[First Reprint]

ASSEMBLY, No. 1427

STATE OF NEW JERSEY

INTRODUCED FEBRUARY 5, 1996

By Assemblywomen WRIGHT and Quigley

AN ACT concerning audits of Medicaid long-term care facilities and amending and supplementing P.L.1968, c.413.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

[1][1. Section 7 of P.L.1968, c.413 (C.30:4D-7) is amended to read as follows:

7. Duties of commissioner. The commissioner is authorized and empowered to issue, or to cause to be issued through the Division of Medical Assistance and Health Services, all necessary rules and regulations and administrative orders, and to do or cause to be done all other acts and things necessary to secure for the State of New Jersey the maximum federal participation that is available with respect to a program of medical assistance, consistent with fiscal responsibility and within the limits of funds available for any fiscal year, and to the extent authorized by the medical assistance program plan; to adopt fee schedules with regard to medical assistance benefits and otherwise to accomplish the purposes of this act, including specifically the following:

a. Subject to the limits imposed by this act, to submit a plan for medical assistance, as required by Title XIX of the federal Social Security Act, to the federal Department of Health and Human Services for approval pursuant to the provisions of such law; to act for the State in making negotiations relative to the submission and approval of such plan, to make such arrangements, not inconsistent with the law, as may be required by or pursuant to federal law to obtain and retain such approval and to secure for the State the benefits of the provisions of such law;

b. Subject to the limits imposed by this act, to determine the amount and scope of services to be covered, that the amounts to be

EXPLANATION - Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined <u>thus</u> is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Assembly AHL committee amendments adopted May 12, 1997.

paid are reasonable, and the duration of medical assistance to be furnished; provided, however, that the department shall provide medical assistance on behalf of all recipients of categorical assistance and such other related groups as are mandatory under federal laws and rules and regulations, as they now are or as they may be hereafter amended, in order to obtain federal matching funds for such purposes and, in addition, provide medical assistance for the foster children specified in section 3i. (7) of this act. The medical assistance provided for these groups shall not be less in scope, duration, or amount than is currently furnished such groups, and in addition, shall include at least the minimum services required under federal laws and rules and regulations to obtain federal matching funds for such purposes.

The commissioner is authorized and empowered, at such times as he may determine feasible, within the limits of appropriated funds for any fiscal year, to extend the scope, duration, and amount of medical assistance on behalf of these groups of categorical assistance recipients, related groups as are mandatory, and foster children authorized pursuant to section 3i. (7) of this act, so as to include, in whole or in part, the optional medical services authorized under federal laws and rules and regulations, and the commissioner shall have the authority to establish and maintain the priorities given such optional medical services; provided, however, that medical assistance shall be provided to at least such groups and in such scope, duration, and amount as are required to obtain federal matching funds.

The commissioner is further authorized and empowered, at such times as he may determine feasible, within the limits of appropriated funds for any fiscal year, to issue, or cause to be issued through the Division of Medical Assistance and Health Services, all necessary rules, regulations and administrative orders, and to do or cause to be done all other acts and things necessary to implement and administer demonstration projects pursuant to Title XI, section 1115 of the federal Social Security Act, including, but not limited to waiving compliance with specific provisions of this act, to the extent and for the period of time the commissioner deems necessary, as well as contracting with any legal entity, including but not limited to corporations organized pursuant to Title 14A, New Jersey Statutes (N.J.S.14A:1-1 et seq.), Title 15, Revised Statutes (R.S.15:1-1 et seq.) and Title 15A, New Jersey Statutes (N.J.S.15A:1-1 et seq.) as well as boards, groups, agencies, persons and other public or private entities;

c. To administer the provisions of this act;

d. To make reports to the federal Department of Health and Human Services as from time to time may be required by such federal department and to the New Jersey Legislature as hereinafter provided;

e. To assure that any applicant, qualified applicant or recipient shall be afforded the opportunity for a hearing should his claim for medical

assistance be denied, reduced, terminated or not acted upon within a reasonable time;

f. To assure that providers shall be afforded the opportunity for an administrative hearing within a reasonable time on any valid complaint arising out of the claim payment process;

g. To provide safeguards to restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with administration of this act;

h. To take all necessary action to recover any and all payments incorrectly made to or illegally received by a provider from such provider or his estate or from any other person, firm, corporation, partnership or entity responsible for or receiving the benefit or possession of the incorrect or illegal payments or their estates, successors or assigns, and to assess and collect such penalties as are provided for herein**[**;**]**.

(1) Except as provided in paragraph 3 of this subsection, if the division audits a cost study submitted by a Medicaid participating long-term care facility, the audit shall be initiated within three years of the due date of the cost study or the date the cost study was filed with the division, whichever is later. The division shall not be permitted to initiate such an audit after the three-year period expires.

(2) Except as provided in paragraph 3 of this subsection, if the division audits a Medicaid participating long-term care facility to determine whether the facility has correctly reported a Medicaid recipient resident's monthly income that is used to offset the resident's monthly Medicaid benefit, the audit shall be initiated within three years of the date that the income was reported or should have been reported to the division, as appropriate. The division shall not be permitted to initiate such an audit after the three-year period expires.

(3) The three-year audit limitation set forth in paragraphs 1 and 2 of this subsection shall not apply if the Medicaid participating long-term care facility, its agents or employees engaged in fraudulent activity or failed to cooperate with the division, or if a law enforcement agency or administrative agency with jurisdiction over the facility requested a delay causing the audit to extend beyond the three-year period;

i. To take all necessary action to recover the cost of benefits incorrectly provided to or illegally obtained by a recipient, including those made after a voluntary divestiture of real or personal property or any interest or estate in property for less than adequate consideration made for the purpose of qualifying for assistance. The division shall take action to recover the cost of benefits from a recipient, legally responsible relative, representative payee, or any other party or parties whose action or inaction resulted in the incorrect or illegal payments or who received the benefit of the divestiture, or from their respective estates, as the case may be and to assess and

collect the penalties as are provided for herein, except that no lien shall be imposed against property of the recipient prior to his death except in accordance with section 17 of P.L.1968, c.413 (C.30:4D-17). No recovery action shall be initiated more than five years after an incorrect payment has been made to a recipient when the incorrect payment was due solely to an error on the part of the State or any agency, agent or subdivision thereof;

j. To take all necessary action to recover the cost of benefits correctly provided to a recipient from the estate of said recipient in accordance with sections 6 through 12 of this amendatory and supplementary act;

k. To take all reasonable measures to ascertain the legal or equitable liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability; where it is known that a third party has a liability, to treat such liability as a resource of the individual on whose behalf the care and services are made available for purposes of determining eligibility; and in any case where such a liability is found to exist after medical assistance has been made available on behalf of the individual, to seek reimbursement for such assistance to the extent of such liability;

l. To compromise, waive or settle and execute a release of any claim arising under this act including interest or other penalties, or designate another to compromise, waive or settle and execute a release of any claim arising under this act. The commissioner or his designee whose title shall be specified by regulation may compromise, settle or waive any such claim in whole or in part, either in the interest of the Medicaid program or for any other reason which the commissioner by regulation shall establish;

m. To pay or credit to a provider any net amount found by final audit as defined by regulation to be owing to the provider. Such payment, if it is not made within 45 days of the final audit, shall include interest on the amount due at the maximum legal rate in effect on the date the payment became due, except that such interest shall not be paid on any obligation for the period preceding September 15, 1976. This subsection shall not apply until federal financial participation is available for such interest payments;

n. To issue, or designate another to issue, subpoenas to compel the attendance of witnesses and the production of books, records, accounts, papers and documents of any party, whether or not that party is a provider, which directly or indirectly relate to goods or services provided under this act, for the purpose of assisting in any investigation, examination, or inspection, or in any suspension, debarment, disqualification, recovery, or other proceeding arising under this act;

o. To solicit, receive and review bids pursuant to the provisions of P.L.1954, c.48 (C.52:34-6 et seq.) and all amendments and

supplements thereto, by any corporation doing business in the State of New Jersey, including nonprofit hospital service corporations, medical service corporations, health service corporations or dental service corporations incorporated in New Jersey and authorized to do business pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), P.L.1940, c.74 (C.17:48A-1 et seq.), P.L.1985, c.236 (C.17:48E-1 et seq.), or P.L.1968, c.305 (C.17:48C-1 et seq.), and to make recommendations in connection therewith to the State Medicaid Commission;

p. To contract, or otherwise provide as in this act provided, for the payment of claims in the manner approved by the State Medicaid Commission;

q. Where necessary, to advance funds to the underwriter or fiscal agent to enable such underwriter or fiscal agent, in accordance with terms of its contract, to make payments to providers;

r. To enter into contracts with federal, State, or local governmental agencies, or other appropriate parties, when necessary to carry out the provisions of this act;

s. To assure that the nature and quality of the medical assistance provided for under this act shall be uniform and equitable to all recipients;

t. To provide for the reimbursement of State and county-administered skilled nursing and intermediate care facilities through the use of a governmental peer grouping system, subject to federal approval and the availability of federal reimbursement.

(1) In establishing a governmental peer grouping system, the State's financial participation is limited to an amount equal to the nonfederal share of the reimbursement which would be due each facility if the governmental peer grouping system was not established, and each county's financial participation in this reimbursement system is equal to the nonfederal share of the increase in reimbursement for its facility or facilities which results from the establishment of the governmental peer grouping system.

(2) On or before December 1 of each year, the commissioner shall estimate and certify to the Director of the Division of Local Government Services in the Department of Community Affairs the amount of increased federal reimbursement a county may receive under the governmental peer grouping system. On or before December 15 of each year, the Director of the Division of Local Government Services shall certify the increased federal reimbursement to the chief financial officer of each county. If the amount of increased federal reimbursement to a county exceeds or is less than the amount certified, the certification for the next year shall account for the actual amount of federal reimbursement that the county received during the prior calendar year.

(3) The governing body of each county entitled to receive increased federal reimbursement under the provisions of this

amendatory act shall, by March 31 of each year, submit a report to the commissioner on the intended use of the savings in county expenditures which result from the increased federal reimbursement. The governing body of each county, with the advice of agencies providing social and health related services, shall use not less than 10% and no more than 50% of the savings in county expenditures which result from the increased federal reimbursement for community-based social and health related programs for elderly and disabled persons who may otherwise require nursing home care. This percentage shall be negotiated annually between the governing body and the commissioner and shall take into account a county's social, demographic and fiscal conditions, a county's social and health related expenditures and needs, and estimates of federal revenues to support county operations in the upcoming year, particularly in the areas of social and health related services.

(4) The commissioner, subject to approval by law, may terminate the governmental peer grouping system if federal reimbursement is significantly reduced or if the Medicaid program is significantly altered or changed by the federal government subsequent to the enactment of this amendatory act. The commissioner, prior to terminating the governmental peer grouping system, shall submit to the Legislature and to the governing body of each county a report as to the reasons for terminating the governmental peer grouping system;

u. The commissioner, in consultation with the Commissioner of Health, shall:

(1) Develop criteria and standards for comprehensive maternity or pediatric care providers and determine whether a provider who requests to become a comprehensive maternity or pediatric care provider meets the department's criteria and standards;

(2) Develop a program of comprehensive maternity care services which defines the type of services to be provided, the level of services to be provided, and the frequency with which qualified applicants are to receive services pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

(3) Develop a program of comprehensive pediatric care services which defines the type of services to be provided, the level of services to be provided, and the frequency with which qualified applicants are to receive services pursuant to P.L.1968, c.413 (C.30:4D-1 et seq.);

(4) Develop and implement a system for monitoring the quality and delivery of comprehensive maternity and pediatric care services and a system for evaluating the effectiveness of the services programs in meeting their objectives;

(5) Establish provider reimbursement rates for the comprehensive maternity and pediatric care services;

v. The commissioner, jointly with the Commissioner of Health, shall report to the Governor and the Legislature no later than two years following the date of enactment of P.L.1987, c.115

(C.30:4D-2.1 et al.) and annually thereafter on the status of the comprehensive maternity and pediatric care services and their effectiveness in meeting the objectives set forth in section 1 of P.L.1987, c.115 (C.30:4D-2.1) accompanying the report with any recommendations for changes in the law governing the services that the commissioners deem necessary.

(cf: P.L.1988, c.6, s.1)**]**[1]

[1]1. Section 17 of P.L.1968, c.413 (C.30:4D-17) is amended to read as follows:

17. (a) Any person who willfully obtains benefits under this act to which he is not entitled or in a greater amount than that to which he is entitled and any provider who willfully receives medical assistance payments to which he is not entitled or in a greater amount than that to which he is entitled is guilty of a high misdemeanor and, upon conviction thereof, shall be liable to a penalty of not more than $10,000.00 or to imprisonment for not more than 3 years or both.

(b) Any provider, or any person, firm, partnership, corporation or entity, who:

(1) Knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any cost study, claim form, or any document necessary to apply for or receive any benefit or payment under this act; or

(2) At any time knowingly and willfully makes or causes to be made any false statement, written or oral, of a material fact for use in determining rights to such benefit or payment under this act; or

(3) Conceals or fails to disclose the occurrence of an event which

(i) affects his initial or continued right to any such benefit or payment, or

(ii) affects the initial or continued right to any such benefit or payment of any provider or any person, firm, partnership, corporation or other entity in whose behalf he has applied for or is receiving such benefit or payment with an intent to fraudulently secure benefits or payments not authorized under this act or in greater amount than that which is authorized under this act; or

(4) Knowingly and willfully converts benefits or payments or any part thereof received for the use and benefit of any provider or any person, firm, partnership, corporation or other entity to a use other than the use and benefit of such provider or such person, firm, partnership, corporation or entity; is guilty of a high misdemeanor and, upon conviction thereof, shall be liable to a penalty of not more than $10,000.00 for the first and each subsequent offense or to imprisonment for not more than three years or both.

(c) Any provider, or any person, firm, partnership, corporation or entity who solicits, offers, or receives any kickback, rebate or bribe in connection with:

(1) The furnishing of items or services for which payment is or may be made in whole or in part under this act; or

(2) The furnishing of items or services whose cost is or may be reported in whole or in part in order to obtain benefits or payments under this act; or

(3) The receipt of any benefit or payment under this act, is guilty of a high misdemeanor and, upon conviction thereof, shall be liable to a penalty of not more than $10,000.00 or to imprisonment for not more than 3 years or both.

This subsection shall not apply to (A) a discount or other reduction in price under this act if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made under this act; and (B) any amount paid by an employer to an employee who has a bona fide employment relationship with such employer for employment in the provision of covered items or services.

(d) Whoever knowingly and willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the conditions or operations of any institution or facility in order that such institution or facility may qualify either upon initial certification or recertification as a hospital, skilled nursing facility, intermediate care facility, or health agency, thereby entitling them to receive payments under this act, shall be guilty of a high misdemeanor and shall be liable to a penalty of not more than $3,000.00 or imprisonment for not more than 1 year or both.

(e) Any person, firm, corporation, partnership, or other legal entity who violates the provisions of any of the foregoing subsections of this section shall, in addition to any other penalties provided by law, be liable to civil penalties of (1) payment of interest on the amount of the excess benefits or payments at the maximum legal rate in effect on the date the payment was made to said person, firm, corporation, partnership or other legal entity for the period from the date upon which payment was made to the date upon which repayment is made to the State, (2) payment of an amount not to exceed three-fold the amount of such excess benefits or payments, and (3) payment in the sum of $2,000.00 for each excessive claim for assistance, benefits or payments.

(f) Any person, firm, corporation, partnership or other legal entity, other than an individual recipient of medical services reimbursable by the Division of Medical Assistance and Health Services, who, without intent to violate this act, obtains medical assistance or other benefits or payments under this act in excess of the amount to which he is entitled, shall be liable to a civil penalty of payment of interest on the amount of the excess benefits or payments at the maximum legal rate in effect on the date the benefit or payment was made to said person, firm, corporation, partnership, or other legal entity for the period

from September 15, 1976 or the date upon which payment was made, whichever is later, to the date upon which repayment is made to the State, provided, however, that no such person, firm, corporation, partnership or other legal entity shall be liable to such civil penalty when excess medical assistance or other benefits or payments under this act are obtained by such person, firm, corporation, partnership or other legal entity as a result of error made by the Division of Medical Assistance and Health Services, as determined by said division; provided, further, that if preliminary notification of an overpayment is not given to a provider by the division within 180 days after completion of the field audit as defined by regulation, no interest shall accrue during the period beginning 180 days after completion of the field audit and ending on the date preliminary notification is given to the provider.

(g) All interest and civil penalties provided for in this act and all medical assistance and other benefits to which a person, firm, corporation, partnership, or other legal entity was not entitled shall be recovered in an administrative procedure held pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1, et seq.), except that recovery actions against minors or incompetents shall be initiated in a court of competent jurisdiction.

(h) Upon the failure of any person, firm, corporation, partnership or other legal entity to comply within 10 days after service of any order of the director or his designee directing payment of any amount found to be due pursuant to subsection (g) of this section, or at any time prior to any final agency adjudication not involving a recipient or former recipient of benefits under this act, the director may issue a certificate to the clerk of the superior court that such person, firm, corporation, partnership or other legal entity is indebted to the State for the payment of such amount. A copy of such certificate shall be served upon the person, firm, corporation, partnership or other legal entity against whom the order was entered. Thereupon the clerk shall immediately enter upon his record of docketed judgments the name of the person, firm, corporation, partnership or other legal entity so indebted, and of the State, a designation of the statute under which such amount is found to be due, the amount due, and the date of the certification. Such entry shall have the same force and effect as the entry of a docketed judgment in the Superior Court. Such entry, however, shall be without prejudice to the right of appeal to the Appellate Division of the Superior Court from the final order of the director or his designee.

(i) In order to satisfy any recovery claim asserted against a provider under this section, whether or not that claim has been the subject of final agency adjudication, the division or its fiscal agents is authorized to withhold funds otherwise payable under this act to the provider. <u>In a contested case, the division or its fiscal agents shall</u>

place the State portion of the disputed recovery claim in escrow, to be released with interest only after final agency adjudication if the provider prevails.

(j) The Attorney General may, when requested by the commissioner or his agent, apply ex parte to the Superior Court to compel any party to comply forthwith with a subpena issued under this act. Any party who, having been served with a subpena issued pursuant to the provisions of this act, fails either to attend any hearing, or to appear or be examined, to answer any question or to produce any books, records, accounts, papers or documents, shall be liable to a penalty of $500.00 for each such failure, to be recovered in the name of the State in a summary civil proceeding to be initiated in the Superior Court. The Attorney General shall prosecute the actions for the recovery of the penalty prescribed in this section when requested to do so by the commissioner or his agent and when, in the judgment of the Attorney General, the facts and law warrant such prosecution. Such failure on the part of the party shall be punishable as contempt of court by the court in the same manner as like failure is punishable in an action pending in the court when the matter is brought before the court by motion filed by the Attorney General and supported by affidavit stating the circumstances.[1]

(cf: P.L.1979, c.365, s.16)

2. (New Section) The Commissioner of [1][Human] Health and Senior[1] Services shall pay or credit a long-term care facility for any net amount discovered to be owing to the facility [1]after notice of underpayment to the facility[1] as a result of an audit performed pursuant to subsection h. of section 7 of P.L.1968, c.413 (C.30:4D-7). If the payment or credit is not made within [1][45] 60[1] days of the [1][audit] notice of underpayment[1], the payment or credit shall include interest on the amount due, at the maximum legal rate in effect on the date the payment became due, except that the duty to pay interest shall not apply until federal financial participation is available for the interest payment.

[1]The provisions of this section shall apply to an audit performed for any fiscal year ending after November 30, 1996.[1]

3. This act shall take effect immediately.

Requires Commissioner of Health and Senior Services to reimburse Medicaid long-term care facilities for underpayments discovered by audit.