Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW JERSEY GENERALLY REPORTED MEDICAID OVERPAYMENTS IN ACCORDANCE WITH FEDERAL REGULATIONS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In New Jersey, the Department of Human Services (State agency) administers the Medicaid program. The State agency uses a statewide surveillance and utilization control program to safeguard against unnecessary or inappropriate use of Medicaid services and excess payments. In March 2009, the State agency's program integrity functions, including audits of Medicaid providers, were transferred to the Office of the Medicaid Inspector General. The Medicaid Fraud Control Unit also conducts audits and investigations of Medicaid providers, and the Department of Health and Senior Services conducts audits of institutional providers. When these agencies identify overpayments, they send letters to the providers that (1) identify the overpayment amount and (2) direct the providers to send payment to the State agency or notify the providers of future payment offsets. Providers are notified of overpayment amounts related to fraud and abuse through settlement agreements and court decisions.

Section 1903(d)(2) of the Act requires the State to refund the Federal share of a Medicaid overpayment. Implementing regulations (42 CFR § 433.312) require the State agency to refund the Federal share of an overpayment to a provider at the end of the 60-day period following the date of discovery, whether or not the State agency has recovered the overpayment. The date of discovery for situations other than fraud or abuse is the date that a provider was first notified in writing of an overpayment and the specified dollar amount subject to recovery (42 CFR § 433.316(c)). For provider overpayments resulting from fraud or abuse, discovery occurs on the date of the State's final written notice of the overpayment determination (42 CFR § 433.316(d)). Federal regulations (42 CFR § 433.304) define an overpayment as "… the amount paid by a Medicaid agency to a provider in excess of the amount that is allowable for the services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." Because the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64, is due on a quarterly basis, the CMS *State Medicaid Manual* requires the Federal share of the overpayments be reported no later than the quarter in which the 60-day period ends.

OBJECTIVE

Our objective was to determine whether the State agency reported Medicaid overpayments on the CMS-64 in accordance with Federal regulations.

SUMMARY OF FINDINGS

The State agency generally reported Medicaid overpayments in accordance with Federal requirements. However, it did not report all of them in accordance with Federal requirements. For Federal fiscal years 2008 and 2009, the State agency did not report Medicaid overpayments totaling $2,812,968 ($1,406,486 Federal share) in accordance with Federal requirements.

Of the 180 overpayments we reviewed, 14 were partially reported or not reported on the CMS-64. The remaining 166 were reported correctly. The State agency also did not report all Medicaid provider overpayments within the 60-day time requirement. The State agency did not properly report these overpayments because it had not developed and implemented policies to ensure that overpayments were reported on the correct CMS-64.

RECOMMENDATIONS

We recommend that the State agency:

- include unreported Medicaid overpayments of $2,812,968 on the CMS-64 and refund $1,406,486 to the Federal Government and

- develop and implement policies to ensure that future Medicaid overpayments are reported on the correct CMS-64 in accordance with Federal requirements.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency partially agreed with our first recommendation and concurred with our second recommendation. Specifically, the State agency agreed with our findings related to five overpayments and disagreed with the remaining nine overpayments. Regarding our second recommendation, the State agency indicated that it intends to create and implement policies to ensure that future Medicaid overpayments are reported on the correct CMS-64 in accordance with Federal requirements. The State agency's comments are included as the Appendix.

After reviewing the State agency's comments and additional documentation that it subsequently provided, we revised our findings and recommendations as appropriate. We maintain that the State agency should include unreported Medicaid overpayments of $2,812,968 on the CMS-64 and refund $1,406,486 to the Federal Government.

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STATE AGENCY COMMENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share (Federal share) of State Medicaid expenditures according to a defined formula. To receive Federal reimbursement, State Medicaid agencies are required to report expenditures on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, Form CMS-64 (CMS-64).

In New Jersey, the Department of Human Services (State agency) administers the Medicaid program. The State agency used a statewide surveillance and utilization control program to safeguard against unnecessary or inappropriate use of Medicaid services and excess payments.[1] In March 2009, the State agency's program integrity functions, including audits of Medicaid providers, were transferred to the Office of the Medicaid Inspector General (OMIG).[2] Further, the Medicaid Fraud Control Unit (MFCU) also conducts audits and investigations of Medicaid providers, and the Department of Health and Senior Services conducts audits of institutional providers. When these agencies identify overpayments, they send letters to the providers that (1) identify the overpayment amount and (2) direct the providers to send payment to the State agency or notify the providers of future payment offsets. Providers are notified of overpayment amounts related to fraud and abuse through settlement agreements and court decisions.

Federal Requirements for Medicaid Overpayments

The Federal Government does not participate financially in Medicaid payments for excessive or erroneous expenditures. Section 1903(d)(2)(A) of the Act requires the Secretary of Health and Human Services to recover the amount of a Medicaid overpayment. Federal regulations (42 CFR § 433.304) define an overpayment as "… the amount paid by a Medicaid agency to a provider in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act." A State has 60 days from the discovery of a Medicaid overpayment to a provider to recover or attempt to recover the overpayment before the Federal share of the overpayment must be refunded to

[1] Overpayments to hospitals are identified by the State agency through reviews of hospital cost report filings.

[2] OMIG's duties and functions were transferred in June 2010 to the Office of the State Comptroller's Medicaid Fraud Division.

CMS.[3] Section 1903(d)(2)(C) of the Act, as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985, and Federal regulations at 42 CFR part 433, subpart F, require a State to refund the Federal share of overpayments at the end of the 60-day period following discovery whether or not the State has recovered the overpayment from the provider.[4] Pursuant to 42 CFR § 433.316(c), an overpayment that is not a result of fraud or abuse is discovered on the earliest date:

> (1) ... on which any Medicaid agency official or other State official first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery; (2) ... on which a provider initially acknowledges a specific overpaid amount in writing to the Medicaid agency; or (3) ... on which any State official or fiscal agent of the State initiates a formal action to recoup a specific overpaid amount from a provider without having first notified the provider in writing.

Pursuant to 42 CFR § 433.316(d), an overpayment resulting from fraud or abuse is discovered on the date of the final written notice of the State's overpayment determination that a Medicaid agency official or other State official sends to the provider. For overpayments identified through Federal reviews, 42 CFR § 433.316(e) provides that an overpayment is discovered when the Federal official first notifies the State in writing of the overpayment and the dollar amount subject to recovery.

Federal regulations (42 CFR § 433.320) require that the State refund the Federal share of an overpayment on its quarterly Form CMS-64. Provider overpayments must be credited on the CMS-64 submitted for the quarter in which the 60-day period following discovery ends.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency reported Medicaid overpayments on the CMS-64 in accordance with Federal regulations.

Scope

Our review covered Medicaid provider overpayments that were identified in audit reports, settlement agreements, court decisions, and overpayment letters issued to providers that should have been reported on the CMS-64 during Federal fiscal years (FY) 2008 and 2009. We also reviewed overpayments partially reported during our audit period that were identified by the

[3] Effective March 23, 2010, section 6506 of the Patient Protection and Affordable Care Act (P.L. No. 111-148) provides an extension period for the collection of overpayments. Except in the case of overpayments due to fraud, States have up to 1 year from the date of discovery of a Medicaid overpayment to recover, or to attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment. For overpayments identified before the effective date, the previous rules on discovery of overpayments remain in effect.

[4] Section 1903(d)(2)(C) and (D) of the Act and Federal regulations (42 CFR § 433.312) do not require the State to refund the Federal share of uncollectable amounts paid to bankrupt or out-of-business providers.

State agency prior to our audit period. We reviewed a total of 180 overpayments totaling $97,085,221.[5]

We did not review the overall internal control structure of the State agency. We limited our internal control review to obtaining an understanding of the identification, collection, and reporting policies and procedures for Medicaid overpayments.

We performed fieldwork at the State agency's, OMIG's, and the Department of Health and Senior Services' offices in Trenton, New Jersey.

Methodology

To accomplish our audit objective, we:

- reviewed Federal laws, regulations, and CMS *State Medicaid Manual* provisions governing Medicaid overpayments;
- interviewed State officials regarding policies and procedures relating to Medicaid overpayments subject to the 60-day rule and reporting overpayments on the CMS-64;
- identified 180 overpayments for Medicaid services subject to the 60-day rule, which totaled $97,085,221;
- established the dates of discovery using the dates that the State notified Medicaid providers in writing of the overpayments and the dollar amount subject to recovery;
- established dates of discovery using the date of settlement agreements and court decisions;
- determined the quarter in which the 60-day period following discovery of the overpayment ended;
- reviewed documentation from the State agency, OMIG, the Department of Health and Senior Services, and MFCU to determine whether Medicaid overpayments were reported;
- reviewed the CMS-64 to determine whether the Medicaid overpayments were reported within the quarter in which the 60-day period following discovery ended;
- reviewed the CMS-64 to determine whether Medicaid overpayments were reported during any subsequent quarter through March 31, 2010;
- calculated the value of the overpayments that were not reported; and

[5] The identified audit reports, settlement agreements, court decisions, and overpayment letters represent overpayments that were subject to the 60-day rule.

- determined whether providers associated with unreported overpayments were bankrupt or out of business.

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 objective.

FINDINGS AND RECOMMENDATIONS

The State agency generally reported most Medicaid overpayments in accordance with Federal requirements. However, it did not report all of them in accordance with Federal requirements. For Federal FYs 2008 and 2009, the State agency did not report Medicaid overpayments totaling $2,812,968 ($1,406,486 Federal share) as of March 31, 2010, in accordance with Federal requirements.

Of the 180 overpayments we reviewed, 14 were partially reported or not reported on the CMS-64. The remaining 166 were correctly reported. Further, the State agency also did not report all Medicaid provider overpayments within the 60-day time requirement. The State agency did not properly report these overpayments because it had not developed and implemented policies to ensure that overpayments were reported on the correct CMS-64.

OVERPAYMENTS NOT REPORTED

Pursuant to 42 CFR § 433.312(a)(2), the State agency "… must refund the Federal share of overpayments at the end of the 60-day period following discovery … whether or not the State has recovered the overpayment from the provider." The regulation provides an exception only when the State is unable to recover the overpayment amount because the provider is bankrupt or out of business (42 CFR § 433.318).

For Federal FYs 2008 and 2009, the State agency did not report Medicaid overpayments in accordance with Federal requirements. Of the 180 overpayments that we reviewed, 14 overpayments, totaling $2,812,968 ($1,406,486 Federal share), were partially reported or not reported on the CMS-64.[6]

OVERPAYMENTS NOT REPORTED TIMELY

Pursuant to 42 CFR § 433.312(a)(2), the State agency "... must refund the Federal share of overpayments at the end of the 60-day period following discovery ... whether or not the State has recovered the overpayment from the provider." For situations other than fraud and abuse, Federal regulations (42 CFR § 433.316(c)) define the date of discovery as the date that a provider was first notified in writing of an overpayment and the specified dollar amount subject to recovery. For overpayments resulting from fraud or abuse, the date of discovery is defined at

[6] Figures are adjusted to reflect portions of partially reported overpayments that were not reported. For these overpayments, the State agency reported only the portion collected—not the amount of the entire overpayment.

42 CFR § 433.316(d) as the date of the final written notice of the overpayment determination that the State sends to the provider. These regulations do not allow for extending the date.

During our review, the Federal regulation was changed to extend the 60 days to 1 year; however, the effective date of the change was after our audit period. During our audit period, the State agency did not report all Medicaid provider overpayments in accordance with the 60-day requirement. Of the 180 overpayments we reviewed, the State agency reported 176 overpayments on the CMS-64, which included 10 overpayments that were only partially reported. For the 176 overpayments that were reported, 42 overpayments totaling $552,813 ($276,427 Federal share) were not reported on the CMS-64 at the end of the 60-day period. The State agency did not report these payments on the correct CMS-64 because it used the date that it collected the overpayment to report the collection—not the end of the 60-day period following the date of discovery. This occurred because the State agency did not have policies to address reporting overpayments on the correct CMS-64.

RECOMMENDATIONS

We recommend that the State agency:

- include unreported Medicaid overpayments of $2,812,968 on the CMS-64 and refund $1,406,486 to the Federal Government and

- develop and implement policies to ensure that future Medicaid overpayments are reported on the correct CMS-64 in accordance with Federal requirements.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency partially agreed with our first recommendation and concurred with our second recommendation. Specifically, the State agency agreed with our findings related to five overpayments and disagreed with the remaining nine overpayments. Regarding our second recommendation, the State agency indicated that it intends to create and implement policies to ensure that future Medicaid overpayments are reported on the correct CMS-64 in accordance with Federal requirements. The State agency's comments are included as the Appendix.

After reviewing the State agency's comments and additional documentation that it subsequently provided, we revised our findings and recommendation as appropriate. We maintain that the State agency should include unreported Medicaid overpayments of $2,812,968 on the CMS-64 and refund $1,406,486 to the Federal Government.[7]

[7] This amount includes $16,128 ($8,066 Federal share) related to the five overpayments that the State agency agreed with.

Incorrect Overpayment Amount

State Agency Comments

The State agency indicated that, for one overpayment, the correct overpayment amount was $2,803, not $4,880.

Office of Inspector General Response

We are not questioning the overpayment amount of $2,803, which was correctly reported. However, the State agency should have included an additional overpayment of $4,881[8] on the CMS-64 and refunded the Federal share of $2,440 to the Federal Government.

Court-Ordered Payments

State Agency Comments

The State agency commented on four court-ordered payments questioned in our draft report. Specifically, the State agency stated that:

- One overpayment totaling $5,500 ($2,750 Federal share) was related to a court order that was not reported on the CMS-64 because these funds were not collected from the associated individual.

- A second overpayment totaling $13,502 ($6,451 Federal share)[9] was related to an employee ordered by a court to pay restitution to the State agency; therefore, the Federal Government is entitled to receive its share of the overpayment as the State collects it.

- A third overpayment involving a court order totaling $51,826 ($25,913 Federal share) was repaid in 2010 to a court, but the court failed to forward $7,763 of that amount to the State, which the State agency still owes to the Federal Government. The State agency implied that it refunded the difference to the Federal Government.

- A fourth overpayment totaling $5,500 ($2,750 Federal share) was a court-ordered fine that was not payable to the State agency.

Office of Inspector General Response

Pursuant to 42 CFR § 433.312, the full amount of the Federal share of the overpayment to the provider should be refunded to CMS within the statutory timeframe, whether or not the State has recovered the full amount of the overpayment from the provider who submitted the claims. This

[8] The difference between the State agency's amount ($4,880) and our amount ($4,881) is due to rounding.

[9] The State agency commented that the total Federal share of the overpayment was $6,451, but this amount included payments collected after our audit period that we did not verify. As of March 31, 2010, the correct Federal share was $6,751.

requirement also applies to refunds of the Federal share for other overpayments discussed in the State agency comments below. CMS provided additional guidance on refunding the Federal share of Medicaid overpayments in an October 28, 2008, letter to State health officials (SHO #08-004). According to the letter, CMS is entitled to the Federal share of a State's entire settlement or final judgment amount and that, when a settlement occurs or judgment is rendered, the State must report the refund of the Federal share on the next CMS-64. In addition, SHO #08-004 states that "A State may not avoid adhering to the requirements set forth in section 1903(d) of the Act by virtue of pursuing legal action against a person or entity that has caused false or fraudulent claims to be submitted rather than the party that directly submitted false or fraudulent claims."

Based on the above Federal requirements, we maintain that the State agency should include the four unreported Medicaid overpayments ($5,500, $13,502, $51,826, and $5,500) on the CMS-64 and refund the associated Federal share ($2,750, $6,751, $25,913, and $2,750) to the Federal Government.[10]

Employee Overpayments

State Agency Comments

The State agency commented on two overpayments questioned in our draft report related to providers' individual employees. Specifically, the State agency indicated that:

- One overpayment totaling $2,478,575 ($1,239,288 Federal share)[11] involved an individual who worked for a provider that went out of business. The individual was ordered by a U.S. District Court to pay restitution to the State agency. The State agency commented that it is required to pay the Federal Government its share of any overpayment only as it is received, because the individual was not a provider and the provider went out of business.

- One overpayment totaling $18,675 (Federal share) was related to an employee who was ordered by a court to pay restitution to the State agency. The State agency commented that it did not recover any additional funds, and the remaining amount due the Federal Government will be shared as it is collected.

Office of Inspector General Response

SHO #08-004 states that "A State may not avoid adhering to the requirements set forth in section 1903(d) of the Act by virtue of pursuing legal action against a person or entity that has caused false or fraudulent claims to be submitted rather than the party that directly submitted false or

[10] Regarding the third overpayment, for which the State agency implied that it had partially refunded the money, we did not verify this amount because it did not appear on the CMS-64 as of March 31, 2010.

[11] The State commented that the Federal share of the overpayment was $1,239,288; however, we determined that the total unreported overpayment is $2,487,675 (1,243,838 Federal share). We did not verify any additional payments that the State may have received after March 31, 2010.

fraudulent claims." For this reason, we maintain that the State agency should include the unreported Medicaid overpayments ($2,487,675 and $37,350) on the CMS-64 and refund the Federal share ($1,243,838 and $18,675) to the Federal Government.

Out-of-Business Provider

State Agency Comments

The State agency indicated that one overpayment totaling $200,544 ($100,272 Federal share)[12] involved a provider that went out of business and that the State was obligated to return any overpayment to the Federal Government only as repayments were made.

Office of Inspector General Response

The State agency did not provide adequate documentation to support its claim that the provider was out of business. Pursuant to 42 CFR § 433.318(d)(2), the State agency must make available an affidavit or certification from the appropriate State legal authority that the provider is out of business and the overpayment cannot be collected. The State agency did not provide such documentation; therefore, we maintain that the State agency should include the unreported Medicaid overpayments ($187,978) on the CMS-64 and refund the Federal share ($93,989) to the Federal Government.

Independent Contractor

State Agency Comments

The State agency commented that one overpayment totaling $2,970[13] was related to an independent contractor ordered by a court to pay restitution to the State agency. The State agency commented that it is obligated to return any overpayment to the Federal Government only as repayments are made.

Office of Inspector General Response

SHO #08-004 states that "A State may not avoid adhering to the requirements set forth in section 1903(d) of the Act by virtue of pursuing legal action against a person or entity that has caused false or fraudulent claims to be submitted rather than the party that directly submitted false or fraudulent claims." For this reason, we maintain that the State agency should include this unreported Medicaid overpayment of $2,628 on the CMS-64 and refund the Federal share of $1,314 to the Federal Government.

[12] The State agency indicated that the overpayment was $200,544; however, our analysis of the State agency's records indicated an overpayment of $187,978 ($93,989 Federal share).

[13] The State agency indicated that the overpayment was $2,970; however, our analysis of the State agency's records indicated an overpayment of $2,628 ($1,314 Federal share).

APPENDIX

APPENDIX: STATE AGENCY COMMENTS

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Governor

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June 25, 2012

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Report Number: A-02-10-01009

Dear Mr. Edert:

This is in response to your letter dated April 26, 2012 concerning the Department of Health and Human Services, Office of the Inspector General's (OIG) draft report entitled *"New Jersey Generally Reported Medicaid Overpayments in Accordance With Federal Regulations"*. Your letter provides the opportunity to comment on this draft report.

The objective of this audit was to determine whether the Division of Medical Assistance and Health Services (DMAHS) reported Medicaid overpayments on the CMS-64 in accordance with Federal regulations.

The draft audit report concluded that DMAHS generally reported Medicaid overpayments in accordance with Federal requirements. However, it did not report all of them in accordance with Federal requirements. For Federal FYs 2008 and 2009, DMAHS did not report Medicaid overpayments totaling $3,151,354 ($1,575,679 Federal share) in accordance with Federal requirements. Of the 180 overpayments reviewed, 18 were partially reported or not reported on the CMS-64. The remaining 162 were reported correctly. DMAHS also did not report all Medicaid provider overpayments within the 60-day time requirement. DMAHS did not properly report these overpayments because it had not developed and implemented policies to ensure that overpayments were reported on the correct CMS-64.

As noted in the draft report, the audit period was from October 1, 2007 to September 30, 2009. The DMAHS program integrity function was transferred to the Office of the Medicaid Inspector General in March 2009, which subsequently became the Medicaid Fraud Division (MFD) of the Office of the State Comptroller in June 2010.

We appreciate the opportunity to provide this response to the draft OIG audit report. Following are the auditors' recommendations and the Division of Medical Assistance and Health Services' and Medicaid Fraud Division's responses:

Recommendation 1:

The OIG recommends that DMAHS refund $1,575,679 to the Federal Government.

The State does not concur in all aspects of this recommendation. The following lists the cases the OIG Auditors recommended that the state reimburse the federal government. Our response to each case is indicated below.

[redacted] is listed by the OIG Auditors as having an overpayment amount of $4,880. This is not the correct overpayment amount. The correct amount is $2,803.07, discovered pursuant to an audit conducted by AmeriGroup (one of DMAHS's Medicaid Managed Care Organizations). The audit reported an overpayment of $2,803.07. The federal share of $1,401.54 was included in the CMS 64 payments for the third quarter of 2009.

[redacted] is listed by the OIG Auditors as having an overpayment amount of $11,000, and that $5,500 was unreported by the state. This case involves court ordered restitution of $5,500. [redacted] was sentenced on November 21, 2008. [redacted] paid the $5,500. No additional funds were collected from this individual so that $2,250 is due the federal government.

[redacted] is listed by the OIG Auditors as having an overpayment amount of $19,902, and that $13,502 was not reported. This case involves court ordered restitution of $50 per month from [redacted] and the current total collected is $7,000. 42 CFR §433.312 at the time of this audit states that the state must share overpayments made to providers with the federal government within 60 days of the date of discovery, whether or not the State has recovered the overpayment from the provider. 42 CFR §433.304 defines provider as any individual or entity furnishing Medicaid services under a *provider agreement* with the Medicaid agency (emphasis added). [redacted] was not a Medicaid provider. He was an optician who worked for [redacted] which was a provider. Therefore the federal government is entitled to receive its share ($9,951) of the overpayment as the state collects it. The state has been sharing with the federal government as it collects money from [redacted], and currently the CMS has received $3,500. The State owes CMS $6,451, to be paid as it is collected.

[redacted] was convicted of Medicaid Fraud and other charges. He was sentenced to pay restitution of $152,215, payable to the DMAHS, and a criminal fine of $75,000. The OIG Auditors' stated that the overpayment was $227,215, and that $166,326.69 was not reported. This was incorrect since the auditors clearly added the restitution and the fine to reach this amount.

On October 7, 2004, [redacted] pharmacist license was revoked. He was co-owner of [redacted], the provider, which was terminated from the Medicaid program on September 22, 2000. [redacted] was also sentenced to five years in state prison. Therefore, pursuant to 42 CFR §433.18 (2)(b)(2), since [redacted] went out of business prior to the date that the overpayment was identified (the date of sentence was January 26, 2004), the state was only obligated to return any overpayment to the federal government as they were received. As of this date the CMS has received $31,836.15 of its share. The State owes CMS $120,378.85, to be paid as it is collected.

Office of Inspector General note: The deleted text has been redacted because it contains personally identifiable and/or other sensitive information.

[redacted] was convicted in federal court on December 12, 2005 and sentenced to pay restitution of $2,500,000 to the U.S. District Court. [redacted] was a pharmacist working at [redacted]. [redacted] lost his pharmacist's license on May 25, 2000 and [redacted] was terminated from the Medicaid program on December 16, 1998. The first time DMAHS became aware of this case was upon receipt of [redacted] first restitution check, which was processed by the court and sent to DMAHS on February 16, 2007. To date he has paid $21,425.

The State of New Jersey is only required to pay the federal government its share of any overpayment as it is received. [redacted] was not a provider nor was he an owner of the pharmacy (42 CFR §433.04) and the provider went out of business (42 CFR §433.318). CMS has received $10,712.50 to date, and is owed $1,239.287.50 to be paid as it is collected.

[redacted] was identified by the OIG Auditors as owing $65,375.65, of which $51,825.65 was not reported. [redacted] was a pharmacist and part owner of [redacted]. The pharmacy was terminated from the Medicaid program on January 12, 2001. The pharmacy was declared bankrupt on June 5, 1998 and [redacted] pharmacist license was revoked on July 15, 2003.

[redacted] was sentenced in federal court on March 21, 2003, and ordered to pay restitution of $65,675.55, $64,394.47 of which was to be paid to DMAHS and the remaining $981.08 to be paid to a private individual. [redacted] restitution was ordered to be jointly paid with his brother [redacted] Thus the total restitution ordered for both brothers was $64,394.47. Restitution was paid in full in 2010, but the U.S. District Court failed to forward the last $7,763 to the state. The court is now going to do so and the federal government will receive the remainder of its share of the overpayment when the state receives the money from the court. [redacted] was listed by the auditors as owing $64,300 in addition to the amount owed by his brother. As indicated above, this is not the case. All the facts listed with respect to [redacted] apply here. [redacted] license to practice medicine was revoked on April 30, 2001. Restitution was paid in full, except as explained above.

[redacted] was sentenced to pay $214,840 in restitution on March 8, 2002. He was the owner of [redacted]. The company was terminated from the Medicaid program on August 7, 1998. Pursuant to 42 CFR §433.18 (2)(b)(2), since [redacted] went out of business prior to the date that the overpayment was identified (the date of sentence in 2002) , the state was only obligated to return any overpayment to the federal government as repayments were made. Currently the state has paid CMS $14,296.29. The remaining $200,543.71 will be repaid as it is collected.

[redacted] was identified by the auditors as having an overpayment of $86,090.77, of which only $78,090.77 was reported. This was not the correct amount of the overpayment. [redacted] was found to have been working at [redacted] even though she was excluded. In June 2003, the State reached an agreement with [redacted] that required her to pay $80,500. The federal share of this amount was $23,233.20 which was paid in the second quarter of 2003. The remainder was entirely state share because it involved claims to the Pharmaceutical Assistance to the Aged and Disabled, which is a state funded program.

[redacted] was an independent contractor employed by [redacted]. [redacted] was not a provider as defined in 42 CFR §433.04. He was ordered to pay restitution of $3,362 to the State on February 11, 2009. Since [redacted] was not a provider, (42 CFR §433.04), the state was only obligated to return any overpayment to the federal government as repayments were made.

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Currently the state has paid the federal government $391.82. The remaining $2,970.18 will be repaid as collected.

[redacted] conducted a self-audit and sent a check for $4,373.94 to the Medicaid Fraud Division on March 30, 2009. This amount was not reported and $2,186.87 is due to CMS. Another check was received from [redacted] in March, 2009 as the result of a different self-audit. That check was for $23,470.06 and was reported, and the federal share of &11,735.03 was paid in the CMS 64 for the first quarter of 2009.

[redacted] was a physician who was not enrolled in Medicaid. He refused to pay $410.30 in 2007 and the State obtained payment through a with-hold by his employer in 2009. Only $270.27 was reported and the federal share of $135.14 was shared with the CMS in the second quarter of 2009. The remaining $139.13 was not reported. As a result, the state owes CMS an additional $70.01.

[redacted] was a Medicaid provider until February 9, 2010. [redacted] conducted a self audit and discovered an overpayment of $53,216 which was identified and paid in May 2009. The federal share was $3,405.82 (Temporary Assistance for Needy Families funds) and was paid to CMS. The auditors stated that the remaining $49,810.18 was unreported. The later amount was not reported nor shared since it was attributable to General Assistance funds and not Medicaid. No further payment is due to CMS.

[redacted] the owner of [redacted], was sentenced to pay restitution of $5,500 and a fine of $5,500 on April 2, 2008. Only the restitution amount of $5,500 was payable to the DMAHS, not the $11,000. The State reported a $1,500 recovery and returned $750 in the first quarter of 2009. The remaining $2,000 does not appear to have been paid and is owed to CMS.

[redacted] a dentist, was sentenced on December 5, 2007 to pay $6,750 in restitution. That amount was paid on April 9, 2008. The federal share of $3,375 was not paid and is owed to CMS.

[redacted] was an excluded pharmacist found to be working at a [redacted]. $13,697.34 was attributable to her work at [redacted] and $3,325.11 was attributable to her work at [redacted]. The total of those two amounts ($17,012.45) was trebled, adding up to $51,037.35. [redacted] overpayment was satisfied in August and September of 2009, and the federal share of that amount ($6,843.67) was reflected in the CMS 64 for the second quarter of 2009. [redacted] was terminated from the Medicaid program in 2008. No other funds have been recovered, so the amount due to CMS is $18,675, to be shared as collected.

[redacted] was identified by the OIG Auditors as having an overpayment of $544.04, which was unreported. The federal share of $272.02 is due CMS.

[redacted] was identified by the OIG Auditors as having an overpayment of $4,372.56 which was unreported. The federal share of $2,186.28 is due CMS.

Recommendation 2:

The OIG recommends that the State develop and implement policies to ensure that future Medicaid overpayments are reported on the correct CMS-64 in accordance with federal requirements:

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The State concurs with the draft report's recommendation and intends to create and implement these polices.

If you have any questions or require additional information, please contact me or Richard Hurd at 609-588-2550.

Sincerely,

Valerie Harr
Director

c: Jennifer Velez
Richard Hurd
Mark Anderson - MFD