach, marketing and education
- Enroll recipients into MCO's

34

## Audit Findings

- Contract Compliance
- Eligibility Determinations

35

## Contract Compliance Findings

- Applications were not processed timely
- Premiums were not collected prior to enrollment
- Refunds were not returned to beneficiaries timely
- Backlog of cases in missing information status
- Vendor failed to hire qualified employees.

36

## Eligibility Findings

Our review found that 49% of case files tested did not have the required supporting documentation to process the case:

- Birth Certificate
- Proof of United States Citizenship
- Proof of Social Security Number

37

## Eligibility

Overall error rate of 39%

- Statistical sample of 193 cases :
  - 31% of individuals determined into a wrong plan
  - 7% of individuals were ineligible
  - .5% vendor could not locate the file.
- Projected sample results:
  - 49,832 individuals are in wrong plan
  - 11,617 ineligible
  - 830 case files can't be located

38

## Partial Care and Partial Hospitalization

39

## Audit Findings

### Improper Claim Payments

- Identified \$570,000 in claims that exceeded the 5 hour maximum per day
- Identified \$100,000 in claims that two or more providers billed for the same client on the same day
- Identified \$1.5 in claims that were span billed

40

## Audit Findings

### Provider Visits

- One hospital provider over-billed \$550,000 by including lunch as therapy time
- Three hospital providers over-billed \$342,000 for their children's program where the hours billed exceed the actual hours of services provided
- Three hospital providers programs over-billed for academic sessions that were included as therapy.

41

## Areas of Cost Savings

- New Regulations should be expanded to include services for children (\$13 million)
- Hospital-Based Reimbursements vs Clinic Rates (\$21 million)
- Partial Care Clinics in Hudson County

42

## Common Weaknesses in Medicaid Programs

- Insufficient Data
- Divisions Inactivity (MMIS Edits)
- Provider driven
- Inadequate or conflicting regulations that allow loopholes

43

## Medicaid Obstacles

- The Three L's

Lawyers  
Lobbyists  
Legislators

44

## Audit Procedures The Auditors Arsenal

SURS

Shared Data Warehouse (SDW)

Inter and Intra governmental information sharing

Provider Visits

45