Medicaid and Managed Care Presentation

Adult Day Health Services

Useful Tools for a Compliant Medicaid Practice

June 1, 2017

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Goals For Today

To help you better understand:

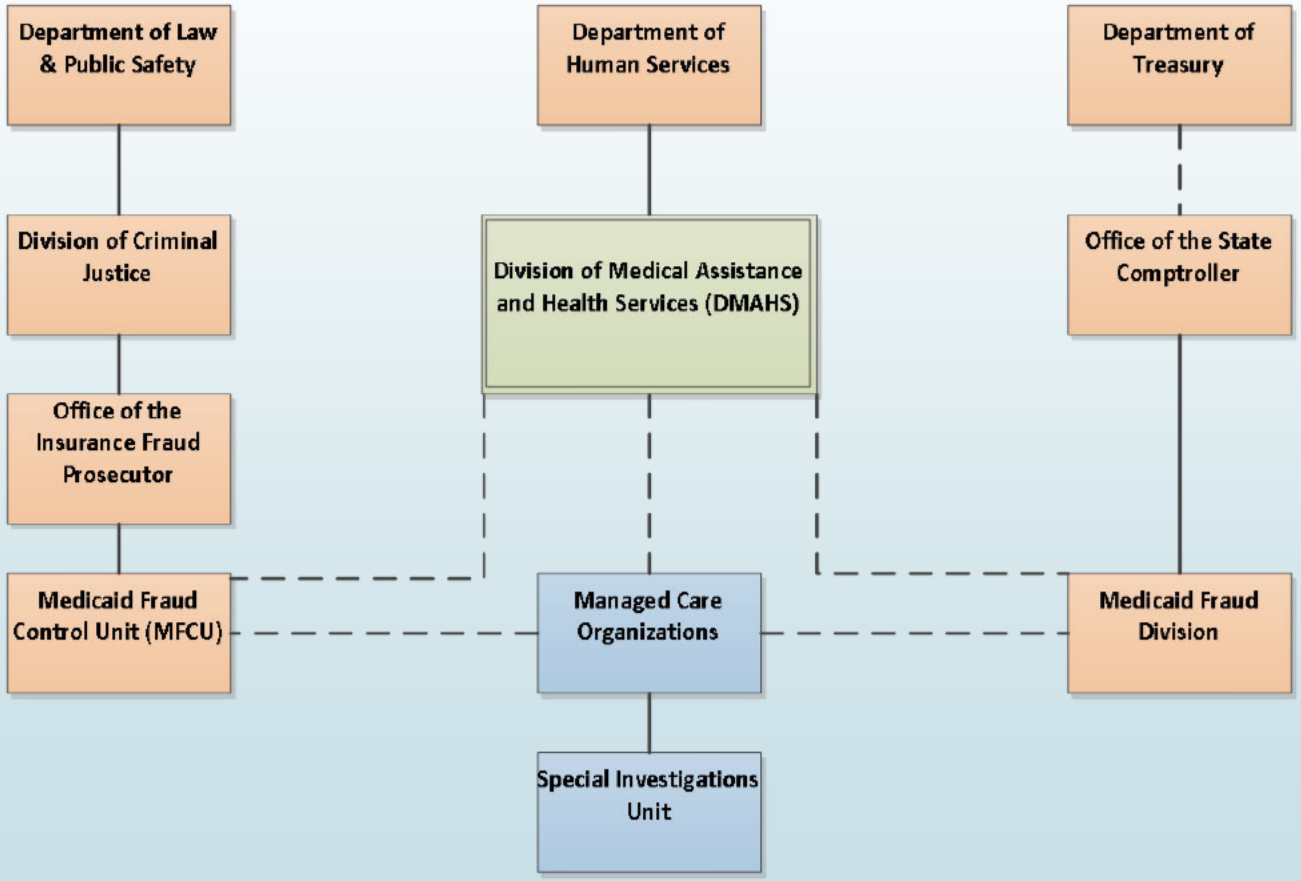
- The State agency and MCO structure
- The Medicaid regulatory framework
- Medicaid documentation requirements
- Third Party Liability (TPL) requirements
- Fraud, waste and abuse obligations
- Consequences for non-compliance
- Your obligations as a ADHS provider

What is Medicaid?

- Medicaid is a joint Federal and State program that helps pay medical costs if individuals have limited income and resources or meet other requirements.

- Medicaid is a voluntary program. If you want to participate, you must know, accept and abide by the rules and regulations.

Administration and Oversight



Medicaid Managed Care Contract

The New Jersey Department of Human Services, DMAHS, has a contract with the following MCOs:

- Aetna Better Health of New Jersey
- Amerigroup New Jersey, Inc.
- Horizon NJ Health
- UnitedHealthcare Community Plan
- WellCare Health Plans of NJ, Inc.

ADHS Background

Neena Kumar

Medicaid Fraud Division

Adult Day Health Services (ADHS)

§ 10:164-1.1 Purpose and scope; participant eligibility

"Adult Day Health Services is a program that provides medically necessary services in an ambulatory care setting to individuals who are nonresidents of the facility, and who, due to their physical and/or cognitive impairment, require such services supportive to their community living.

ADHS Facility are: § 10:164-1.2 Definitions

- Nursing Facility Based
- Hospital Based
- Freestanding Ambulatory Care Facility or
- Other Facility Licensed by the Department

Services include:

- Medical care, Nursing,
- Personal care, Nutritious midday meal,
- Therapeutic Recreational activities

ADHS – Requirements

Eligibility General Requirements: N.J.A.C. 10:164-1.1 and 10:164-1.5

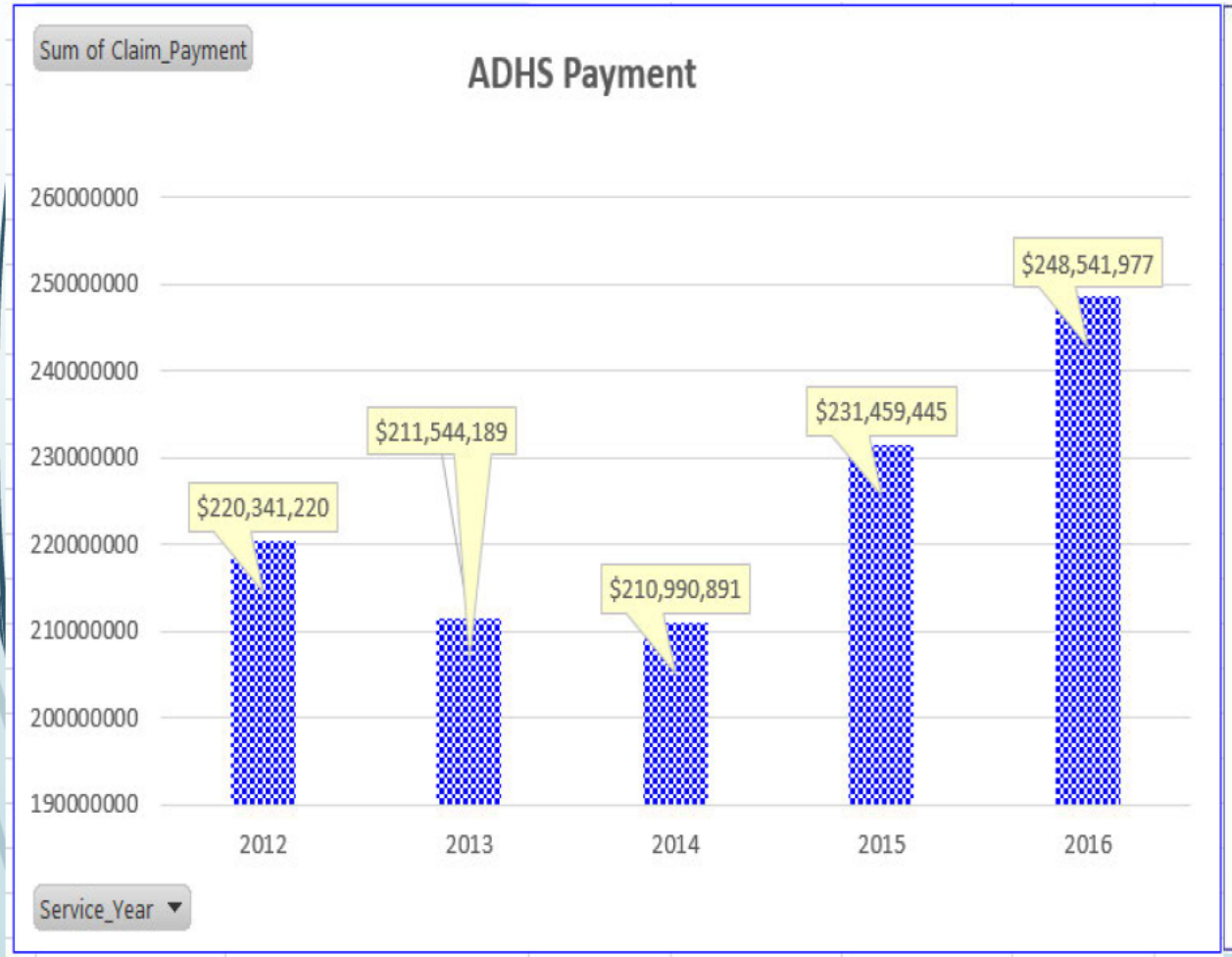
- Individual must satisfy the clinical eligibility and prior authorization requirements.
- Individual must be eligible for Medicaid or enrolled in one of the state-funded programs that offers these services.
- Require supervision or assistance in some activities of daily living (ADL) or require a skilled nursing.

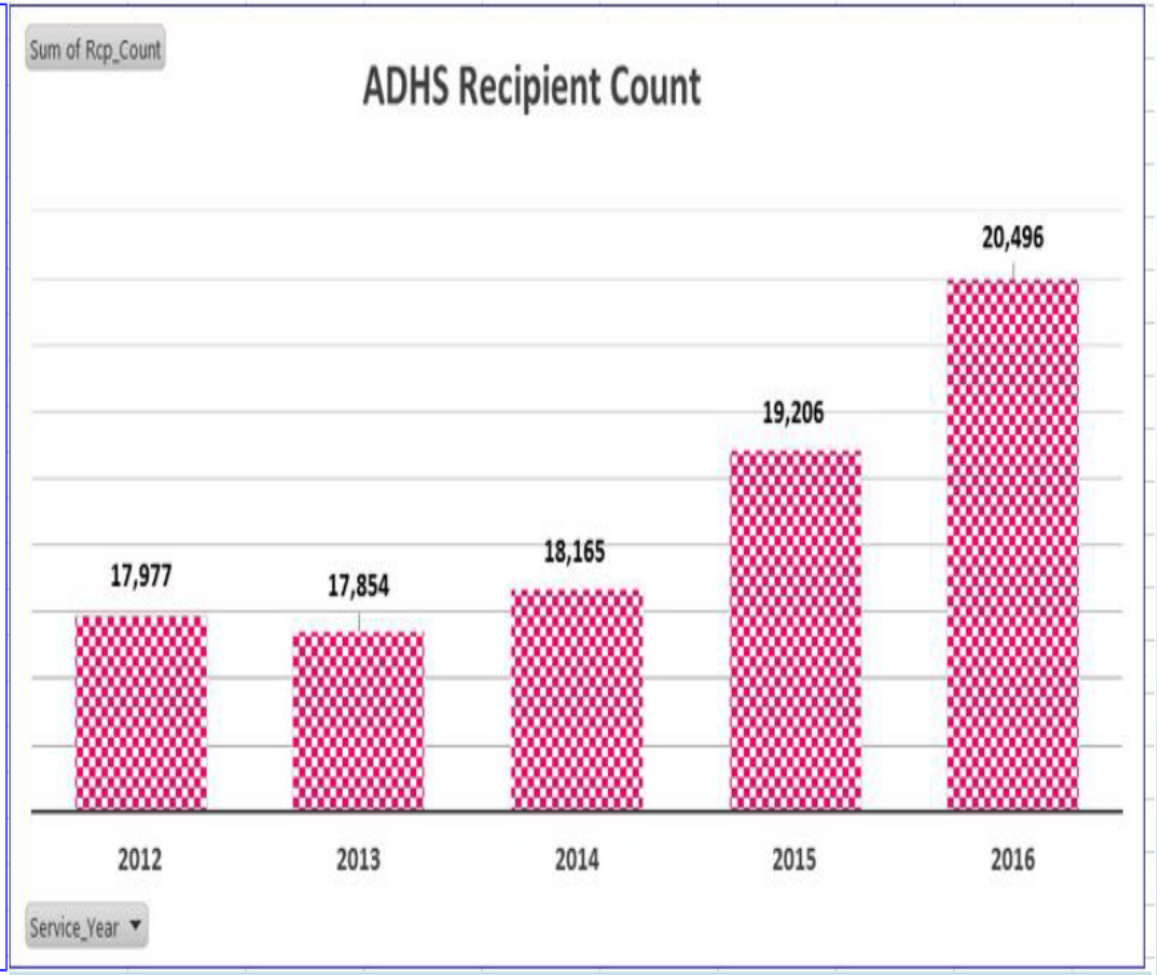
How are ADHS claims categorized?

- Category of Service (COS): 80
- Provider Type: 92
- Procedure Codes: W9002/S5102 (W9002 is the NJ local code that is replaced by National HCPCS Code: S5102)
- § 10:164-2.2 Billing codes:

HCPCS Codes	Description
Z0300	Initial visit, speech-language pathology services
Z0310	Initial comprehensive speech-language pathology evaluation
Z0270	Initial visit, physical therapy
92507	Speech-language pathology services
97799	Physical therapy
W9002	Adult day health services visit
Z1860	Adult day health services visit for the AIDS Community Care Alternatives Program (ACCAP)
J9002	Adult day health services visit for JACC participants

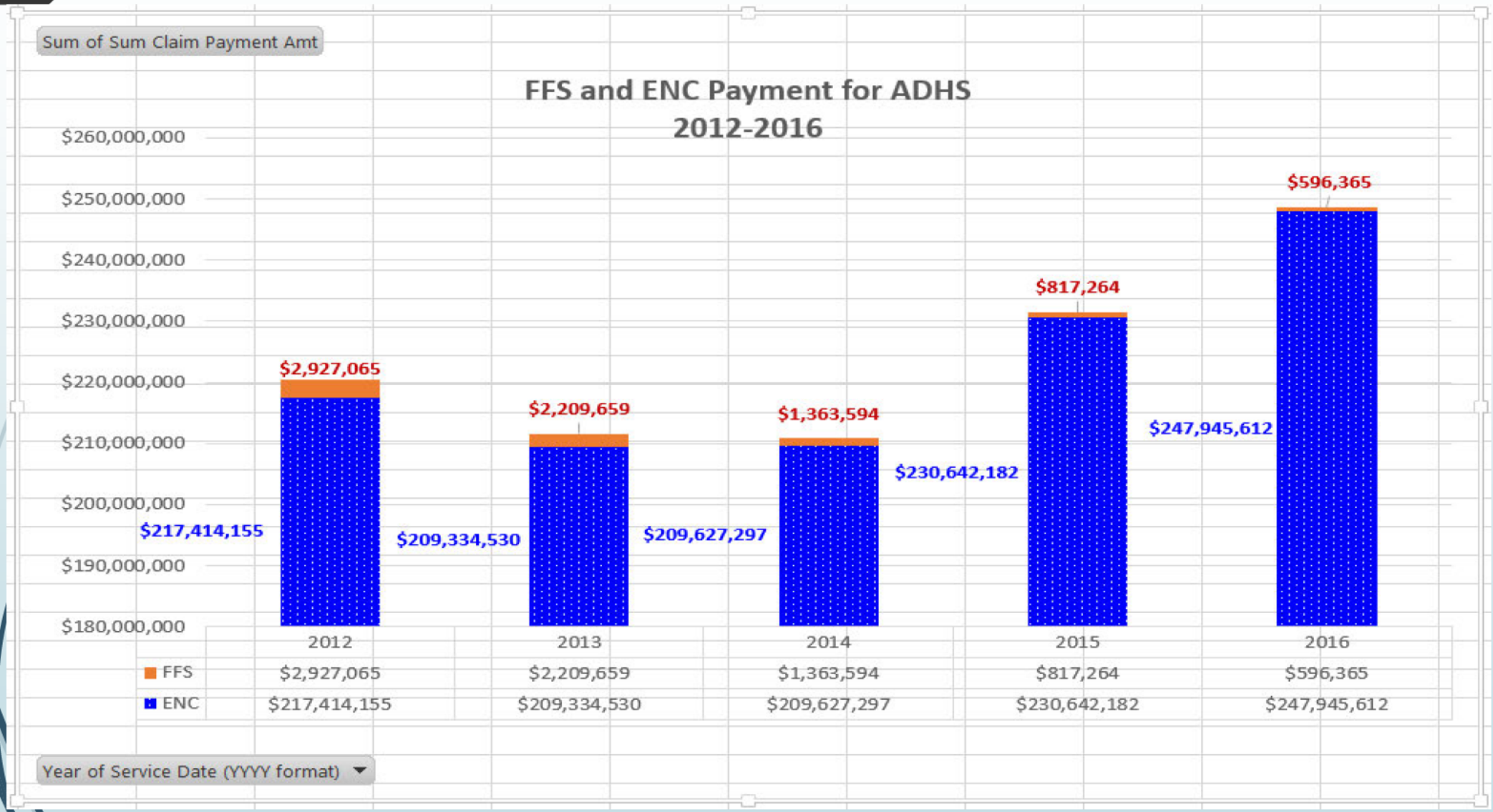
ADHS Payment and Recipient Count (2012-2016)





Average Payment = ~$12,000 per recipient per year

Medicaid Exposure to ADHS (2012-2016)



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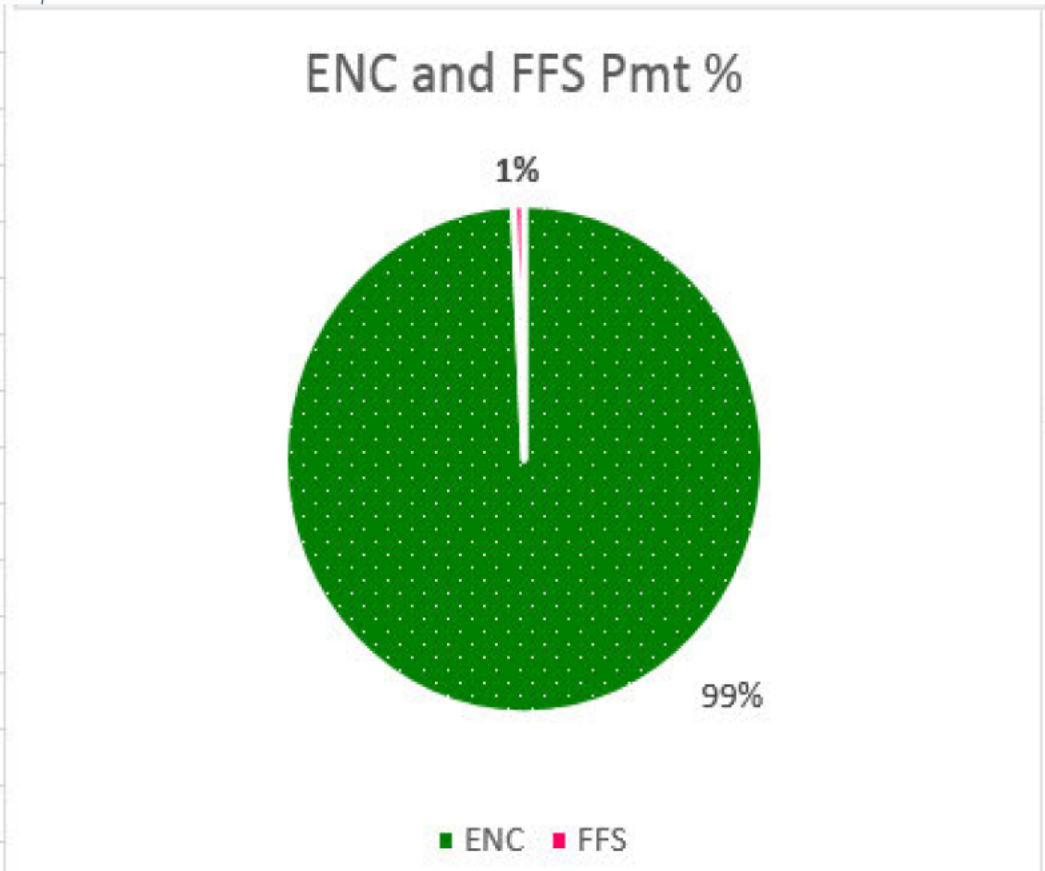
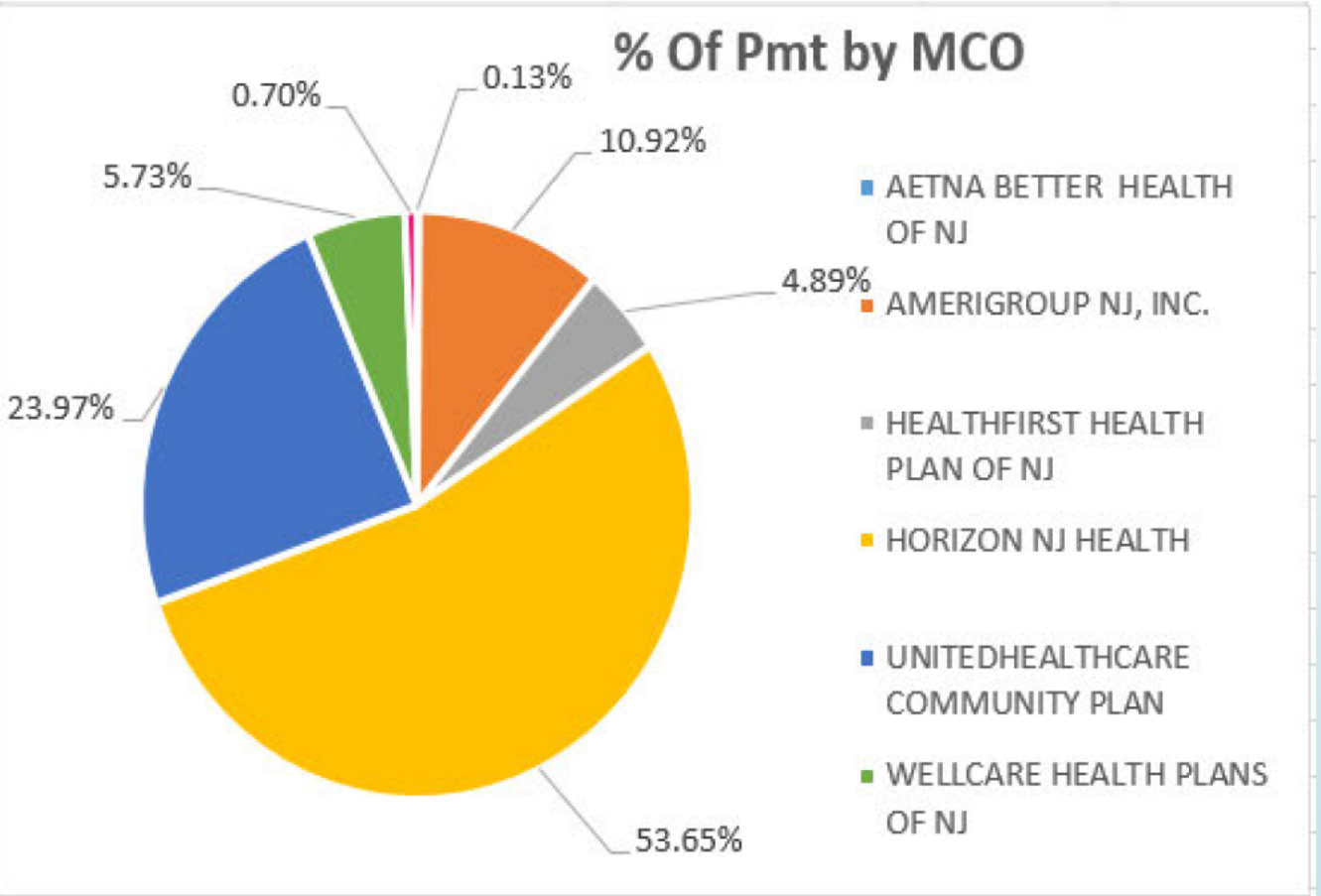




ADHS Risk Category: HIGH

- The MFD and DMAHS assigned ADHS to the high-risk category
- High Dollars Spent
- High Risk for Fraud, Waste and Abuse

Fraud, Waste and Abuse

Meghan Ellerman

MCO Program Specific Requirements

- **Each MCO may have its own unique requirements regarding:**
  - ✓ Physician Order
  - ✓ Assessments
  - ✓ Prior Authorization
  - ✓ Medical Policy
  - ✓ Reimbursement policies

- **When in doubt, consult your MCO-specific resources:**
  - ✓ Provider contract
  - ✓ Provider manual
  - ✓ Provider portal
  - ✓ Provider representative
  - ✓ MCO website
  - ✓ Newsletters and provider alerts

It is your responsibility to know these requirements.

Fraud

Fraud - an intentional deception or misrepresentation made by any person with the knowledge that the deception could result in some unauthorized benefit to that person or another person, including any act that constitutes fraud under applicable federal or State law.

- ***N.J. Stat. § 30:4D-55***

Waste

Waste is not defined in the rules, but is generally understood to encompass overutilization, underutilization or misuse of resources.

Waste is not usually a criminal or intentional act.

CMS's Fraud, Waste and Abuse Toolkit handout

Abuse

Abuse - provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary costs to Medicaid or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

The term also includes recipient practices that result in unnecessary costs to Medicaid.

- ***N.J. Stat. § 30:4D-55***

Third Party Liability

Christine Cheetham
Medicaid Fraud Division

Third Party Liability

…exists when any party is or may be liable to pay all or part of the cost of medical assistance payable by the Medicaid or NJ Family Care program.

N.J.A.C. 10:49-7.3

Third Party Liability

Medicaid and NJ Family Care (NJFC) benefits are **last** payment benefits. All Third Party Liability (TPL) must be used first and to the fullest extent in meeting the costs of the medical needs of a beneficiary.

A TPL's potential liability to pay for services **cannot** prevent a Medicaid beneficiary from receiving covered services.

N.J.A.C. 10:49-7.3

Third Party Liability

When Medicaid is not the primary payer on a claim, payment by Medicaid will be made at the **lesser** of:

The Medicaid allowed amount minus any other payment(s); or

The patient liability, including denied charges, deductible, co-insurance, copayment, and non-covered charges.

N.J.A.C. 10:49-7.3

Third Party Liability (exceptions)

Medicaid and NJ Family Care beneficiaries **may not** be billed for any amount, *except*…

1. For services, goods or supplies not covered or authorized by the NJ Medical Assistance and Health Services Act or by the Division of Medical Assistance and Health Services…

AND if the beneficiary has been informed in writing before the service, etc. is rendered that the service, etc. is not covered…

AND if the beneficiary voluntarily agrees in writing before the service, etc. is rendered to pay for all or part of the provider's fee.

AND the provider has received no program payments from DMAHS or the Medicaid MCO for the service.

N.J.A.C. 10:74-8.7

Third Party Liability (exceptions)

Medicaid and NJ Family Care beneficiaries **may not** be billed for any amount, *except…*

2. The provider does not participate in Medicaid and NJFC either generally or for that service…

AND if the beneficiary has been informed in writing before the service, etc. is rendered that the service, etc. is not covered…

AND if the beneficiary voluntarily agrees in writing before the service, etc. is rendered to pay for all or part of the provider's fee.

AND the provider has received no program payments from DMAHS or the Medicaid MCO for the service.

N.J.A.C. 10:74-8.7

Third Party Liability (exceptions)

Medicaid and NJ Family Care beneficiaries **may not** be billed for any amount, *except*…

3. For payments made to the beneficiary by a third party on claims submitted to the third party by the provider.

4 . For NJFC Plan C enrollee's contribution to care responsibility and for NJFC Plan D enrollee's required copayment.

N.J.A.C. 10:49-7.3

10 Minute Break? Keep going?

Adult Day Care
by Teresa Howard

The Benefit

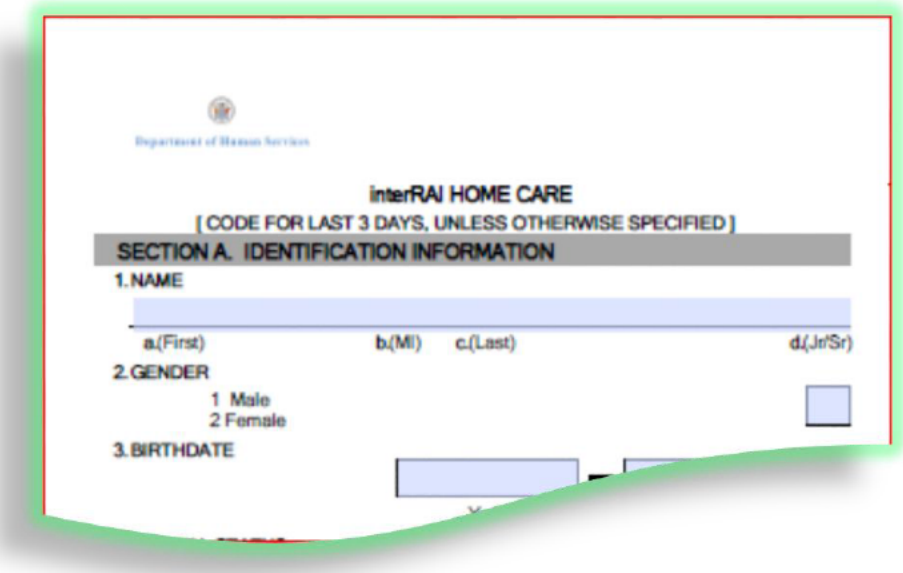
≥5 hours/day

≤5 days/week

(Excludes transportation)

Screening

NJ Choice Assessment Tool for ADHS



interRAI HOME CARE

[CODE FOR LAST 3 DAYS, UNLESS OTHERWISE SPECIFIED]

SECTION A. IDENTIFICATION INFORMATION

1. NAME

a.(First) b.(MI) c.(Last) d.(Jr/Sr)

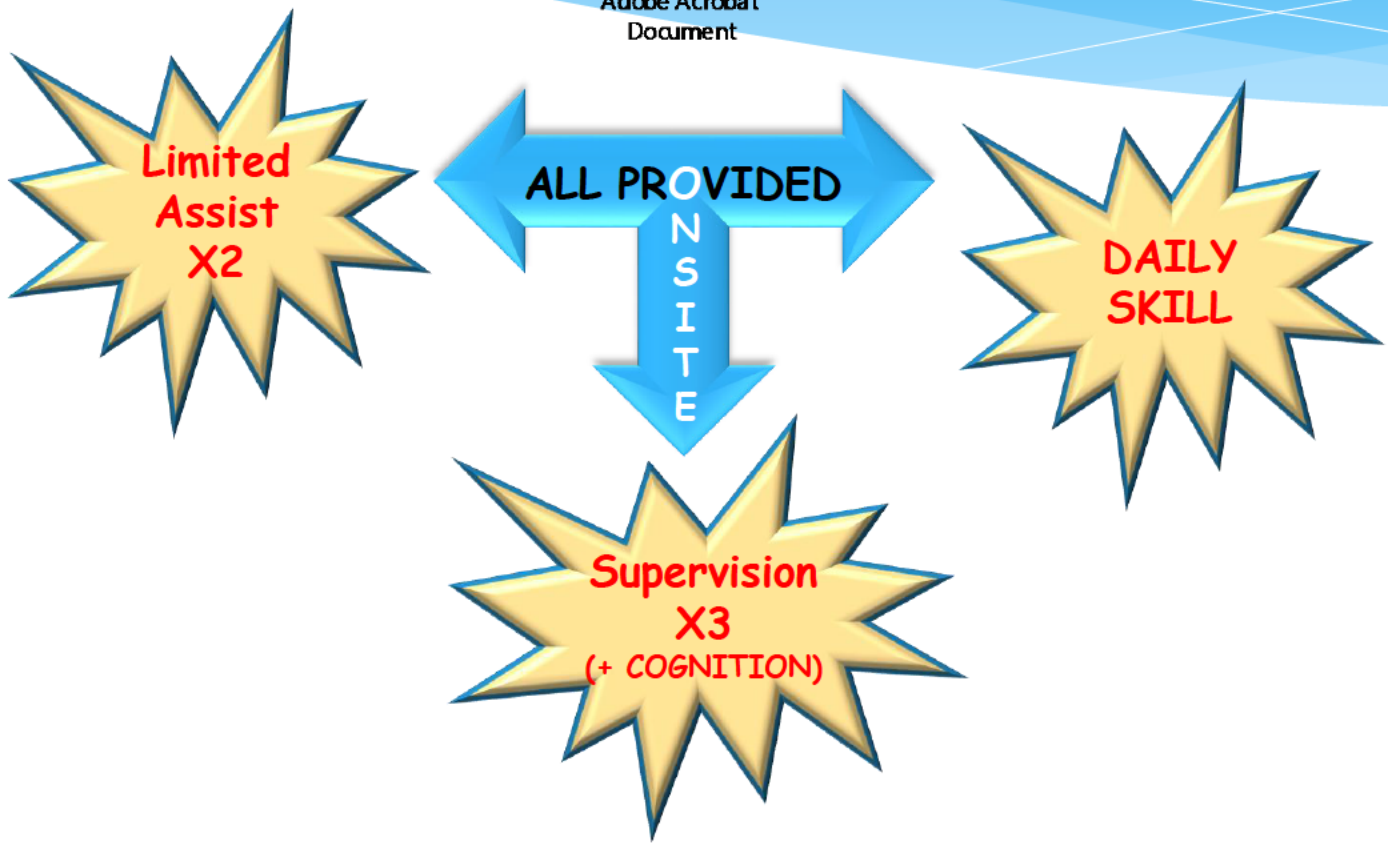
2. GENDER

1 Male
2 Female

3. BIRTHDATE

Medical Eligibility 3 Ways

Adobe Acrobat Document



What are Skilled Needs:

* **Oxygen administration**
* **Ostomy care**
* **Nurse monitoring of vitals with physician notification**
* **Administration of IM or IV Medications**
* **Tube Feeding**
* **Medical Nutrition Treatment**

What are Skilled Needs:

* **Short-term authorizations will be granted ranging from 1-3 months requesting additional supporting clinical information along with a referral for case management.**

* **Utilization Management will meet with Case Management prior to the expiration of the authorization to determine the need for continued services along with a reassessment to reinforce eligibility/Medical Director's determination.**

Authorization Process

* **Preauthorization Request for ADHS**
* **Provide Physician Rx for services**
* **Clinicals for last 30 days if ongoing services**
* **Reauthorization required at 6 months or with change of condition**
* **Reassessment of eligibility for NJ Choice Tool annually or with change of condition**

Ineligibility

SERVICE DUPLICATION

NON-COMMUNITY RESIDENT

ONLY PT or MEDS

INPATIENT or AL (hospital/NF)

STATUS CHANGE to POTENTIAL D/C
(reassessment required)

Red Flags

Ted Pantaleo
Director, Provider Contracting and Strategy
Horizon NJ Health

Red Flags

- **Data Analytics** – Sudden increase in amount paid/claim volume and/or
    - NO discharges/change in billing patterns (i.e., same members billed for months/years at a time)
- **Fraud Detection Software** – Identifies unusual/significant changes in billing patterns
- **MCO Staff Referrals** – Pursuant to assessments and reassessments - Interaction with members and ADHS staff
- **Referrals** – State of NJ (i.e., MFD, DMAHS, Dept of Health-Licensing, etc.)
- **Department of Health** – Web site – Inspection Results/Sanctions/Enforcement Actions
- **Member/Family Complaints**
- **Hotline Calls**
- **Spot Checks** – Quality/Medical Management/Special Investigations – on site visit and random sample review of charts/documentation (i.e., transportation logs, sign-in sheets, medical services provided, etc.)
- **Adequate and Appropriate Staffing** – Administrator, Director of Nursing, Support Staff

Audits and Investigations

Neena Kumar

Medicaid Fraud Division

Medicaid Fraud Division Audits & Investigations

Review Period

N.J. Stat. § 2A:14-1.2 (2017)

- 10-years statute of limitation
- MFD has the capability to review records as far back as 2001

N.J. Stat. § 30:4D-12 (2017)

- Records must be retained for at least 5 years from the date the service was rendered
- Records must include:
  - Name of the recipient
  - Date of service
  - Nature and extent of each service
  - Any additional information that may be required by regulation

Medicaid Fraud Division Audits & Investigations

Relevant Statutes

N.J.A.C. 10:164-1.3 (2017)

- Maintenance of Cost reports and financial statements and their availability for review by, or submission to, the Department upon request
- Maintenance of a daily attendance record that includes the printed name and the arrival and departure times of each beneficiary
- Monthly Attendance Roster form requires ADHS facilities to provide the following information: the name of the facility, the applicable month, the name of and Medicaid number for each beneficiary and each day the beneficiary attended the facility during the month of the roster.
- Must have prior authorization for each beneficiary.

Medicaid Fraud Division Audits & Investigations

Relevant Statutes

N.J.A.C. 10:49-9.8 (2017)

- All providers shall certify that the information furnished on the claims is true, accurate, and complete.
- Providers must keep such records as are necessary to disclose fully the extent of services provided.
  - Example: Proper maintenance of attendance, prior authorization and cost and financial statements.

N.J.A.C. 10:49-5.5 (2017)

- Services not covered by Medicaid if
  - No medical necessity
  - No prior authorization
  - Records inadequate and illegible

NOTE: This is not the complete list of non-covered services. The full list consists of 18 items and can be found in the Administrative Code section listed above.

Consequences

Lt. Joseph Jaruszewski
609-633-2228

Lt. Louis Renshaw
973-599-5954

Medicaid Insurance Fraud is a Serious Crime

- The MFCU in the Office of the Insurance Fraud Prosecutor (OIFP) investigates and prosecutes Medicaid Fraud.
- The MFCU utilizes Attorneys, Investigators, Nurses, Auditors and other support staff to police the Medicaid system.

Medicaid Fraud (*N.J.S.A.* 30:4D-17)

- It is illegal to knowingly and willfully make or cause to be made any false statement in a claim.
- It is illegal to over-bill Medicaid for services provided or services that were not received.
- It is illegal to participate in a scheme to offer or receive kickbacks or bribes in connection with the furnishing of items or services that are billable to Medicaid.

Medicaid Fraud Consequences

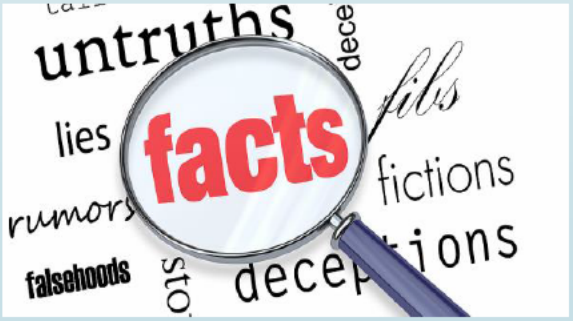
- Punishable by up to 5 years in state prison
- Mandatory penalty up to $25,000 for each violation
- Civil judgments and liens
- Exclusion from the Medicaid/Medicare programs
- Suspension or loss of professional licenses
- Restitution/Recovery of overpayments

Health Care Claims Fraud (*N.J.S.A. 2C:21-4.3*)

- It is illegal to submit a false claim to the Medicaid program or an insurance company in order to be paid for health care services which were not received or provided.
- Punishable by up to 10 years in state prison
- In addition to all other criminal penalties allowed by law, a violator may be subject to a fine up to five times the amount of any false claims.
- Suspension or debarment from government funded healthcare programs
- Forfeiture of professional license

Did you know…

- If you are a practitioner and hold a professional license, you only need to submit one false claim to be convicted.
- Willful ignorance of the truth or falsity of a claim is not a defense.
- You can be found guilty of Health Care Claims Fraud even if your claims were not intentionally fraudulent.



Whistleblower/Qui Tam

- Empowers people to file civil suit against individuals and companies that defraud the federal, state or local government.
- A person filing suit might be eligible for up to a 30 percent share of the recovery.
- A person filing suit might be protected from being fired or retaliated against by their employer for reporting fraud and abuse to authorities.

Sample Cases

True Crime

- **Shore Winds Adult Medical Day Care**
  - Coached patients to lie about their health on their eligibility assessment
  - Submitted claims for services that were not provided or not fully provided
  - Owner sentenced to 3 years in State Prison
  - Ordered to pay $147,000 in fines and penalties
  - Debarred from Medicaid

Civil Consequences

- **Broadway Adult Day Care & Bayonne Adult Medical Day Care**
  - The Medicaid Fraud Division determined that the day cares did not maintain required documentation to demonstrate that their services, such as ADLs and blood glucose monitoring, were in fact, performed.
  - The day cares paid $325,000 each to the Medicaid Fraud Division to settle their cases.

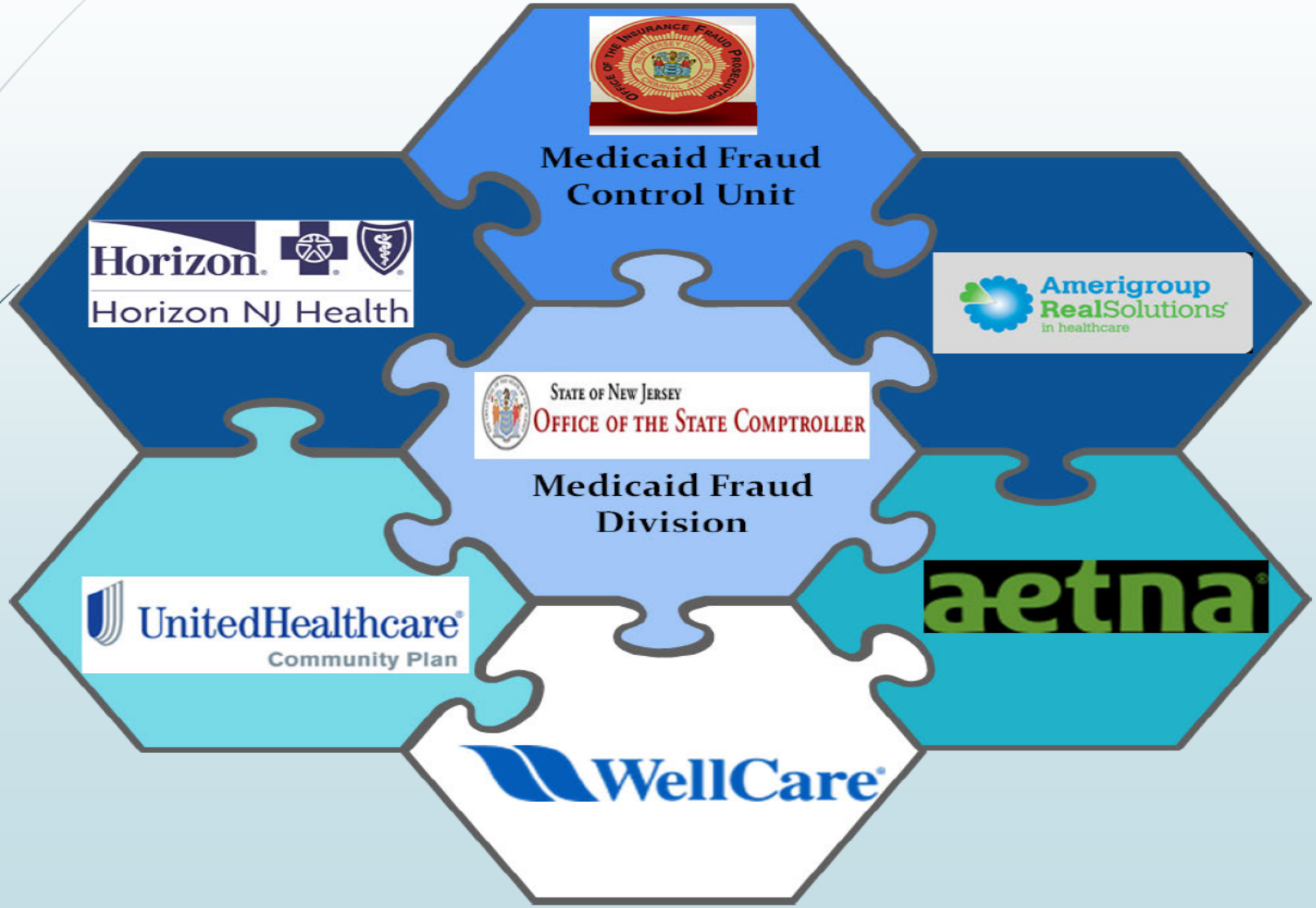
“Ignorance of the law excuses no one.”

Conclusion

Josh Lichtblau

Medicaid Fraud Division

MFD Brings us Together Regularly to Discuss FW&A Issues



Affordable Care Act

- 42 CFR §455.450 contains the screening requirements for providers who wish to enroll in the Medicaid program

Debarred Providers

- A debarred provider is a person or an organization that has been excluded from participation in Federal or State funded health care programs.
- Any products or services that a debarred provider directly or indirectly furnishes, orders or prescribes are not eligible for payment under those programs.
- It is incumbent upon providers to perform Exclusion Checks, upon hire and monthly thereafter.

Self-Disclosure

- Providers who find problems within their own organizations, must reveal those issues to MFD and return inappropriate payments.
- Affordable Care Act §6402 and *N.J.A.C.* §10:49-1.5 (b)(1), (7) require overpayments to Medicaid and/or Medicare be returned within 60 days of identifying that they have been received.
- Failure to return an overpayment makes you liable to the imposition of penalties of $5,500 to $11,000 per claim.

Self-Disclosure

- MFD's self-disclosure policy is more liberal than OIG's policy
- If MFD agrees with your analysis, we do not impose interest or penalties
- MFD's Self-Disclosure policy can be found on our website, www.nj.gov/comptroller/divisions/medicaid/disclosure

MCO/MFD Recovery Actions

- Once an overpayment has been identified as a result of an investigation, actions to initiate recoupment of the funds will take place.
  - MCO will send a letter to the provider with the overpayment amount.
  - MFD will send a Notice of Estimated Overpayment or Notice of Intent and, if necessary, a Notice of Claim.
  - MFD may add false claim penalties between $5,500 and $11,000.

What You Learned Today

- All of the State agencies and MCOs that have oversight of your contracts and billing
- What the Medicaid Regulatory Framework looks like
- How the Medicaid requirements apply to you
- Your obligation to comply with rules and regulations for documentation and billing in order to avoid allegations of fraud, waste and abuse
- What can happen to you if you are not compliant

Who to Contact

Questions

- Thank you for attending!
- Your opinion matters. Please complete your evaluation form before you leave.