

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**NEW JERSEY MEDICAID  
FRAUD CONTROL UNIT:  
2013 ONSITE REVIEW**



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**September 2013  
OEI-02-13-00020**

**EXECUTIVE SUMMARY: NEW JERSEY MEDICAID FRAUD CONTROL UNIT:  
2013 ONSITE REVIEW  
OEI-02-13-00020**

**WHY WE DID THIS STUDY**

The Office of Inspector General (OIG) oversees all Medicaid Fraud Control Units (MFCU or Unit) with respect to Federal grant compliance. As part of this oversight, OIG reviews all Units. These reviews assess Unit performance in accordance with the 12 MFCU performance standards and monitor Unit compliance with Federal grant requirements, laws, and regulations.

**HOW WE DID THIS STUDY**

We based our review on an analysis of data from seven sources: (1) a review of policies, procedures, and documentation related to the Unit's operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit's management and staff; (6) an onsite review of case files; and (7) an onsite review of Unit operations.

**WHAT WE FOUND**

From fiscal year (FY) 2010 through FY 2012, the Unit's recoveries increased but felony charges and convictions decreased. The Unit also investigated fewer cases of patient abuse and neglect in FY 2012 than in FY 2010. Although most case files included opening and closing documents, half lacked documentation of supervisory review. Further, the Unit did not refer 94 percent of convictions to OIG appropriately. The Unit also did not meet the requirements of its training plan in FY 2012. In addition, the Unit Director does not supervise the majority of Unit staff and does not oversee part of the Unit's caseload. Lastly, the Unit identified as beneficial a case management tool that tracks tasks and deadlines and includes descriptions of investigative and legal issues that arise.

**WHAT WE RECOMMEND**

We recommend that the Unit: (1) take steps to ensure that its case mix includes more cases of patient abuse and neglect; (2) ensure that case files contain supervisory reviews; (3) appropriately refer individuals to OIG for program exclusion; (4) ensure that staff receive at least the minimum training required in the Unit's training plan; and (5) change its supervisory structure to provide the Unit Director with supervision of all of the Unit's staff and oversight of all of its caseload. The Unit concurred with our first four recommendations and described plans to implement each. In response to the fifth recommendation, the Unit did not specifically state whether it concurred.

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## OBJECTIVES

To conduct an onsite review of the New Jersey State Medicaid Fraud Control Unit (MFCU or Unit).

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## BACKGROUND

The mission of State MFCUs, as established by Federal statute, is to investigate fraud and patient abuse and neglect by Medicaid providers and to prosecute it under State law.<sup>1</sup> Pursuant to Title XIX of the SSA, each State must maintain a certified Unit unless the Secretary of Health and Human Services determines that operation of a Unit would not be cost-effective because (1) minimal Medicaid fraud exists in that State and (2) the State has other adequate safeguards to protect Medicaid beneficiaries from abuse and neglect.<sup>2</sup> Currently, 49 States and the District of Columbia (States) have created such Units.<sup>3</sup> In fiscal year (FY) 2012, combined Federal and State grant expenditures for the Units totaled \$217.3 million, with Federal funds representing \$162.9 million of this amount.<sup>4</sup> In FY 2012, the New Jersey Unit was awarded \$5.8 million in combined State and Federal funds.<sup>5</sup>

To carry out its duties and responsibilities in an effective and efficient manner, each Unit must employ an interdisciplinary staff that consists of at least an investigator, an auditor, and an attorney.<sup>6</sup> Unit staff review complaints provided by the State Medicaid agency and other sources and determine their potential for criminal prosecution and/or civil action. In FY 2012, the 50 Units collectively obtained 1,337 convictions and 823 civil settlements or judgments.<sup>7</sup> That year, the Units reported recoveries of approximately \$2.9 billion.

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<sup>1</sup> Social Security Act (SSA) § 1903(q).

<sup>2</sup> SSA §§ 1902(a)(61). Regulations at 42 CFR 1007.11(b)(1) add that the Unit's responsibilities may include reviewing complaints of misappropriation of patients' private funds in residential health care facilities.

<sup>3</sup> North Dakota and the territories of American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands have not established Units.

<sup>4</sup> OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures And Statistics*, March 2013. Accessed at [https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures\\_statistics/fy2012.asp](https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2012.asp) on March 5, 2013. All FY references in this report are based on the Federal FY (October 1 through September 30).

<sup>5</sup> Office of Inspector General (OIG) analysis of Notice of Award for New Jersey for FY 2012.

<sup>6</sup> SSA § 1903(q)(6) and 42 CFR §1007.13.

<sup>7</sup> OIG, *State Medicaid Fraud Control Units Fiscal Year 2012 Grant Expenditures And Statistics*, March 2013. Accessed at [https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures\\_statistics/fy2012.asp](https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2012.asp) on March 5, 2013.

Units are required to have either Statewide authority to prosecute cases or formal procedures to refer suspected criminal violations to an agency with such authority.<sup>8</sup> In New Jersey and 43 other States, the Units are located within offices of State Attorneys General; in the remaining six States, the Units are located in other State agencies.<sup>9</sup> Generally, Units outside of the Attorneys General offices must refer cases to other offices with prosecutorial authority.

Additionally, each Unit must be a single identifiable entity of State government, distinct from the State Medicaid agency, and each Unit must develop a formal agreement—i.e., a Memorandum of Understanding (MOU)—that describes the Unit’s relationship with that agency.<sup>10</sup>

### **Oversight of the MFCU Program**

The Secretary of Health and Human Services delegated to OIG the authority to annually certify the Units and to administer grant awards to reimburse States for a percentage of their costs in operating certified Units.<sup>11</sup> All Units are currently funded by the Federal Government on a 75-percent matching basis, with the States contributing the remaining 25 percent.<sup>12</sup> To receive Federal reimbursement, each Unit must submit an initial application to OIG.<sup>13</sup> OIG reviews the application and notifies the Unit if the application is approved and the Unit is certified. Approval and certification are for a 1-year period; the Unit must be recertified each year thereafter.<sup>14</sup>

Pursuant to Title XIX of the SSA, States must operate Units that effectively carry out their statutory functions and meet program requirements.<sup>15</sup> OIG developed and issued 12 performance standards to define the criteria it applies in assessing whether a Unit is effectively carrying out statutory

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<sup>8</sup> SSA § 1903(q)(1).

<sup>9</sup> Among those States with a Unit, the Unit shares responsibility for protecting the integrity of the Medicaid program with the section of the State Medicaid agency that functions as the Program Integrity Unit. Some States also employ a Medicaid Inspector General who conducts and coordinates activities combating fraud, waste, and abuse for the State agency.

<sup>10</sup> SSA § 1903(q)(2); 42 CFR § 1007.9(d).

<sup>11</sup> The portion of funds reimbursed to States by the Federal Government for its share of expenditures for the Federal Medicaid program, including the MFCUs, is called Federal Financial Participation.

<sup>12</sup> SSA § 1903(a)(6)(B).

<sup>13</sup> 42 CFR § 1007.15(a).

<sup>14</sup> 42 CFR § 1007.15(b) and (c).

<sup>15</sup> SSA § 1902(a)(61).

functions and meeting program requirements.<sup>16</sup> Examples include maintaining an adequate caseload through referrals from several sources, maintaining an annual training plan for all professional disciplines, and establishing policy and procedure manuals to reflect the Unit's operations. See Appendix A for a complete list of the performance standards.<sup>17</sup>

### **New Jersey Unit**

The Unit is located in the New Jersey Attorney General's Office. The MFCU Director reports to the Insurance Fraud Prosecutor, who reports directly to the Attorney General. The Insurance Fraud Prosecutor, appointed by the Governor, is also responsible for investigating and prosecuting automobile and property fraud. The Unit has the authority to prosecute Medicaid fraud and patient abuse and neglect cases and also includes a False Claims Unit that is responsible for civil cases of health care fraud.

As of January 2013, the Unit had 35 employees—22 located in the State capital of Trenton, and 13 located in a satellite office in Whippany.<sup>18</sup> Investigative teams are composed of Unit attorneys, with support from at least two detectives assigned by the Unit Director. As needed, auditors and/or support staff may also be assigned to the teams.

The Unit receives referrals of provider fraud from the State Medicaid agency—the Division of Medical Assistance and Health Services (DMAHS), in the Department of Human Services—and from the Medicaid Fraud Division in the Office of the State Comptroller. The Unit receives referrals of patient abuse and neglect from the State Ombudsman for the Institutionalized Elderly (the State's Long-Term Care Ombudsman) and from the Division of Health Facilities Evaluation and Licensing, the State survey and certification agency. From FY 2010 through FY 2012, the Unit received an average of 70 referrals of fraud each year, and an average of 63 referrals of patient abuse and neglect each year. (See Appendix B for a breakdown of referrals by type, year, and source.)

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<sup>16</sup> 59 Fed. Reg. 49080 (Sept. 26, 1994). Accessed at <http://oig.hhs.gov> on November 5, 2012. OIG published a revision of the performance standards, 77 Fed. Reg. 32645 (June 1, 2012). This review applies the previous standards (published on September 26, 1994) for the review period of FY 2010 through May 31, 2012, and the standards published on June 1, 2012, when assessing Unit operations after May 31, 2012.

<sup>17</sup> Appendix A contains the performance standards dated September 26, 1994. For the June 1, 2012, performance standards, see <https://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf>.

<sup>18</sup> The Unit Director has an office in both locations.

When the Unit receives a referral, it determines whether the referral has the potential for criminal or civil prosecution. For referrals that are civil in nature, the Unit assigns them to the False Claims Unit.<sup>19</sup> See Appendix C for additional information on the Unit’s opened and closed cases, including a breakdown by case type and provider category.

The Unit may open a case and pursue it through a variety of actions, including criminal prosecution or civil action. The Unit may close a case through a criminal or civil resolution or through a referral to another agency, or for other reasons.

The Unit participated in several “global”—i.e., multi-State—civil cases, coordinated by the National Association of Medicaid Fraud Control Units (NAMFCU), during the review period. One of the Unit’s attorneys serves as an “intake attorney” on these cases.

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## METHODOLOGY

Our review covered the 3-year period of FYs 2010 through 2012. We analyzed data from seven sources: (1) a review of policies, procedures, and documentation relating to the Unit’s operations, staffing, and caseload for FYs 2010 through 2012; (2) a review of financial documentation for FYs 2010 through 2012; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit’s management and staff; (6) an onsite review of case files that were open in FYs 2010 through 2012; and (7) an onsite review of Unit operations conducted in January 2013.

We analyzed data from all seven sources to describe the caseload and assess the performance of the Unit. We also analyzed the data to identify any opportunities for improvement and any instances in which the Unit did not meet the performance standards or was not operating in accordance with laws, regulations, and policy transmittals.<sup>20</sup> In addition, we described noteworthy practices that appeared to benefit the Unit, based on statements from Unit staff, data analysis, and our own judgment. We did not independently verify the effectiveness of these practices, but

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<sup>19</sup> The Unit may also open cases that were not referred by another agency. For example, a case may be initiated from work on a related case. The Unit may also join a False Claims Act case initiated by the National Association of Medicaid Fraud Control Units (NAMFCU). NAMFCU is a voluntary association of all 50 Units that provides training opportunities and facilitates the settlement of “global” (multi-State) civil False Claims Act cases involving the U.S. Department of Justice and other State MFCUs. More information on NAMFCU and its involvement in global cases is available online at <http://www.namfcu.net>.

<sup>20</sup> All relevant regulations, statutes, and policy transmittals are available online at <http://oig.hhs.gov>.

included the information because it may be useful to other Units in their operations.

### **Data Collection and Analysis**

*Review of Unit Documentation.* We requested and reviewed documentation, policies, and procedures related to the Unit's operations, staffing, and cases, including its annual reports, quarterly statistical reports, and responses to recertification questionnaires. We also requested and reviewed the Unit's data describing its caseload, prosecutions, and recoveries. Data collected included information such as the number of referrals received by the Unit and the number of investigations opened and closed.

*Review of Financial Documentation.* To evaluate internal controls, we reviewed policies and procedures related to budgeting, accounting systems, cash management, procurement, property, and personnel. We obtained from the Unit its claimed grant expenditures for FYs 2010 through 2012 so that we could: (1) review final Federal Status Reports<sup>21</sup> and supporting documentation, (2) select and review transactions within categories of direct costs to determine whether costs were allowable, and (3) verify that indirect costs were accurately computed using the approved indirect cost rate. We also reviewed records in the HHS Payment Management System (PMS)<sup>22</sup> and revenue accounts to identify any unreported program income.<sup>23</sup>

*Interviews With Key Stakeholders.* We conducted structured interviews with nine individual stakeholders who were familiar with Unit operations. Specifically, we interviewed the two individuals who served as Unit directors during our review period. We also interviewed the Acting Insurance Fraud Prosecutor; the Director of the Medicaid Fraud Division within the Office of the State Comptroller; the Ombudsman for the Institutionalized Elderly; the Deputy Chief of Detectives for the Division of Criminal Justice; the Assistant Division Director for the Division of Medical Assistance and Health Services in the Department of Human Services; the Assistant Commissioner for the Division of Health Facilities Evaluation and Licensing in the New Jersey State Department of Health; and the Assistant Special Agent in Charge for OIG's Region II. These interviews focused on the Unit's interaction with external agencies, Unit

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<sup>21</sup> The Unit transmits financial status reports to OIG's Office of Management and Policy on a quarterly and annual basis. These reports detail Unit income and expenditures.

<sup>22</sup> The PMS is a grant payment system operated and maintained by the HHS Program Support Center, Division of Payment Management. The PMS provides disbursement, grant monitoring, reporting, and cash management services to awarding agencies and grant recipients, such as the Units.

<sup>23</sup> Program income is defined as "gross income received by the grantee or subgrantee directly generated by a grant supported activity, or earned only as a result of the grant agreement during the grant period." 45 CFR § 92.25(b).



operations, opportunities for improvement, and any practices that appeared to benefit the Unit and that may be useful to other Units in their operations.

*Survey of Unit Staff.* We conducted an electronic survey of all nonmanagerial Unit staff. We requested and received responses from each of the 29 nonmanagerial staff members, for a 100-percent response rate. Our questions focused on operations of the Unit, opportunities for improvement, and practices that appeared to benefit the Unit and that may be useful to other Units in their operations. The survey also sought information about the Unit's compliance with applicable laws, regulations, and policy transmittals.

*Interviews with Unit Management and Staff.* We conducted structured interviews with the Unit's Director (also the Chief Attorney for criminal cases), the assistant section chief, the Chief Attorney for False Claims Act cases, and the senior investigator. We asked these managers to provide us with additional information to better understand the Unit's operations, identify opportunities for improvement, identify practices that appeared to benefit the Unit and that may be useful to other Units, and clarify information obtained from other data sources. We also interviewed the Unit's two auditors, two attorneys from the False Claims Unit, and the nurse investigator. We asked similar questions of these staff.

*Onsite Review of Case Files.* We selected a simple random sample of 100 case files from the 1,004 cases that were open at any point from FY 2010 through FY 2012. The design of this sample allowed us to estimate the proportion of all 1,004 case files with certain characteristics at the 95-percent confidence level. We reviewed these 100 sampled case files and the Unit's processes for monitoring the status and outcomes of cases. From these 100 case files, we selected another simple random sample of 50 cases for a more in-depth review.

*Onsite Review of Unit Operations.* While onsite, we reviewed the Unit's operations. Specifically, we reviewed the Unit's process for intake of referrals, security of data and case files, and the general functioning of the Unit.

## **Standards**

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

## FINDINGS

### **From FY 2010 through FY 2012, Unit recoveries increased but felony charges and convictions decreased**

The Unit experienced an 80 percent increase in recoveries from FY 2010 through FY 2012. Global civil false claims cases accounted for much of the increase in recoveries. In total, the Unit reported recoveries of \$144 million in 3 years—an average of \$48 million annually (see Table 1).

**Table 1: New Jersey MFCU Recoveries, FYs 2010 through 2012**

	FY 2010	FY 2011	FY 2012	Total	Annual Average
Reported Criminal Recoveries	\$241,220	\$692,552	\$255,690	\$1,189,462	\$396,487
Reported Civil Recoveries – State Only	\$0	\$0	\$2,266	\$2,266	\$755
Reported Civil Recoveries – Global	\$43,781,406	\$20,423,360	\$78,637,924	\$142,842,690	\$47,614,230
Total Reported Recoveries	\$44,022,626	\$21,115,912	\$78,895,880	\$144,034,418	\$48,011,473

Source: OIG analysis of Unit data, 2013.

At the same time, the Unit’s criminal prosecutions saw a marked decrease. Specifically, the number of convictions decreased from 54 to 13, while the number of individuals or corporations charged with a felony decreased from 60 to 18. The Unit Director explained that the decrease resulted from the Unit making a shift towards more complex, high-profile cases, which take longer to prosecute. She further stated that this strategy will yield more defendants charged per case.

### **The Unit investigated fewer cases of patient abuse and neglect in FY 2012 than in FY 2010**

According to Performance Standard 4, the Unit should take steps to ensure that it “maintains an adequate workload through referrals” from the State Medicaid agency and other sources. The Unit should also ensure that it receives adequate referrals of patient abuse complaints from all sources. From FY 2010 through FY 2012, the Unit’s number of cases of patient abuse and neglect decreased 70 percent, from 108 to 32.

We identified two actions by the MFCU that may explain this decrease in abuse and neglect cases. In 2010, the Unit dismantled its Patient Protection Unit, which focused solely on patient abuse and neglect cases. A number of staff noted that the Patient Protection Unit was helpful in maintaining a

unique focus on these issues and that its staff “were highly specialized.” The Patient Protection Unit also worked closely with a number of potential referral sources, including the State Department of Health, the Office of the Ombudsman for the Institutionalized Elderly, and the State Medicaid Agency. The Unit Director explained that she did not believe that a specialized unit was necessary because all Unit attorneys should be capable of handling these cases.

In 2012, the Unit developed a new policy for accepting referrals of patient abuse and neglect. The Unit previously accepted the majority of such referrals and investigated them to determine the feasibility of each case. In contrast, the Unit now only accepts referrals where the abuse or neglect was witnessed by someone other than the patient and was documented in the medical record. Also, for cases involving theft of patient funds (a type of abuse or neglect), the Unit now generally accepts only referrals where the financial loss is \$100,000 or more and the accused is not a family member.

The Unit director explained that these thresholds were carefully considered and that they were intended to ensure that the cases undertaken by the Unit would likely lead to a successful prosecution. She noted that referral sources are being more selective in what they send to the Unit now. Stakeholders who refer cases of patient abuse and neglect to the Unit confirmed that they now send fewer referrals to the Unit as a result of the policy and send more cases to county prosecutors instead.

### **Although most case files included opening and closing documents, half lacked documentation of supervisory review**

According to Performance Standard 6, the Unit should complete cases within a reasonable timeframe. As a part of this standard, supervisors should approve the opening and closing of cases and supervisory reviews should be “conducted periodically and noted in the case file” to ensure timely case completion. In our review, we found that almost all case files contained opening and closing documents. Specifically, 91 percent of case files had an opening memorandum and 97 percent had a closing memorandum. See Appendix E for confidence intervals. However, 50 percent of Unit case files lacked documentation of at least one supervisory review.<sup>24</sup>

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<sup>24</sup> The point estimate is 50 percent with a 95-percent confidence interval of 37 to 63 percent. This analysis did not include global cases or cases that the Unit opened and closed on the same day.

## **The Unit did not refer 94 percent of convictions to OIG appropriately**

According to Performance Standard 8(d), the Unit must send reports of convictions to OIG “within 30 days or other reasonable time period” for the purpose of excluding providers and nonproviders from participation in Federally-funded healthcare programs, including Medicare and Medicaid.<sup>25</sup>

From FY 2010 through FY 2012, 50 individuals were sentenced for healthcare fraud, patient abuse, neglect, or financial exploitation. The Unit did not refer 47 of these individuals (94 percent) to OIG appropriately. It never referred 6 individuals to OIG, and it referred 41 individuals after the 30-day timeframe. The Unit referred the remaining 3 individuals within the 30-day timeframe. It took an average of 103 days to send notice to OIG after the individual was sentenced; in one case, the Unit sent notice 260 days after sentencing. If a Unit fails to properly refer convicted providers for exclusion, the providers may be able to continue to submit fraudulent claims and receive payments from Federally-funded healthcare programs.

## **The Unit did not meet the requirements of its training plan in FY 2012**

According to Performance Standard 12, the Unit must maintain an annual training plan for all professional disciplines. In addition, Performance Standard 12b states that the Unit must have a minimum number of required training hours for each professional discipline, and staff must comply with the requirement. The training plan for the New Jersey Unit states that each professional discipline in the Unit shall participate in 3 hours of Medicaid fraud training and 3 hours of False Claims Act training sponsored by the Unit. Additionally, each employee must attend two Medicaid Fraud trainings offered by NAMFCU, subject to available funding and supervisory approval.

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<sup>25</sup> Under 42 U.S.C. § 1320a-7(a), OIG is required to exclude from participation in Federal health care programs any person or entity convicted of a criminal offense related to the delivery of an item or service under the Medicaid program or to the neglect or abuse of patients in residential health care facilities. See also 42 CFR § 1001.1901. For individuals and entities convicted of program-related crimes, patient abuse, felony healthcare fraud, and felonies relating to controlled substances, a mandatory exclusion is required. See SSA § 1128(a).

Not all staff met the training requirements.<sup>26</sup> The Unit training logs indicate that of the 33 Unit staff in a professional discipline that were working in the Unit in FY 2012, 23 met the Medicaid fraud training requirement in FY 2012.<sup>27</sup> The remaining 10, which included attorneys and detectives, received no Medicaid fraud training. In addition, none of the staff met the False Claims Act training requirement in FY 2012. The training logs also showed that both types of training were rarely offered in the prior 2 fiscal years. Staff also rarely met the requirement for NAMFCU training; only seven staff members attended NAMFCU training in the 3 fiscal years under review.

More than half of the non-managerial staff reported that they needed more training, with the majority of those staff members specifically citing concerns about not receiving an adequate amount of Medicaid fraud training.

### **The Unit Director does not supervise the majority of Unit staff and does not oversee part of the Unit's caseload**

Social Security Act § 1903(q)(6) requires Units to “employ [...] such auditors, attorneys, investigators, and other necessary personnel and [be] organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.” We found that although the Unit has a Unit Director, 20 of 34 staff do not report to her, and she does not oversee any of the Unit's civil cases. The Director has supervisory responsibility only for the 14 attorneys and auditors working on criminal cases. The 5 attorneys and auditors working on civil cases, as well as all of the Unit's 15 detectives, do not report to the Director.

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<sup>26</sup> Although we reviewed training records, we did not evaluate the staff's professional qualifications. Rather, we applied the performance standards to evaluate whether the Unit maintained a formal training plan for each professional discipline and whether staff met the training plan requirements. We recognize that attorneys, investigators, and auditors receive professional and law enforcement training, and that not meeting the training plan requirements does not suggest that professional staff are unqualified.

<sup>27</sup> The Unit's training plan considers technical analysts and support staff to have their own professional disciplines and provides training for all disciplines accordingly. In contrast, OIG normally limits its recognition of professional disciplines in the MFCUs to attorneys, detectives, and auditors. Our review of the New Jersey Unit used the definition provided by the Unit.

***The Unit Director does not supervise the staff or oversee the caseload of the False Claims Unit***

Although the False Claims Unit is part of the MFCU, the False Claims Unit staff do not report to the Unit Director. Rather, as reflected on the Unit's organizational chart (see Appendix D), the head of the False Claims Unit—i.e., the lead attorney in the False Claims Unit—reports directly to the Insurance Fraud Prosecutor.

The Unit Director does not supervise the staff or oversee the caseload of the False Claims Unit. Instead, the lead attorney in the False Claims Unit supervises the False Claims Unit and reports directly to the Insurance Fraud Prosecutor. The lead attorney manages the day-to-day operations of the False Claims Unit, which includes approving the opening and closing of all Medicaid False Claims Act cases and managing all of the decisions about how cases are to be prosecuted. The Unit Director is copied on False Claims Unit emails, but is otherwise not involved in the prosecution. During biweekly meetings with the Insurance Fraud Prosecutor, the Unit Director reports on her top criminal cases, while the lead attorney of the False Claims Unit reports on his top civil cases. Additionally, the Unit Director also does not conduct the performance reviews of staff in the False Claims Unit; the lead attorney is responsible for conducting these reviews.

***The Unit Director does not supervise the Unit's detectives***

All of the Unit's 15 detectives report to a lieutenant in the Unit who is responsible for approving and addressing any issues with their time, attendance, leave, resource needs, and performance. This lieutenant does not report to the Unit Director, but instead reports to the Deputy Chief of Detectives, who is outside of the Unit. The Deputy Chief of Detectives is the second-level supervisor for the MFCU detectives as well as for the detectives who investigate private insurance fraud in the Office of the Insurance Fraud Prosecutor. The Deputy Chief of Detectives reports to the Chief of Detectives, who reports to the Insurance Fraud Prosecutor.

The Unit Director acknowledged that she currently provides only informal feedback to the detectives, including the lieutenant, and does not conduct their performance evaluations. She noted that this may change in the future, as the Unit is currently testing a procedure that would allow her to have formal input on the evaluations of the Unit's detectives.<sup>28</sup> As the Unit Director noted, "We want control over the evaluations of the sergeants and detectives. I think we should have a say in commenting on

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<sup>28</sup> The lead attorney in the False Claims Unit is also participating in this pilot program. He will provide written input on the one detective in his Unit.

and preparing their evaluations.” Under this pilot program, the Unit Director may provide written comments on draft evaluations of the detectives; these comments are then included in the final versions that are submitted to the Insurance Fraud Prosecutor. The State Attorney General will determine whether to implement this process on a permanent basis.

Although the Unit Director noted that she works collaboratively with the detectives, one former director noted that the current management structure can create tension and potential problems when the Unit Director differs with the detectives on how a case should proceed. He observed that when he was director, there were times when the lieutenants in the Unit set different priorities than his and that this difference hurt the performance of the Unit, as cases took longer to progress.

### **Other observation: Case management tool**

The Unit identified a case management tool that benefited the Unit—a joint investigation plan that continually monitors progress of its investigations.

*Joint Investigation Plan.* The Unit developed a supervisory review document called a Joint Investigation Plan that includes tasks and deadlines, as well as descriptions of significant investigative and legal issues. An investigative plan is a standard tool used in complex investigations. The Unit’s plan contains an additional feature—a “punch list” of steps that the investigative team will need to undertake. Every 30 days, the plan is updated and initialed by the assigned attorney and investigator, as well as the Unit lieutenant who oversees all investigations. The plan is then reviewed during monthly supervisory case reviews until the case is completed. The Unit started using the Joint Investigation Plan beginning in November 2011, primarily for new cases.

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## CONCLUSION AND RECOMMENDATIONS

From FY 2010 through FY 2012, Unit recoveries increased but felony charges and convictions decreased. The Unit also investigated fewer cases of patient abuse and neglect in FY 2012 than in FY 2010. Additionally, although most case files included opening and closing documents, half lacked documentation of supervisory review. Further, the Unit did not refer 94 percent of convictions to OIG appropriately. The Unit also did not meet the requirements of its training plan in FY 2012. In addition, the Unit Director does not supervise the majority of Unit staff and does not oversee part of the Unit's caseload.

Our financial review found no significant instances where the Unit failed to maintain proper fiscal control of its resources. In addition, the Unit identified as beneficial a case management tool that includes tasks and deadlines, as well as descriptions of significant investigative and legal issues.

We recommend that the New Jersey Unit:

### **Take Steps to Ensure That the Unit's Case Mix Includes More Cases of Patient Abuse and Neglect**

The Unit should conduct outreach to potential sources of referrals, and work with existing sources to determine whether the Unit is receiving the appropriate referrals. Additionally, the Unit should consider revising its referral policy since it may not be receiving all appropriate patient abuse and neglect referrals because of this policy.

### **Ensure That Case Files Contain Supervisory Reviews**

The Unit should include documentation in its case files to demonstrate that supervisors conducted periodic reviews, as required by the performance standards. Use of the Joint Investigation Plan should help the Unit ensure that it has the appropriate documentation.

### **Appropriately Refer Individuals to OIG for Program Exclusion**

The Unit should refer convictions to OIG for purposes of program exclusion within 30 days of their sentencing, in accordance with Performance Standard 8(d) of the revised performance standards.

### **Ensure That Staff Receive at Least the Minimum Training Required in the Unit's Training Plan**

The Unit should ensure that staff are complying with the training requirements in the Unit's training plan. Staff should receive the required 3 hours of Medicaid training and 3 hours of False Claims Act training.



### **Change Its Supervisory Structure To Provide the Unit Director With Supervision of All Unit Staff and Oversight of All Its Caseload**

To ensure that the Unit is organized in such a manner to promote effective and efficient conduct of the Unit's activities, the Unit should reorganize its supervisory structure. Specifically, the Unit Director should be made the person primarily responsible for the hiring and termination, discipline, day-to-day case activities, and performance evaluations of all Unit staff, including all the detectives and False Claims Unit staff. The Unit Director could exercise this authority either as an immediate supervisor or through complete supervision of the existing first-line supervisors.

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## UNIT COMMENTS

The New Jersey Acting Attorney General, on behalf of the New Jersey Unit, concurred with the first four recommendations and described plans to implement each. In response to the fifth recommendation, the Unit did not specifically state whether it concurred.

The Unit concurred with our recommendation to take steps to ensure that its case mix includes more cases of patient abuse and neglect. The Unit stated that in June 2013 it implemented a revised policy for referral standards that it believes will result both in more appropriate cases being referred to the Unit and a better case mix.

The Unit also concurred with our recommendation to ensure that case files contain supervisory reviews. The Unit noted that it had recently updated the Joint Investigation Plan to include signature lines for the Unit Director and Assistant Section Chief, and that the Unit Director had instructed all Deputy Attorneys General that it must be used and brought to each monthly case review.

The Unit concurred with our recommendation to appropriately refer individuals to OIG for program exclusion. The Unit stated that it has taken steps to remedy the lag time and started sending notifications of court action to the regional OIG office at the time a defendant is sentenced or when the defendant has been accepted into a deferred sentence program. To ensure that this practice is uniformly followed, the Unit Director issued a written reminder to all Unit attorneys to submit timely notification to OIG of convictions.

The Unit concurred with our recommendation to ensure that staff receive at least the minimum training required in the Unit's training plan. The Unit described plans to offer in-house training on Medicaid fraud and training on the False Claims Act, and to require this training of all new hires as well as staff who have not completed this training in the past. The Unit also noted that it intends to send staff to NAMFCU training and to budget for future out-of-State training.

The Unit did not specifically state whether it concurred with our recommendation to change its supervisory structure to provide the Unit Director with supervision of all Unit staff and oversight of all of the Unit's caseload. The Unit stated that it believes that the supervision of the personnel within the Unit continues to be effective and that the current structure was put in place in order to respond to certain law enforcement issues. The Unit indicated that changing its structure will have a substantial impact upon how the Unit and other law enforcement areas operate within the State Attorney General's Office. It further noted that

during the next several months, in collaboration with other State agencies, it will review the supervisory structure of the Unit and strategize on how best to proceed in order to address the concerns raised, and will make modifications as needed. The Unit stated that it would notify OIG of any organizational changes. We ask that the Unit also more clearly indicate whether it concurs with this recommendation.

The full text of the Unit's comments is provided in Appendix F.

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## APPENDIX A

### **Performance Standards for Medicaid Fraud Control Units [59 Fed. Reg. 49080, Sept. 26, 1994]<sup>29</sup>**

- 1. A Unit will be in conformance with all applicable statutes, regulations, and policy transmittals.** In meeting this standard, the Unit must meet, but is not limited to, the following requirements:
  - a. The Unit professional staff must consist of permanent employees working full-time on Medicaid fraud and patient abuse matters.
  - b. The Unit must be separate and distinct from the single State Medicaid agency.
  - c. The Unit must have prosecutorial authority or an approved formal procedure for referring cases to a prosecutor.
  - d. The Unit must submit annual reports, with appropriate certifications, on a timely basis.
  - e. The Unit must submit quarterly reports on a timely basis.
  - f. The Unit must comply with the Americans with Disabilities Act, the Equal Employment opportunity requirements, the Drug Free workplace requirements, Federal lobbying restrictions, and other such rules that are made conditions of the grant.
  
- 2. A Unit should maintain staff levels in accordance with staffing allocations approved in its budget.** In meeting this standard, the following performance indicators will be considered:
  - a. Does the Unit employ the number of staff that was included in the Unit's budget as approved by [the Office of Inspector General (OIG)]?
  - b. Does the Unit employ the number of attorneys, auditors, and investigators that were approved in the Unit's budget?
  - c. Does the Unit employ a reasonable size of professional staff in relation to the State's total Medicaid program expenditures?
  - d. Are the Unit office locations established on a rational basis and are such locations appropriately staffed?
  
- 3. A Unit should establish policies and procedures for its operations, and maintain appropriate systems for case management and case tracking.** In meeting this standard, the following performance indicators will be considered:
  - a. Does the Unit have policy and procedure manuals?

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<sup>29</sup> For the June 1, 2012 performance standards, see:  
<https://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf>.

- b. Is an adequate, computerized case management and tracking system in place?
- 4. A Unit should take steps to ensure that it maintains an adequate workload through referrals from the single State agency and other sources.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit work with the single State Medicaid agency to ensure adequate fraud referrals?
  - b. Does the Unit work with other agencies to encourage fraud referrals?
  - c. Does the Unit generate any of its own fraud cases?
  - d. Does the Unit ensure that adequate referrals of patient abuse complaints are received from all sources?
- 5. A Unit's case mix, when possible, should cover all significant provider types.** In meeting this standard, the following performance indicators will be considered:
- a. Does the Unit seek to have a mix of cases among all types of providers in the State?
  - b. Does the Unit seek to have a mix of Medicaid fraud and Medicaid patient abuse cases?
  - c. Does the Unit seek to have a mix of cases that reflect the proportion of Medicaid expenditures for particular provider groups?
  - d. Are there any special Unit initiatives targeting specific provider types that affect case mix?
  - e. Does the Unit consider civil and administrative remedies when appropriate?
- 6. A Unit should have a continuous case flow, and cases should be completed in a reasonable time.** In meeting this standard, the following performance indicators will be considered:
- a. Is each stage of an investigation and prosecution completed in an appropriate time frame?
  - b. Are supervisors approving the opening and closing of investigations?
  - c. Are supervisory reviews conducted periodically and noted in the case file?
- 7. A Unit should have a process for monitoring the outcome of cases.** In meeting this standard, the following performance indicators will be considered:
- a. The number, age, and type of cases in inventory.
  - b. The number of referrals to other agencies for prosecution.
  - c. The number of arrests and indictments.
  - d. The number of convictions.

- e. The amount of overpayments identified.
- f. The amount of fines and restitution ordered.
- g. The amount of civil recoveries.
- h. The numbers of administrative sanctions imposed.

**8. A Unit will cooperate with OIG and other Federal agencies, whenever appropriate and consistent with its mission, in the investigation and prosecution of health care fraud.** In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit communicate effectively with OIG and other Federal agencies in investigating or prosecuting health care fraud in their State?
- b. Does the Unit provide OIG regional management, and other Federal agencies, where appropriate, with timely information concerning significant actions in all cases being pursued by the Unit?
- c. Does the Unit have an effective procedure for referring cases, when appropriate, to Federal agencies for investigation and other action?
- d. Does the Unit transmit to OIG, for purposes of program exclusions under section 1128 of the Social Security Act, reports of convictions, and copies of Judgment and Sentence or other acceptable documentation within 30 days or other reasonable time period?

**9. A Unit should make statutory or programmatic recommendations, when necessary, to the State government.** In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit recommend amendments to the enforcement provisions of the State's statutes when necessary and appropriate to do so?
- b. Does the Unit provide program recommendations to single State agency when appropriate?
- c. Does the Unit monitor actions taken by State legislature or State Medicaid agency in response to recommendations?

**10. A Unit should periodically review its memorandum of understanding (MOU) with the single State Medicaid agency and seek amendments, as necessary, to ensure it reflects current law and practice.** In meeting this standard, the following performance indicators will be considered:

- a. Is the MOU more than 5 years old?
- b. Does the MOU meet Federal legal requirements?
- c. Does the MOU address cross-training with the fraud detection staff of the State Medicaid agency?

- d. Does the MOU address the Unit's responsibility to make program recommendations to the Medicaid agency and monitor actions taken by the Medicaid agency concerning those recommendations?

**11. The Unit Director should exercise proper fiscal control over the Unit resources.**

In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit Director receive on a timely basis copies of all fiscal and administrative reports concerning Unit expenditures from the State parent agency?
- b. Does the Unit maintain an equipment inventory?
- c. Does the Unit apply generally accepted accounting principles in its control of Unit funding?

**12. A Unit should maintain an annual training plan for all professional disciplines.**

In meeting this standard, the following performance indicators will be considered:

- a. Does the Unit have a training plan in place and funds available to fully implement the plan?
- b. Does the Unit have a minimum number of hours training requirement for each professional discipline, and does the staff comply with the requirement?
- c. Are continuing education standards met for professional staff?
- d. Does the training undertaken by staff aid in the mission of the Unit?

## APPENDIX B

### Referrals of Patient Abuse and Neglect, Provider Fraud, and Theft of Patient Funds to the Medicaid Fraud Control Unit by Source, Fiscal Years 2010 through 2012

**Table B-1: Total Referrals of Patient Abuse and Neglect, Provider Fraud, and Theft of Patient Funds to the Medical Fraud Control Unit and Annual Average Referrals**

Case Type	Fiscal Year (FY) 2010	FY 2011	FY 2012	3-Year Total	Annual Average
Patient Abuse and Neglect	39	17	14	70	23
Provider Fraud	25	50	135	210	70
Theft of Patient Funds	69	33	17	119	40
<b>Total</b>	<b>133</b>	<b>100</b>	<b>166</b>	<b>399</b>	<b>133</b>

Source: Office of Inspector General (OIG) analysis of New Jersey Medicaid Fraud Control Unit (Unit) data, 2013.

**Table B-2: Unit Referrals, by Referral Source**

Referral Source	FY 2010			FY 2011			FY 2012			Total	Percentage of All Referrals
	Fraud	Abuse and Neglect	Theft of Patient Funds	Fraud	Abuse and Neglect	Theft of Patient Funds	Fraud	Abuse and Neglect	Theft of Patient Funds		
State Survey and Certification	0	38	25	2	14	21	4	7	2	113	31.2
Private Citizens	13	1	7	18	3	4	41	1	5	93	25.7
Long-Term Care Ombudsman	0	0	32	0	0	7	0	1	4	44	12.2
State Medicaid Agency	1	0	1	12	0	0	22	1	1	38	10.5
Unit Hotline	2	0	0	3	0	0	17	0	2	24	6.6
Other State Agencies	0	0	1	3	0	0	11	1	0	16	4.4
Providers	1	0	2	2	0	0	3	0	0	8	2.2
Licensing Board	0	0	0	3	0	0	4	0	1	8	2.2
OIG	0	0	0	1	0	0	2	1	0	4	1.1
Outside Prosecutors	2	0	0	1	0	0	0	0	1	4	1.1
Law Enforcement	0	0	0	0	0	0	0	1	0	1	0.3
Private Health Insurers	0	0	0	0	0	0	0	0	0	0	0.0
Provider Associations	0	0	0	0	0	0	0	0	0	0	0
Adult Protective Services	0	0	0	0	0	0	0	0	0	0	0
Other	3	0	0	1	0	0	4	1	0	9	2.5
<b>Total</b>	<b>25</b>	<b>39</b>	<b>69</b>	<b>50</b>	<b>17</b>	<b>33</b>	<b>135</b>	<b>14</b>	<b>17</b>	<b>362</b>	<b>100</b>

Source: OIG analysis of Unit data, 2013.



## APPENDIX C

### Cases Opened and Closed by Provider Category and Case Type, Fiscal Years 2010 through 2012

**Table C-1: Total Annual Opened and Closed Cases, by Case Type**

Case Type	Fiscal Year (FY) 2010	FY 2011	FY 2012	3-Year Total	Annual Average
Opened	191	157	358	706	235
Patient Abuse and Neglect	39	17	15	71	24
Provider Fraud	83	106	326	515	172
Theft of Patient Funds	69	34	17	120	40
Closed	142	138	366	646	215
Patient Abuse and Neglect	28	28	31	87	29
Provider Fraud	56	58	251	365	122
Theft of Patient Funds	58	52	84	194	65

Source: Office of Inspector General (OIG) analysis of New Jersey Medicaid Fraud Control Unit (Unit) data, 2013.

**Table C-2: Outcomes for Closed Cases, by Case Type**

Type of Investigations	Closed by Prosecution			Closed by Civil Action			Closed due to Insufficient evidence			Closed by Referral		
	FY 2010	FY 2011	FY 2012	FY 2010	FY 2011	FY 2012	FY 2010	FY 2011	FY 2012	FY 2010	FFY 2011	FY 2012
Investigations of Fraud	11	12	10	15	11	14	29	30	159	3	3	68
Investigations of Patient Abuse and Neglect	3	1	0	0	0	0	25	27	22	0	0	9
Investigation of Theft of Patient Funds	5	4	4	0	0	0	41	54	46	6	0	34
<b>Total Investigations</b>	<b>19</b>	<b>17</b>	<b>14</b>	<b>15</b>	<b>11</b>	<b>14</b>	<b>95</b>	<b>111</b>	<b>227</b>	<b>9</b>	<b>3</b>	<b>111</b>

Source: OIG analysis of Unit data, 2013.

**Table C-3: Provider Fraud Cases Opened and Closed, by Provider Type**

Provider Type	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
<b>Facilities</b>						
Hospitals	1	0	1	1	1	3
Nursing Facilities	0	1	0	0	7	10
Other Long-Term Care Facilities	0	0	0	0	1	1
Substance Abuse Treatment Centers	0	0	0	1	4	3
Other Facilities	5	6	10	1	8	17
<b>Practitioners</b>						
Doctors of Medicine or Osteopathy	7	7	9	6	39	45
Dentists	2	1	4	2	8	10
Optometrists/Opticians	0	0	0	0	2	1
Other Practitioners	0	0	2	0	1	4
Counselors/Psychologists	0	0	0	0	0	0
Podiatrists	0	0	0	0	0	0
<b>Medical Support</b>						
Home Health Care Aides	1	0	0	0	2	3
Other Medical Support	0	2	1	4	1	2
Pharmaceutical Manufacturers	0	0	0	0	0	0
Durable Medical Equipment Suppliers	0	0	5	0	7	9
Transportation Services	0	0	1	2	4	4
Pharmacies	11	18	15	16	6	21
Laboratories	0	0	0	0	2	2
Home Health Care Agencies	0	0	6	2	4	7
Nurses/Physician's Assistants/ Nurse Practitioners/Certified Nurse Aides	0	0	1	1	1	2
Radiologists	0	1	1	0	1	2
<b>Program Related</b>						
Managed Care	0	0	0	0	0	0
Medicaid Program Administration	0	0	0	0	0	0
Billing Companies	0	2	1	1	0	0
Other Program Related	2	2	1	2	56	45
<b>Other</b>						
Global	54	16	48	19	171	60
<b>Total</b>	<b>83</b>	<b>56</b>	<b>106</b>	<b>58</b>	<b>326</b>	<b>251</b>

Source: OIG analysis of Unit data, 2013.

**Table C-4: Cases of Patient Abuse and Neglect Opened and Closed, by Provider Type**

Provider Type	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Nursing Facilities	6	2	2	2	4	8
Other Long-Term Care	0	0	0	0	2	4
Nurses/ Physician's Assistants/ Nurse Practitioners/ Certified Nurse Aides	22	18	11	17	6	14
Home Health Aides	3	2	1	1	0	1
Other	8	6	3	8	3	4
<b>Total</b>	<b>39</b>	<b>28</b>	<b>17</b>	<b>28</b>	<b>15</b>	<b>31</b>

Source: OIG analysis of Unit data, 2013.

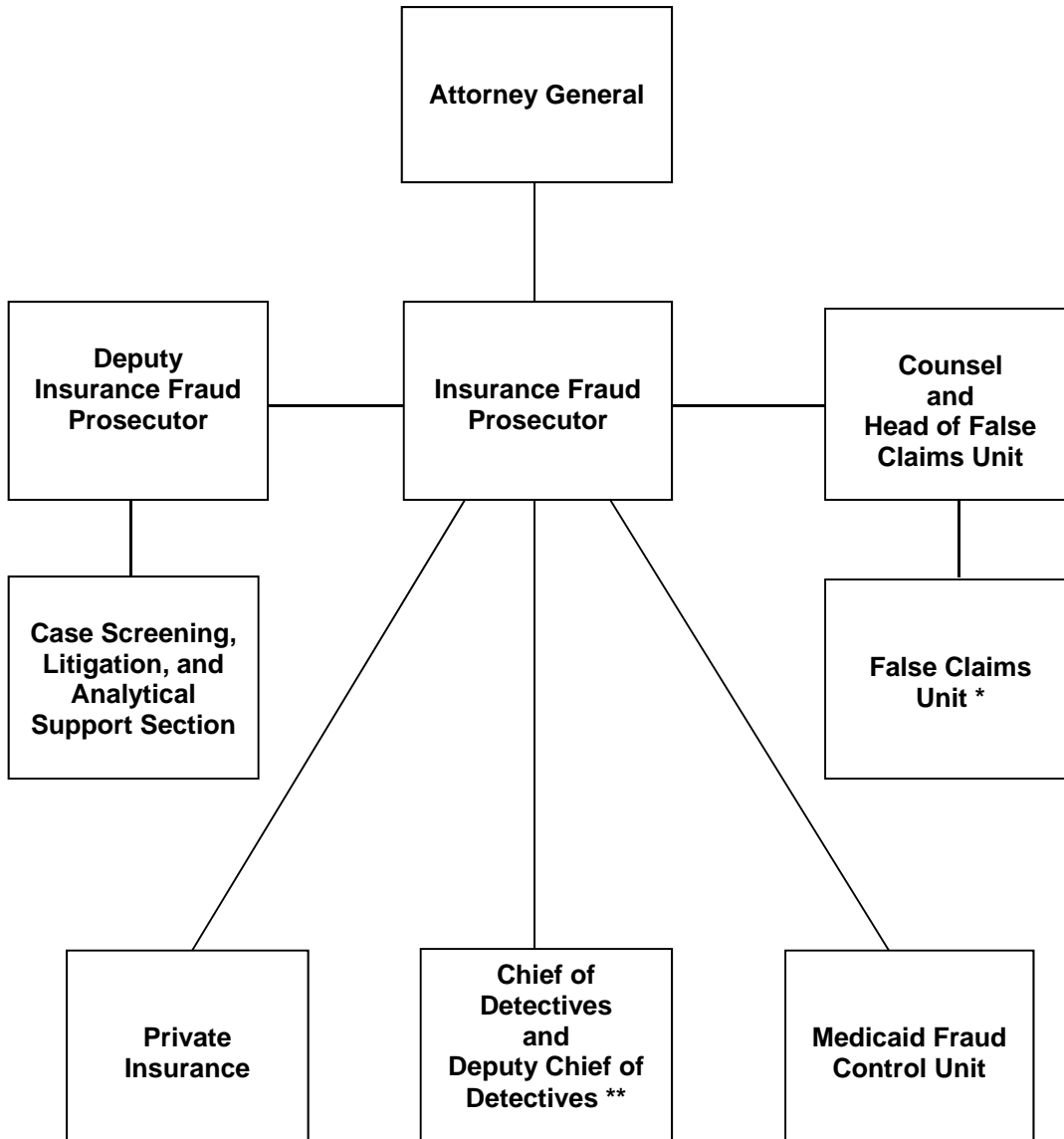
**Table C-5: Cases of Theft of Patient Funds Opened and Closed, by Provider Type**

Provider Type	FY 2010		FY 2011		FY 2012	
	Opened	Closed	Opened	Closed	Opened	Closed
Non-Direct Care	3	1	1	1	1	5
Nurses/ Physician's Assistants/ Nurse Practitioners/ Certified Nurse Aides	10	6	5	5	2	9
Home Health Aides	0	0	0	0	0	0
Other	56	51	28	46	14	70
<b>Total</b>	<b>69</b>	<b>58</b>	<b>34</b>	<b>52</b>	<b>17</b>	<b>84</b>

Source: OIG analysis of Unit data, 2013.

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**APPENDIX D**  
**Organizational Chart**



Source: New Jersey Medicaid Fraud Control Unit, 2012.

\* Staff at the False Claims Unit are MFCU staff.

\*\* The Chief of Detectives and Deputy Chief of Detectives are not MFCU staff; however, they oversee the MFCU detectives and Private Insurance detectives.

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## APPENDIX E

### Confidence Intervals for Estimates

**Table D-1: Confidence Intervals for Key Data from Case File Review**

<b>Estimate Description</b>	<b>Sample Size</b>	<b>Point Estimate</b>	<b>95-Percent Confidence Interval</b>
Case Files With Opening Documents	100	91.0%	84.0–95.1%
Case Files With Closing Documents	68	97.1%	89.5–99.2%
Case Files With No Documentation Indicating at Least One Supervisory Review (Does Not Include Global Cases or Cases Opened and Closed on the Same Day)	50	50.0%	36.9–63.1%

## APPENDIX F

### Unit Comments



CHRIS CHRISTIE  
*Governor*

KIM GUADAGNO  
*Lt. Governor*

*State of New Jersey*  
OFFICE OF THE ATTORNEY GENERAL  
DEPARTMENT OF LAW AND PUBLIC SAFETY  
PO BOX 080  
TRENTON, NJ 08625-0080

JOHN J. HOFFMAN  
*Acting Attorney General*

JENNIFER E. FRADEL  
*Administrator*

August 19, 2013

Mr. Stuart Wright  
Deputy Inspector General For Evaluations and Inspections  
Office of the Inspector General  
Room 5660, Cohen Building  
330 Independence Avenue, SW  
Washington, DC 20201

Re: New Jersey Medicaid Fraud Unit: 2013 Onsite Review, OEI-02-13-00020

Dear Mr. Wright,

Thank you for the opportunity to respond to the Office of the Inspector General (OIG) 2013 Onsite Review, OEI-02-13-00020. The New Jersey Office of the Attorney General recognizes and greatly respects the role of the OIG, and has taken this review as an opportunity to improve our Unit as a whole, with emphasis on the areas recommended in the report. We appreciate the diligence and insight the OIG staff has shown during this review process, and we look forward to continuing the professional and constructive relationship we have developed.

The Office of the Inspector General has requested our comments on each of the recommendations in the report. It has been asked that our comments include whether we concur with the recommendation and statements in the report, along with the actions and any timelines associated with actions taken as a result of the recommendations.

In the enclosed response, we have included the summary recommendation from the Onsite Review; our plan to comply with the recommendation; and our plan to implement the changes for each recommendation noted. Please do not hesitate to contact me if you have any questions or need additional information.

Sincerely,

/s/

John J. Hoffman  
Acting Attorney General



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c: Jennifer Fradel, Administrator  
Ronald Chillemi, Acting Insurance Fraud Prosecutor  
Joshua Lichtblau, Assistant Attorney General  
Nicolo Rizzolo, NJMFCU Director  
Peter Traum, Director of Strategic Planning  
Kathlyn Bender, Supervising Administrative Analyst

Enclosure

## New Jersey Medicaid Fraud Control Unit: 2013 Onsite Review

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### **Recommendation:**

*Take Steps to Ensure That the Unit's Case Mix Includes More Cases of Patient Abuse and Neglect - The Unit should conduct outreach to potential sources of referrals, and work with existing sources to determine whether the Unit is receiving the appropriate referrals. Additionally, the Unit should consider revising its referral policy since it may not be receiving all appropriate patient abuse and neglect referrals because of this policy.*

### **Response:**

We concur with the recommendation. To address this decline in referrals, MFCU leadership revised the referral policy.

### **Analysis:**

The MFCU is part of the Office of the Insurance Fraud Prosecutor (OIFP). In November 2011, OIFP revised its criminal case selection criteria to focus its efforts on aggressively prosecuting "Statement Cases." Statement Cases are cases that involve one or more of the following: significant dollar amount (fraud amount), significant target (by identity or profession), potential for significant deterrent message, significant fraud type or topical area, model case for counties to replicate, other facts on case-by-case basis. Consistent with OIFP's criminal case selection criteria, MFCU issued revised standards for the referral of patient abuse and neglect cases to the Office of the Ombudsman for the Institutionalized Elderly in April 2012 and to the New Jersey Department of Health in May 2012. The standards are outlined in the Onsite Review Report.

### **Plan:**

MFCU's implementation of revised referral standards in April/May 2012 caused the number of patient abuse and neglect cases referred to MFCU to decline. To address that decline, when the MFCU Director, Nurse Investigator, a Sergeant and the Deputy Insurance Fraud Prosecutor met with the Ombudsman, Office of the Ombudsman for the Institutionalized Elderly and the Program Manager, Long Term Care Complaints from the New Jersey Department of Health in June 2013 at the Quarterly Patient Abuse and Neglect meeting, MFCU leadership included as an agenda topic the revision of the referral standards with a goal of increasing referrals of patient abuse and neglect cases. From that discussion, MFCU leadership decided to relax its referral standards and implemented a revised referral standard policy later in June 2013. The new referral standards include serious criminal abuse and neglect cases that are medically documented or witnessed by someone other than the alleged victim and which, based on experience, are better handled by the State. The new standards also include financial exploitation that does not involve family members and where the loss is in excess of \$50,000, and cases that are indicative of a pattern of abuse or neglect at a particular facility. We believe that these changes will result in more appropriate cases being referred to the Unit, and a better case mix as recommended in the report.



## New Jersey Medicaid Fraud Control Unit: 2013 Onsite Review

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### **Recommendation:**

*Ensure That Case Files Contain Supervisory Reviews - The Unit should include documentation in its case files to demonstrate that supervisors conducted periodic reviews, as required by the performance standards. Use of the Joint Investigation Plan should help the Unit ensure that it has the appropriate documentation.*

### **Response:**

We concur with the recommendation. We agree that use of the Joint Investigation Plan should help the Unit ensure that it has the appropriate documentation.

### **Analysis:**

The reviewers found that 91% of the Unit's case files had an opening memorandum and 97% of the Unit's case files had a closing memorandum in accordance with Performance Standard 6. Performance Standard 6 also mandates that supervisory reviews be "conducted periodically and noted in the case file" to ensure timely case completion. The Unit Director conducts monthly Case Reviews with all DAsG. At the monthly Case Review, all cases assigned to each DAG are discussed in detail. The DAsG bring completed Joint Investigation Plans (JIPs), which are updated and signed by the assigned DAG, assigned Detective and Unit Lieutenant every thirty (30) days, to Case Review. The reviewers identified the JIP as a "supervisory review document" and a "case management tool that benefitted the Unit - a joint investigation plan that continually monitors progress of its investigations." The reviewers were provided with the Unit's monthly Case Review schedule.

In addition to monthly Case Reviews of the Unit's entire docket, the Unit Director, Lieutenant and Supervising Sergeant meet every two (2) weeks with the Acting and Deputy Insurance Fraud Prosecutors to discuss the status and progress of the top three (3) priority cases assigned to each DAG. In preparation for the meeting, the Unit Director meets with the assigned DAsG and prepares a detailed chart that is distributed to those attending the Top 3 meeting.

### **Plan:**

The Unit recently updated the Joint Investigation Plan to include signature lines for the Unit Director and Assistant Section Chief. The Unit Director instructed all DAsG that the revised JIP must be used and brought to each monthly Case Review. The Unit Director or Assistant Section Chief will sign the JIP at the Case Review and provide copies of same to the Unit secretary. The Unit secretary will scan the signed JIP into the Unit's electronic case database, InfoShare.

### **Recommendation:**

*Refer individuals for the purpose of program exclusion to OIG appropriately. According to Performance standard 8(d), the Unit must send reports of convictions to OIG "within 30 days or other reasonable time period" for the purpose of excluding providers and non providers from*

## New Jersey Medicaid Fraud Control Unit: 2013 Onsite Review

*participation in Federally-funded healthcare programs, including Medicare and Medicaid. Excluded healthcare providers may no longer receive payment for items or services provided, ordered or prescribed. Non-healthcare providers convicted of patient abuse, neglect or financial exploitation may no longer provide care.*

### **Response:**

We concur with the recommendation.

### **Analysis:**

Based on prior practice, the MFCU had been sending notice of convictions to the regional OIG office after MFCU has received (I) all necessary documentation from the Superior Court where the conviction occurred, and (II) the transcript memorializing such conviction from the appropriate independent transcription service. Due to delays in receiving one or both parts of this package (documentation from the Court or transcript from the transcription company), the NJ MFCU often failed to report convictions to OIG within the 30 day time frame. The NJ MFCU acknowledges that the past practice of waiting for an entire file to be assembled, before sending it as a whole, has resulted in untimely notice of convictions.

### **Plan:**

The NJ MFCU has taken steps to remedy the lag time that it has experienced in sending notices of conviction to OIG. As of January, 2013, the Unit has sent the regional OIG office notifications of court action at the time a defendant is sentenced or when the defendant has been accepted into a deferred sentence program. As part of this practice, the Unit has transmitted all relevant documentation that is available at the time of sentencing to OIG along with the notification of conviction. Additional documentation is being sent as it is received by the Unit after the date of sentencing. To ensure that this practice is uniformly followed, Unit Director Rizzolo issued a written reminder to all MFCU attorneys that they must submit timely notification to OIG of convictions.

### **Recommendation:**

*Ensure That Staff Receive at Least the Minimum Training Required in the Unit's Training Plan - The Unit should ensure that staff are complying with the training requirements in the Unit's training plan. Staff should receive the required 3 hours of Medicaid training and 3 hours of False Claims Act training.*

### **Response:**

We concur with the recommendation.

## New Jersey Medicaid Fraud Control Unit: 2013 Onsite Review

### Analysis:

As Footnote 26 indicates, the reviewers did not evaluate the Unit staff's professional qualifications and the fact that not all Unit staff met the training requirements during the review period does not suggest that professional staff are unqualified. Two of the Unit Detectives were assigned to the Unit after the in-house Medicaid training was offered in calendar year 2012 and will receive this training when it is presented this calendar year. Although the DAsG and Detectives assigned to the False Claims Act (FCA) Unit did not receive the full 3 hours of training outlined in the Unit's training policy, DAsG and Detectives assigned to the FCA Unit attended training on FCA electronic billing at the National Association of Medicaid Fraud Control Unit's (NAMFCU) Annual Training in New York, New York in October 2012.

### Plan:

The New Jersey MFCU has a written training policy, and a staff member maintains a calendar year spreadsheet that details, by discipline, all training (course title, date, number of hours) attended by Unit personnel. In-house Medicaid Fraud training and FCA training will be offered before December 2013. Attendance will be required for all new hires and staff that have not completed this training in the past.

All members of the Unit have submitted applications to attend Medicaid 101 and Medicaid 102 training sponsored by NAMFCU. As of July 2013, 6 members of the Unit have attended NAMFCU-sponsored training in calendar year 2013. The Unit intends to send students to NAMFCU's Medicaid 102 training in September 2013, and NAMFCU's Annual Training Program in October 2013. The Unit has appropriately budgeted for future out-of-state training.

We agree that adequate staff training is necessary in order to assure that the Unit functions efficiently. Accordingly, we plan to meet or exceed the training requirements for the current year, and continue to do so going forward.

### Recommendation

***Change its Supervisory Structure To Provide the Unit Director with Supervision of All Unit Staff and Oversight of All Its Caseload*** – *To ensure that the Unit is organized in such a manner to promote effective and efficient conduct of the Unit's activities, the Unit should reorganize its supervisory structure. Specifically, the Unit Director should be made the person primarily responsible for the hiring and termination, discipline, day-to-day case activities, and performance evaluations of all Unit staff, including all the detectives and False Claims Unit staff. The Unit Director could exercise this authority either as an immediate supervisor or through complete supervision of the existing first-line supervisors.*

### Response:

Although we believe that the supervision of the personnel within NJMFCU continues to be effective, we appreciate the concerns expressed in the above recommendation. We do note that

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the current structure was put in place in order to respond to certain law enforcement issues as described below.

### **Plan:**

The current supervisory structure is in place in order to deal with concerns, such as sworn law enforcement personnel understanding and respecting a chain of command within the ranks; the use of appropriate law enforcement performance evaluation standards and methods; and the development and implementation of law enforcement protocols, including internal affairs processes. Changing our structure to conform to this recommendation will have a substantial impact upon how NJMFCU and other law enforcement areas operate within the New Jersey Attorney General's Office. Any such changes must be implemented in a manner that addresses all concerns in an appropriate manner. Accordingly, during the next several months, the NJ Office of the Attorney General, the NJ Office of Insurance Fraud Prosecutor, the Medicaid Fraud Control Unit and other areas of the NJ Department of Law and Public Safety will review the supervisory structure of the Unit and strategize on how best to proceed in order to address the concerns raised, and will make modifications as needed. We will notify the OIG of any changes, and provide new organization charts for their files.

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## ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Judy Kellis and Vincent Greiber served as the team leaders for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Lucia Fort and Jennifer Karr. Central office staff who provided support include Thomas Brannon, Kevin Farber, Christine Moritz, and Sherri Weinstein. Office of Audit Services staff who provided support include Julio Agosto, Paul Lee, and Dain Wisdom. Office of Investigations staff who provided support include Kerri Navarro.

# Office of Inspector General

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