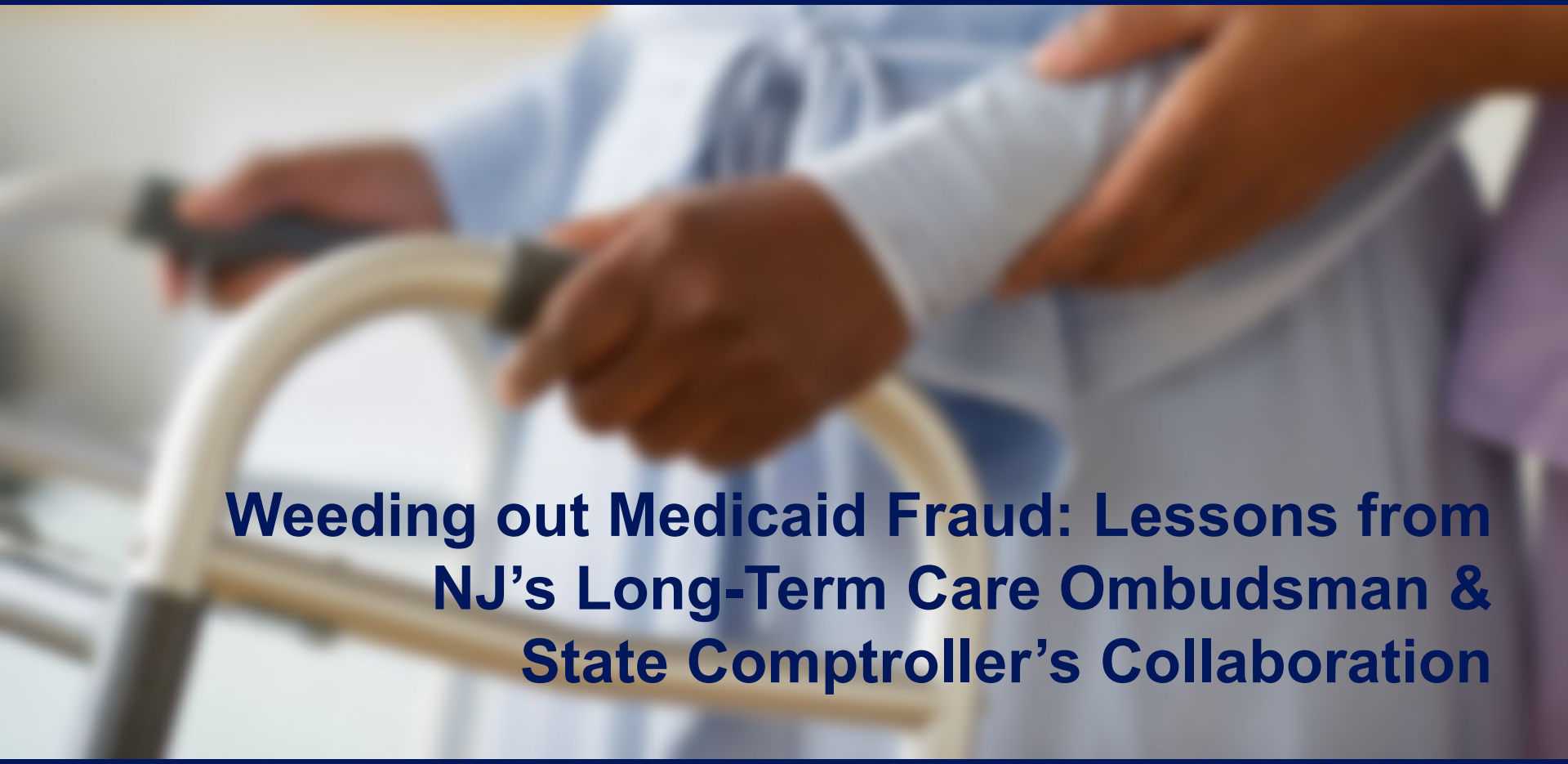


Weeding out Medicaid Fraud: Lessons from NJ's Long-Term Care Ombudsman & State Comptroller's Collaboration

A joint presentation of the
New Jersey Office of the State Comptroller and
New Jersey Office of the Long-Term Care Ombudsman

January 2025

WHO WE ARE

Laurie Facciarossa Brewer
Long-Term Care Ombudsman
State of New Jersey

Kevin D. Walsh
Acting State Comptroller
State of New Jersey

Joshua Lichtblau
Director, Medicaid Fraud Division
State of New Jersey

HISTORY & ROLES OF OSC/MFD AND LTCO

Office of the State Comptroller, Medicaid Fraud Division (MFD)

- OSC's mission is to make the state more efficient, transparent, and accountable
- MFD was made independent of the State Medicaid agency in 2010; consolidated within OSC
- MFD is the State watchdog for the Medicaid program

Office of the Long-Term Care Ombudsman (LTCO)

- LTCO originally established in 1977, name changed in 2017
- Critical on-the-ground presence in LTCs
- Resident-focused, person-centered advocacy

NEW JERSEY OFFICE OF THE STATE COMPTROLLER

New Jersey L.T.C.O. Long-Term Care Ombudsman

OSC STAR-RATINGS REPORTS

- Series of 3 reports looking at CMS star ratings
- Quantified amount of Medicaid funds spent on NJ's worst-rated nursing homes
- Several nursing homes on list multiple times, some one-star for decades

The Star-Ledger

These 15 nursing homes are the worst in N.J. and need to improve or shut down, report says

By Ted Sherman and Susan K. Livio
NJ Advance Media
February 2, 2022

The state comptroller said the state's 15 worst nursing homes are costing Medicaid more than $100 million a year and should be kicked out of the program if they don't fix what's wrong and provide better care.

In a report issued Wednesday, the watchdog agency said 15 "one-star" ranked nursing homes have failed to improve for years but have not faced any significant consequences. Fourteen out of the 15 are for-profit facilities and several are affiliated with other poorly rated long-term care providers, according to the report.

"Close to 2,000 New Jerseyans woke up this morning in these one-star nursing homes," said Acting State Comptroller Kevin D. Walsh at a press conference. "We found that hundreds of millions of Medicaid dollars flowed to one-star facilities despite the facilities having been repeatedly cited for serious health and safety issues."

The report looked at cumulative ratings of the New Jersey nursing homes over the past two years.

Walsh said New Jersey taxpayers should not be funding nursing homes that have failed to improve for years, appear unlikely to improve, and put residents in harm's way.

He said his office was "seeking to shine a light on the kind of care" residents are receiving at facilities that are below hit with

Among the nursing homes named in the report was the Andover Subacute and Rehabilitation Center in Sussex County, which came into the national spotlight over the discovery of 17 bodies, some being stored in a makeshift morgue, at the height of the COVID pandemic. Now renamed the Woodland Behavioral and Nursing Center, it remains under the same ownership and is rated a one-start facility in the latest report by The Center for Medicare and Medicaid Services, or CMS.

Some were designated as a Special Focus Facility, or SFF, placing them among other facilities that have a pattern of serious health and safety violations.

Walsh said his office did not contact any of the facilities, relying on publicly available data to do its analysis.

Only two of the nursing homes responded to requests for comment by NJ Advance Media.

Ari Lee, the administrator of Complete Care at Fair Lawn Edge, noted the most recent CMS data for January 2022 shows it's facility received a two-star ranking by CMS. That was is fact the case. The nursing home received an overall two-star or "below average" rating, but had repeatedly scored one-star through most of 2020 and 2021, according to CMS data. But the facility received a top ranking, or "much above average" for quality of resident

Grove Respiratory and Nursing Center in Williamstown, said that facility was acquired just two weeks prior to the survey cited by the comptroller's office, adding that inspectors haven't been in the building since February 2020 to witness the changes that have occurred.

"These survey results from two years ago are outdated and do not give an accurate picture of the quality of care provided at Cedar Grove Respiratory and Nursing Center," said Broyde. "With the arrival of new management, we have experienced a dramatic turnaround and are confident the improvement will be reflected in the results of the next survey."

Most nursing homes depend on Medicaid reimbursement, a joint federal and state program that helps pay for long-term care costs and serves as a safety net for those with limited income and resources. The Medicaid program annually spends around $1.74 billion for long-term care services, representing about 12% of the annual Medicaid budget, officials say.

CMS rates nursing homes on a five-star ranking system, based on issues found during health inspections. Health officials say inspectors show up unannounced to a nursing home and can spend several days evaluating resident rights and quality of life at the facility.

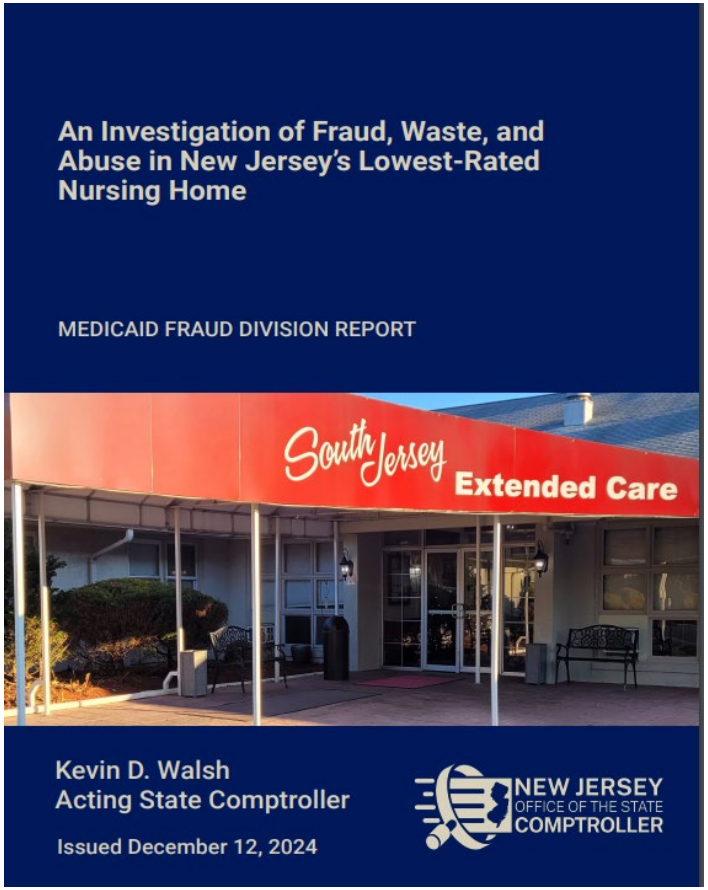
According to the comptroller, nearly half – 45.2 % – of one-star nursing homes nationally have been cited for an "immediate jeopardy" violation. In comparison, just 0.1 % of five-star nursing homes have received such a citation. Five-star is the highest ranking. One-star, or "much below average," is the lowest.

The comptroller recommended that the state's Division of Medical Assistance and Health Services within the Department of Human Services, which oversees the Medicaid program, impose restrictions on one-star long-term care facilities to improve the quality of their care. That included barring long-term care facilities from participating in Medicaid if they don't improve.

There has been a renewed focus on the quality of

SOUTH JERSEY EXTENDED CARE REPORT

- Failure to meet direct care staffing requirements in 75/75 days
- Missing qualified staff in key roles: Director of Nursing, Social Worker, MDS Coordinator
- Missing plans of care; poor medical record-keeping
- Concealed related party contracts: management, staffing, medical supplies, food, dietary services
- Inflated costs paid to related parties
- Principals operated network of nursing homes, LLCs, non-profits



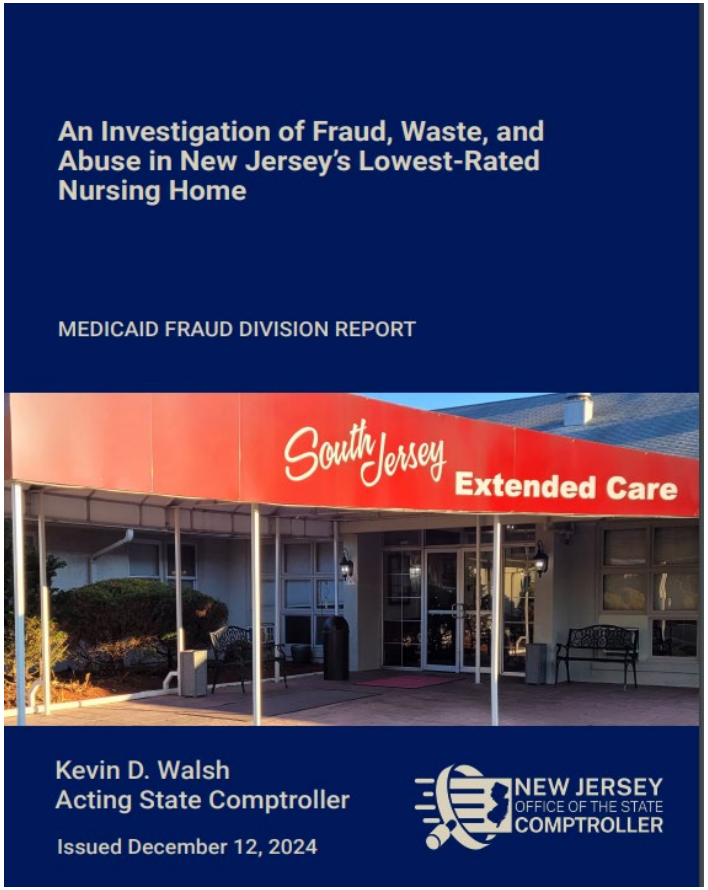
SJEC REPORT RECOMMENDATIONS

- Comprehensive approach to analyzing ownership, management, control, and financial operations
- More comprehensive vetting processes, including vetting of management companies
- Prohibition against taking equity out without approval
- Authorization to review/approve/reject leases or land transfers
- Active monitoring for financial distress
- Transfers completed by independent third party if suspended/ debarred
- Updates to the PCR

SJEC REPORT (CONT.)

Results

- Investigation ongoing
- Suspensions of principals, their related entities, and nursing homes they own to take effect February 10
- Recovery of improper payments, administrative sanctions, or other actions possible
- Referrals to other agencies
- Closure of Sterling Manor



EXCLUSION ACTIONS

MFD has authority to take the following types of exclusion actions:

- Suspension
- Debarment
- Disqualification

EXCLUSION ACTIONS – KEY DIFFERENCES

Debarment / Disqualification

- Not immediate; does not take effect while appeal pending
- Permanent for defined period; usually several years
- Must re-apply to be Medicaid provider
- No Medicaid funds to excluded parties; no involvement in Medicaid program

Suspension

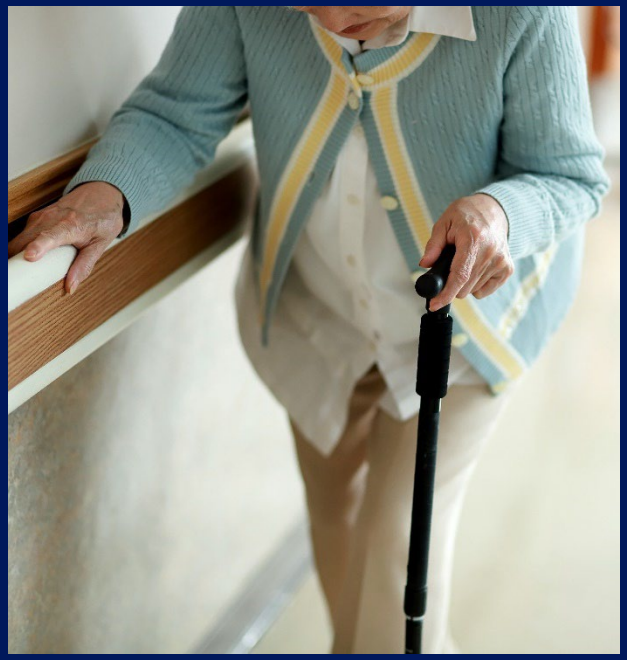
- Can be immediate; appeal rights come later
- Temporary pending conclusion of investigation or litigation
- Attorney General approval
- Must re-apply to be Medicaid provider
- No Medicaid funds to excluded parties; no involvement in Medicaid program

“GOOD CAUSE” FOR EXCLUSION

- MFD has authority to exclude a “person” from the Medicaid program.*
- Examples of “good cause” to exclude:
  - Commission of certain crimes (1 and 2)
  - Violations of laws/regulations/codes of ethics of occupations or regulated industries (7)
  - Presenting false or fraudulent claims for payment (11)
  - Failure to provide quality services within accepted medical community standards (15)
  - Causing an individual to receive service(s)/goods that were not required (18)
  - Violating any provision of the Medicaid laws or regulations (20)
  - Any other cause affecting responsibility as a State contractor of a serious and compelling nature (23)
  - Exclusion from participation in Medicaid program in another state (25)
  - And more reasons, outlined in N.J.A.C. 10:49-11.1(d)1-27

**Person includes individuals and companies or other entities.*

EXCLUSION ACTIONS – OTHER CONSIDERATIONS



- Timing is important
- Notice/counseling to residents
- Assessment of care needs, options for residents
- Coordination among stakeholders
- Effects on other entities owned/operated by suspended parties
- Transfers to affiliates/related parties of excluded individuals

HIGH-RISK PROVIDER ENROLLMENT

Denial of Enrollment into Medicaid Program

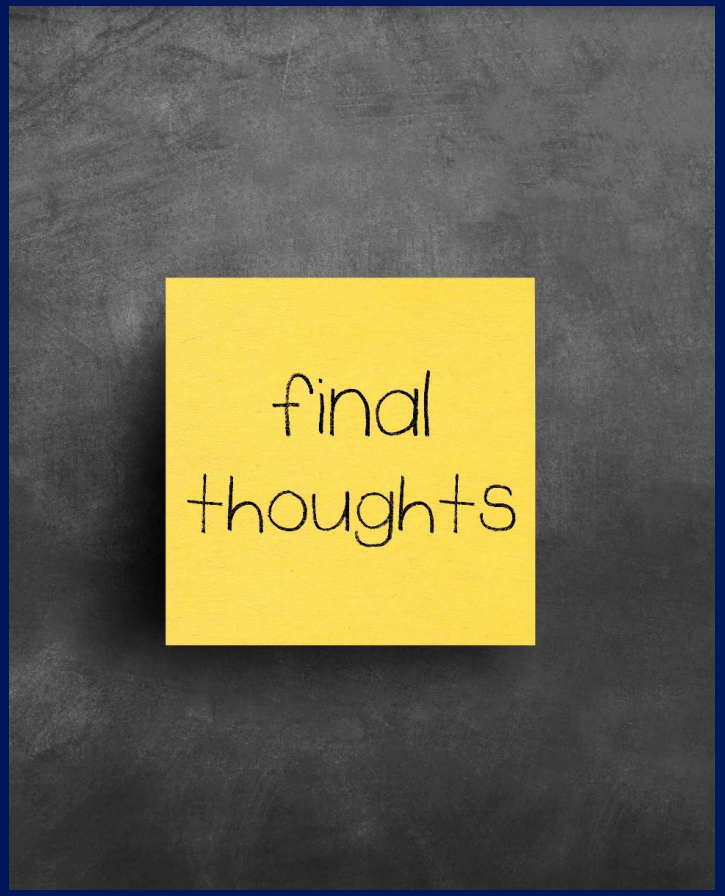
- MFD can deny enrollment into the Medicaid program for high-risk providers or terminate any existing Medicaid agreement if good cause for exclusion is found. N.J.A.C. 10:49-3.2(f)
- Skilled nursing facilities have been designated high risk providers by CMS
- Separate from DOH vetting process

RECEIVERSHIP OR "MANAGEMENT SUPPORT" AUTHORIZED

- Receivership authorized for violations of standards of health, safety, or resident care
  - See N.J.S.A. 26:2H-38
- Receivership or "management support" authorized for nursing homes in acute financial distress or at risk of filing for bankruptcy protection.
  - See N.J.S.A. 26:2H-42.1

CONCLUSIONS & FINAL THOUGHTS

- Transparency is important first step but not final step
- Fraud/siphoning and quality of care are linked
- Government should use its purchasing power and enforcement/regulatory powers



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