Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

New Jersey Comprehensive Program Integrity Review

Final Report

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Offical Response from New Jersey A1

Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the New Jersey Medicaid Program. The MIG review team conducted the onsite portion of the review at the Medicaid Fraud Division (MFD) offices. The review team also visited the office of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of the MFD, which is responsible for Medicaid program integrity in New Jersey. This report describes three effective practices, seven regulatory compliance issues, and seven vulnerabilities in the State's program integrity operations.

The CMS is concerned that the review identified two partial repeat findings, one repeat issue, and two repeat vulnerabilities from its 2009 review of New Jersey. The CMS plans on working closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

The Review

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help New Jersey improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of New Jersey's Medicaid Program

The Division of Medical Assistance and Health Services (DMAHS) administers the New Jersey Medicaid program. As of January 1, 2011, the program served 1.1 million beneficiaries, 93 percent of whom were enrolled in four managed care organizations (MCOs). The State had 34,576 fee-for-service (FFS) enrolled providers and 35,133 MCO providers. Medicaid net expenditures in New Jersey for the State fiscal year (SFY) ending June 30, 2011 totaled $10,601,527,963. This figure includes $1,835,202,634 in payments to MCOs.

Medicaid Fraud Division

In New Jersey, the MFD is the organizational component dedicated to fraud and abuse activities. The MFD is located in New Jersey's Office of the State Comptroller. At the time of the review, the MFD had 72 full-time equivalent positions allocated to Medicaid program integrity functions with 6 vacant positions. The table below presents the total number of administrative sanctions and overpayment amounts identified and collected in the last four SFYs because of MFD program integrity activities. Since the start of SFY 2012, the MFD has begun tracking preliminary and full investigations separately.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Number of Administrative Sanctions	Amount of Overpayments Identified	Amount of Overpayments Collected***
2008	Not tracked separately	Not tracked separately	238	$13,038,184	$12,493,039
2009	"	"	194	$27,118,581	$18,779,471
2010	"	"	121	$22,186,479	$20,055,288
2011	"	"	112	$28,504,586	$26,755,742

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.
***These amounts do not include third party liability, cost avoidance, and overpayments that were not a result of preliminary or full investigations. The administrative sanction overpayments identified and collected varies based on the number of providers and months sanctioned.

Methodology of the Review

In advance of the onsite visit, the review team requested that New Jersey complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, and managed care. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of November 14, 2011, the MIG review team visited the MFD and MFCU offices. The team conducted interviews with numerous MFD and DMAHS officials as well as with staff from the MFCU. To determine whether the MCOs were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the State's managed care contract. The team conducted in-depth interviews with representatives from the four MCOs and met separately with DMAHS staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate New Jersey's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of MFD, but also considered the work of DMAHS, and contractors responsible for a range of program integrity functions, including provider enrollment, contract management, and provider training. The New Jersey Children's Health Insurance Program operates under Title XXI of the Social Security Act and was, therefore, excluded from this review.

Unless otherwise noted, New Jersey provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that MFD provided.

Results of the Review

Effective Practices

As part of its comprehensive review process, the CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. New Jersey reported the use of a special projects unit to screen high-risk providers, joint collaboration and communication between MFD, managed care, and MFCU staff on program integrity issues, and recovery audit contractor engagement in the Medicaid program.

High-risk provider screenings by the Medicaid Fraud Division

The MFD performs background checks on provider types known to be high risk for fraudulent activities or most readily able to submit fraudulent billings. Such provider types include pharmacies, durable medical equipment suppliers, laboratories, independent mental health clinics, and adult medical day care centers. The MFD reviews all new applications and change of ownership requests. After its review, the MFD advises the applicant whether its application to be a provider has been approved or denied. While DMAHS has the final say on approving enrollments, the activity of the MFD allows the State to protect the integrity of the Medicaid program through an extensive pre-enrollment screening of potentially problem providers.

Joint collaboration and communication with the managed care program on program integrity issues

The MFD, DMAHS, MCOs, and MFCU work together to make the program integrity activities of the managed care program more effective. The MFD hosts monthly meetings with the MCOs' special investigation units to provide guidance in developing cases, while the MFCU hosts quarterly meetings with MCOs to discuss and provide training on current fraud schemes and abuse issues. In addition, these meetings include discussions of fraud and abuse cases, provide guidance to MCOs in developing cases, and provide opportunities for training on current fraud and abuse issues and fraud schemes.

Recovery audit contractor engagement in the Medicaid program

Since New Jersey's recovery audit contractor program was implemented on April 1, 2011, the State has recouped over $4,000,000 in overpayments and identified $19,000 in underpayments. The contractor's focus has been on: (1) hospital claims (low birth weights, ventilator support greater than 96 hours); (2) procedure unrelated to principal diagnosis; (3) tracheotomy; (4) excisional debridement; (5) physician Emergency Room E&M upcoding; (6) short stay reviews; (7) ambulance transports with overlapping inpatient stay; (8) hospital readmits within 7 days; (9) durable medical equipment claims inappropriately billed in a skilled nursing facility setting; (10) duplicate claims for hospice services; (11) improper billing for units for case management code Z1400; (12) improper billing for units for Habilitation supported employment; (13) improper units for traumatic brain injury therapy; (14) long term care overpayments; and (15) laboratory unbundling of claims.

Regulatory Compliance Issues

The State does not comply with Federal regulations relating to the referral of suspected fraud cases to the MFCU, the suspension of Medicaid payments in credible allegation of fraud cases, and provider disclosures. Issues also include not conducting complete exclusion searches and non-compliance with the State Plan regarding False Claims education.

The State does not refer all cases of suspected provider fraud to the MFCU.

Under the Federal regulation at 42 CFR § 455.21, State Medicaid agencies must refer all cases of suspected provider fraud to the MFCU; promptly comply with requests for access to records or information, including computerized data, from the agency or its contractors, and from providers; and initiate administrative or judicial actions to recover improper payments from providers.

The regulation requires the State Medicaid agency to refer all cases of suspected provider fraud to the MFCU. However, MFD is only sending criminal referrals to the MFCU. The MFD relies upon a State statute, *N.J. Stat. § 30:4D-57 (2009),* that only requires the referral of complaints alleging criminal conduct to be sent to the MFCU. According to the statute, MFD will investigate and prosecute civil Medicaid or fraud matters in coordination with the MFCU's investigation. The MFD director indicated during interviews that the office operates according to the statute.

In addition, the memorandum of understanding (MOU) between DMAHS, MFD, and the MFCU prompts DMAHS to refer potential cases relating to suspected criminal acts to the MFCU and MFD. However, the MOU does not define the role of MFD. Moreover, MFD reported that it investigates suspected provider fraud and abuse complaints prior to sending the referral to the MFCU. During case sampling, the review team noted that MFD spends a considerable amount of time developing a case before making a referral to the MFCU. For example, some cases appeared to be delayed as long as two years before a referral was made to the MFCU. The MFD director describes this process as necessary to ensure referrals are deemed acceptable by the MFCU. The MFCU indicated that a portion of the referrals received from MFD are developed to the point that only the overpayment needs to be collected by the time the case is referred. Case sampling also validated the MFCU concerns.

Recommendations: Develop and implement policies and procedures that provide for all suspected provider fraud cases to be directly referred to the MFCU in accordance with the requirements of 42 CFR § 455.21(a)(1). Update the State agency's MOU with the MFCU to include methods for ensuring that it is consistent with the regulation.

The State does not suspend payments in cases of credible allegations of fraud.

The Federal regulation at 42 CFR § 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part. Under 42 CFR § 455.23(d) the State Medicaid agency must make a fraud referral to either a MFCU or to an appropriate law enforcement agency in States

with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

The MFD is not suspending Medicaid payments upon referral to the MFCU, nor is it maintaining documentation for exception requests, as required by the regulation at 42 CFR § 455.23(a) that went into effect on March 25, 2011. The MFCU has verbally requested that MFD not suspend payment to allow time to determine if the referral will be accepted. During case sampling, the review team found three cases where there was a credible allegation of fraud and the State did not suspend payments or document the cases with good cause not to suspend the payments.

Recommendations: Develop and implement policies and procedures to suspend payments to providers when an investigation determines there is a credible allegation of fraud or document a good cause exception not to suspend. Refer such cases to the MFCU and comply with the documentation requirements of 42 CFR § 455.23.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or managed care entity, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under § 455.104(b)(2), a disclosing entity, fiscal agent, or managed care entity must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or managed care entity as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or managed care entity in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or managed care entity. As set forth under § 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and managed care entities prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or managed care entity.

The State's FFS ownership and control interest statement (dated 3/7/11) which collects disclosures from disclosing entities and fiscal agents, and the disclosure form used for the non-emergency medical transportation (NEMT) broker do not request tax identification numbers of persons with an ownership or control interest in the disclosing entity or in subcontractors as required by the regulation. Furthermore, the MCO disclosure form does not solicit the required tax identification numbers. Nor does the MCO disclosure form solicit DOB and SSN from persons with an ownership or control interest, as required by this regulation.

In addition, the ownership and disclosure form requires the NEMT broker to disclose only those with ownership and control of 10 percent or more. This does not comply with the regulation

requiring the disclosure of ownership and control interests of all persons with a 5 percent or more ownership or control interest in the disclosing entity. Moreover, the disclosure form does not ask if persons with an ownership or control interest in the broker are related to persons with ownership or control interests in any subcontractor in which the broker has a 5 percent or more ownership or control interest.

As of March 25, 2011, State agencies must capture SSNs and DOBs and enhanced address information for all persons with an ownership or control interest in providers seeking enrollment in a State Medicaid program. None of the disclosure forms used by New Jersey's FFS entity providers, fiscal agent, MCOs, or NEMT broker allow for the disclosure of the name, address, DOB, and SSN of any managing employee as required in Section (b)(4) of the regulation. The FFS application form (FD-20) does request this information for professional staff and employees directly related to the delivery of medical services and the processing of claims, however, it does not request this information from all types of managing employees. The issue as it relates to fiscal agents was identified as a finding in the CMS 2009 review.

Recommendations: Develop and implement policies and procedures or modify contracts for the appropriate collection of disclosures from disclosing entities, fiscal agents, or MCOs regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities, fiscal agents, or MCOs. Modify disclosure forms as necessary to capture all disclosures required under the regulation. The MIG made the same recommendation regarding collection of disclosures from fiscal agents in the 2009 review report.

The State does not adequately address business transaction disclosure requirements in its provider contracts. (Uncorrected Partial Repeat Finding)

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services information about certain business transactions with wholly owned suppliers or any subcontractors.

While the State relies on Section 7.37B of the managed care contract and the use of the disclosure form to report business transactions within 35 days of a request, the disclosure form does not allow for disclosure of business transaction information required by the regulation. The form only asks for information on types of transactions with a party of interest and not the regulatory information described in the contract. In addition, the NEMT contract does not contain the appropriate language.

Recommendation: Revise provider contracts to require disclosure upon request of the information identified in 42 CFR § 455.105(b). The MIG made the same recommendation regarding MCOs in the 2009 review report.

The State does not capture criminal conviction disclosures from providers or contractors.

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request.

The regulation further requires that the Medicaid agency notify the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) whenever such disclosures are made. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The State provider application (FD-22) utilized for individual FFS providers requests the practitioner to disclose any convictions of any Federal or State crime. However, the form does not ask for the same criminal conviction disclosures from persons with an ownership or control interest in the provider, agents, or managing employees as required by the regulation. In addition, the NEMT broker disclosure form does not ask owners, agents, and managing employees to disclose any criminal convictions.

Recommendations: Develop and implement policies and procedures and modify contracts for the appropriate collection of disclosures from providers and NEMT brokers regarding persons with an ownership or control interest, or persons who are agents or managing employees of the providers or brokers, who have been convicted of a criminal offense related to Medicare, Medicaid, or Title XX since the inception of the programs. Modify disclosure forms as necessary to capture all disclosures required under the regulation.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid. (Uncorrected Repeat Issue)

The Federal regulation at 42 CFR § 455.436 requires that the State Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS) no less frequently than monthly.

During the initial FFS enrollment process, only the legal name of the provider listed on the application and disclosure forms is searched for Federal exclusions and State debarments. Therefore, persons with an ownership or control interest in the provider, managing employees, and agents are not searched. In addition, the contractor used by MFD to conduct criminal background checks on high-risk providers does not search the EPLS for Federal debarments.

After enrollment, a manual comparison is performed of the provider master file and a spreadsheet which includes HHS-OIG exclusion notifications received by the State. However, this check is only performed when there is a change of ownership. The provider file contains the provider name, but no names of persons with ownership or control interests, managing employees, or agents.

In addition, the State is not searching the EPLS for Federal debarments on a monthly basis. According to State representatives, a work request has been submitted to automate monthly exclusion and debarment searches to compare this information against the provider master file.

The managed care contract language only requires MCOs to certify that they do not have a relationship with debarred and excluded individuals. The issues regarding monthly exclusion

checks for FFS and managed care programs were identified as a vulnerability in the 2009 CMS review report.

Recommendations: Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the Medicare Exclusion Database (MED)) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities in accordance with 42 CFR § 455.436.

Modify the managed care contract to require MCOs to search the LEIE and EPLS upon contract execution and monthly thereafter by the names of any person with an ownership or control interest in the MCO, or who is an agent or managing employee of the MCO. The same recommendations were made in the 2009 CMS review report.

The State does not comply with its State plan amendment regarding False Claims education monitoring.

Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least $5 million annually under a State's Medicaid program have: (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent State laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent State laws and rules.

New Jersey has an approved State plan amendment for false claims education. Entities that receive or make annual payments of at least $5 million must certify to the State annually that they have incorporated Section 6032 of the Deficit Reduction Act (DRA) into their policies and procedures. However, as of the onsite review date, some entities had not submitted the required certification for calendar years 2010 and 2011.

The State reviews a sample of the entity certifications by requiring them to submit additional documentation to support their certification. Onsite reviews may also be conducted to verify compliance with Section 6032 of the DRA. The entities that have not submitted certifications for calendar years 2010 through 2011 would not be included in this sample and therefore, do not comply with the State plan amendment. The MFD director told the review team that the State would continue to follow up with these entities to obtain the necessary certifications, but it is likely the entities continue to comply with Section 6032 of the DRA because they submitted certifications for calendar years 2007 through 2009.

Recommendation: Implement policies and procedures to monitor compliance of all providers and contractors in accordance with the State Plan amendment.

Vulnerabilities

The review team identified seven areas of vulnerability in the State's practices. These are related to inadequate policies and procedures, not requiring MCOs to verify that enrollees received services, and the failure to collect required disclosures from MCO network providers. Additional issues include incomplete exclusion searches and not reporting adverse actions to HHS-OIG.

Not having adequate written policies and procedures.

Under the regulation at 42 CFR § 455.13, the State Medicaid agency must have methods and criteria for identifying and investigating suspected fraud cases. The regulations prescribe additional requirements for the effective functioning of the States' Medicaid program integrity operations. The State has no written policies and procedures for program integrity functions. The absence of written policies and procedures leaves the State vulnerable to inconsistent operations and ineffective functioning in the event the State loses experienced program integrity or provider enrollment staff.

The MFD does not have written policies and procedures on methods and criteria for identifying and investigating suspected fraud cases. Although the State has a number of processes which support its program integrity operations, there was no program integrity manual. The State lacked written program integrity policies and procedures in such areas as surveillance and utilization review subsystem, timely claims payment, identification, investigation and referral of fraud, reporting to the HHS-OIG, checking for excluded parties, and other key areas. The MFD informed the review team that policies and procedures are in draft, but they have not had an opportunity to share these with leadership and staff. The MFD plans to have policies and procedures in final draft by March 2012.

In addition, there were no policies and procedures for program integrity oversight of managed care. The State relies on Section 7.38 of the managed care contract that requires the MCOs to comply with all State and Federal statutes and regulations regarding 42 CFR §438.608 and Section 6032 of the DRA as their policies and procedures. The managed care contract lacks detailed procedures to support program integrity operations. The State also lacks policies and procedures that would exclude MCOs from doing business with any Health Maintenance Organization (HMO) that could be excluded for reasons listed in 42 CFR 1001.1001 or 42 CFR 1001.1051. These regulations require the exclusion of entities owned and controlled by a sanctioned person and the exclusion of individuals with ownership or control interests in sanctioned entities.

Recommendation: Develop, compile, implement, and update as necessary, written policies and procedures addressing all program integrity functions related to FFS and managed care services pursuant to 42 CFR § 455.13.

Not verifying with managed care enrollees whether services billed were received. (Uncorrected Repeat Vulnerability)

The regulation at 42 CFR § 455.20 requires the State Medicaid agency to have a method for verifying with beneficiaries whether services billed by providers were received.

The State-MCO contract stipulates the contractor shall comply with all State and Federal Medicaid requirements. However, the contract does not require MCOs to have a method for verifying with beneficiaries whether services were received. Three MCOs reported that they do not verify receipt of Medicaid services with beneficiaries, while one reported only verifying services as part of an investigation to validate services received by the beneficiary. This issue was also identified in the 2009 CMS review.

Recommendation: Develop and implement procedures to verify with MCO enrollees whether services billed by providers were received. The MIG made the same recommendation in the 2009 review report.

Not capturing ownership and control disclosures from network providers.
Three of the State's MCO network provider applications for facilities do not require the name, address, DOB, SSN, or employer identification number of persons with an ownership or control interest in the provider or subcontractors that Federal regulations at 42 CFR § 455.104 would otherwise require from FFS providers. The MCO network provider is also not required to disclose the relationship of disclosed owners or interests in another disclosing entity. In addition, MCOs do not capture the name, address, DOB, and SSN of managing employees.

Recommendations: Modify the managed care contract to require, or ensure that managed care provider enrollment forms require, the disclosure of complete ownership, control, and relationship information from all managed care network providers. Include contract language requiring MCOs to notify the State of such disclosures on a timely basis.

Not adequately addressing business transaction disclosures in network provider contracts. (Uncorrected Repeat Vulnerability)
The credentialing forms and provider agreements used by the State's contracted MCOs do not require the disclosure of certain business transactions with wholly owned suppliers or any subcontractors upon request. Although the managed care contract requires MCOs to provide business transactions upon request, the review team found no documentation that the plans require this of their network providers. This issue was also identified in the 2009 CMS review.

Recommendation: Modify the managed care contract to require disclosure upon request of the information identified in 42 CFR § 455.105(b). The MIG made the same recommendation regarding the collection of business transaction disclosures in the 2009 review report.

Not capturing criminal conviction disclosures from network providers.
Three of the State's MCOs do not request disclosure of criminal convictions in health care-related crimes from their network providers that Federal regulations at 42 CFR § 455.106 would otherwise require from FFS providers. The managed care applications do not request health care-related criminal conviction disclosures since the inception of the Federal programs. In addition, they do not request similar disclosures from persons with an ownership or control

interest in the provider, agents, or managing employees.

Recommendations: Modify the managed care contract to require, or ensure that managed care provider enrollment forms require, the disclosure of health care-related criminal convictions on the part of persons with an ownership or control interest, or persons who are agents or managing employees of network providers. Include contract language requiring managed care entities to notify the State of such disclosures on a timely basis.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

The regulations at 42 CFR §§ 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the Medicaid Management Information System, then the State cannot conduct adequate searches of the LEIE or the MED.

The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the EPLS on a monthly basis.

The MCO contract states the contractor shall not knowingly have a relationship with debarred, suspended, or excluded individuals. The State delegates the oversight of this verification to an External Quality Review Organization (EQRO) to ensure the MCO is not doing business with debarred individuals/entities. However, neither the State nor the EQRO is searching the names of parties disclosed in any of the exclusion or debarment databases. The EQRO Annual Assessment of HMO Operations Guideline only requires review of the MCO contract for compliance and checking exclusion or debarment databases is not included.

However, the State's MCO contract requires credentialing procedures to include verification on a monthly basis that providers and subcontractors have not been suspended, debarred, disqualified, terminated, or otherwise excluded from Medicaid, Medicare, or any other Federal or State health care program.

Two MCOs reported during interviews that they do not check the EPLS monthly. However, one health plan is developing a database that is similar to the LEIE automated process to conduct monthly checks. Although the MCOs indicated they perform monthly checks of the LEIE

databases for network providers, the checks do not include exclusion searches for owners, officers, and managing employees.

Recommendations: Amend the contract to require the appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Require the contractor to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or re-credentialing of network providers, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Not reporting all adverse actions taken on provider participation to the HHS-OIG.
The State Medicaid agency does not have clear policies and procedures or contract requirements directing the MCOs to report to it any program integrity-related adverse actions the MCO takes on a provider's participation in the network, e.g., denials of credentials, enrollment, or contracts, or terminations of credentials, enrollment, or contracts. Program integrity reasons include fraud, integrity, or quality.

The State Medicaid agency does not require MCOs to inform them when the MCOs have denied or terminated enrollment or credentialing of a provider due to program integrity concerns, and the State is therefore unable to make the required report to the HHS-OIG. Although one MCO reported terminations are sent to DMAHS, they do not specify the reason the provider is no longer in the network.

Recommendations: Require contracted MCOs to notify the State when they take adverse action against a network provider for program integrity-related reasons. Develop and implement procedures for reporting these actions to HHS-OIG, and modify MCO contracts to require proper reporting to the State.

Conclusion

The State of New Jersey applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These practices include:

- high-risk provider screenings,
- effective collaboration and communication with managed care on program integrity issues, and
- recovery audit contractor's engagement in the Medicaid program.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of seven areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, seven areas of vulnerability were identified. The CMS is particularly concerned over the five repeat findings and vulnerabilities. The CMS expects the State to closely examine the vulnerabilities that were identified in this review and correct them as soon as possible.

To that end, we will require New Jersey to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of New Jersey will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If New Jersey has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of New Jersey on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

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Re: New Jersey Response - CMS Review of New Jersey Medicaid Program Integrity Procedures and Processes

Dear Mr. Miller:

Thank you for giving the New Jersey Division of Medical Assistance & Health Services (DMAHS) and the Medicaid Fraud Division of the Office of the State Comptroller (MFD) the opportunity to comment on the final Program Integrity Review report dated June 21, 2012.

1. Issue: The State does not refer all cases of suspected fraud to the MFCU.

Recommendation:

Develop and implement policies and procedures that provide for all suspected provider fraud cases to be directly referred to the Medicaid Fraud Control Unit (MFCU) in accordance with the requirements of 42 CFR § 455.21(a)(1). Update the State agency's Memorandum of Understanding (MOU) with the MFCU to include methods for ensuring that it is consistent with the regulation.

State Response:

The Medicaid Fraud Division (MFD) has implemented policies and procedures to provide for all suspected provider fraud cases to be directly referred to the MFCU in accordance with the requirements of 42 CFR §455.21 (a)(1). The MFD, the MFCU and Division of Medical Assistance and Health Services (DMAHS) have an amended MOU that should be finalized within the next 90 days.

Robb Miller
August 9, 2012

2. Issue: The State does not suspend payments in cases of credible allegations of fraud.

Recommendation:

Develop and implement policies and procedures to suspend payments to providers when an Investigation determines there is a credible allegation of fraud or document a good cause exception not to suspend. Refer such cases to the MFCU and comply with the documentation requirements of 42 CFR §455.23.

State Response:

The MFD has implemented policies and procedures to suspend payments to providers when an investigation determines there is a credible allegation of fraud or to document a good cause exception not to suspend. These cases have been and are being referred to the MFCU and are being documented according to the requirements of 42 CFR §455.23.

3. Issue: The State does not capture all required ownership and control disclosures from disclosing entities.

Recommendation:

Develop and implement policies and procedures or modify contracts for the appropriate collection of disclosures from disclosing entities, fiscal agents, or MCOs regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities, fiscal agents, or MCOs. Modify disclosure forms as necessary to capture all disclosures required under the regulation.

State Response:

DMAHS is in the process of revising its Disclosure of Ownership Form as well as its provider enrollment applications to address the requirements of 455.104 with respect to capturing social security numbers and dates of birth for all persons with an ownership or control interest or managing employees in providers seeking enrollment in the Medicaid program.

With respect to the MCO contract, the Disclosure Form in the contract, effective July 1, 2011, requires that all persons with an ownership interest or control interest and managing employees disclose their name, address, date of birth, social security number, and tax 10 number as required by 42 CFR §104(b)(1)(ii) and (b)(4). The contract provision, including the revised form, was approved by CMS in September 2011.

The report pointed out that three of the four MCOs do not ask for disclosure information concerning individuals with ownership or control and relationship information from individual providers in the credentialing and re-credentialing process, nor do the MCOs capture the name, address, date of birth and Social Security number or managing employees. These issues were addressed in sections 4.6.1 (C)(5) and (6) of the

managed care contract, effective January 1, 2012, and received CMS approval in May 2012.

DMAHS agreed with the Non-Emergency Medical Transportation (NEMT) contractor in the fall of 2011 to begin collecting the information necessary to comply with the requirements of 42 CFR §455.1 04(b)(1)(ii) and (iii) the contract with the NEMT contractor was formally amended as of July 1, 2012.

4. Issue: The State does not adequately address business transaction disclosure requirements in its provider contracts.

Recommendation:

Revise provider contracts to require disclosure upon request of the information identified in 42 *CFR* § *455.105(b)*

State Response:

Effective July 1, 2011, Section B.7.2 at 2, which addressed required language in all provider contracts and subcontracts was amended. Also, effective July 1, 2011 Section 7.37B of the contract with the MCOs was amended, as was question 111.(g) of the revised Disclosure of Ownership Form, to include the requirement that reporting must be made to the Secretary of the United States Department of Health and Human Services and the 35 day requirement to do so.

Section 7.37 of the contract was amended again in September 2011 to require that the disclosure form be completed by the contractor's providers, subcontractors, and subcontractor's providers at the time of credentialing and re-credentialing. This requirement is referenced in sections 3.3.2 on Provider Credentialing, 4.6.1 on Quality Assessment and Quality Improvement Plan, and 4.85 (Credentialing and Recredentialing). The September amendments were effective January 1, 2012 and received CMS approval in May 2012.

5. Issue: The State does not capture criminal conviction disclosures from providers or contractors.

Recommendation:

Develop and implement policies and procedures and modify contracts for the appropriate collection of disclosures from providers and NEMT brokers regarding persons with an ownership or *control interest,* or *persons who are agents* or *managing employees of the providers* or *brokers, who have been convicted of* a *criminal offense related to Medicare, Medicaid,* or *Title XX since the inception of the programs. Modify disclosure forms* as *necessary to capture all disclosures required under the regulation.*

State Response:

DMAHS is in the process of revising its Disclosure of Ownership Form and provider enrollment applications to include agents and managing employees.

Effective January 1, 2012, Section 7.37 of the managed care contract was amended to require the MCOs to capture the required criminal conviction information from the contractor's providers, subcontractors, and subcontractor's providers. Section IV of the Disclosure Form for MCOs includes the required criminal conviction information from managing employees or agents of the MCO.

6. Issue: The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

Recommendations:

Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an *ownership* or *control interest,* or *who* is *an agent* or *managing employee of the provider. Search the List of Excluded Individuals/Entities (LEIE) (or the Medicare Exclusion Database (MED)) and the Excluded Parties List System (EPLS) upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons* or *entities In accordance with 42 CFR* § 455.436.

Modify the managed care contract to require MCOs to search the LEIE and EPLS upon contract execution and monthly thereafter by the names of any person with an ownership or *control Interest in the MCO,* or *who* is an *agent* or *managing employee of the MCO.*

State Response:

Currently Molina Medicaid Solutions (Molina), the state's fiscal agent, searches the LEIE and EPLS databases for new applicants to the Medicaid program. Additionally, DMAHS is presently working with Molina to meet the requirements of 42 CFR §455,436, with a goal to be in compliance by January 2013.

Effective January 1, 2012, Section 3.3.2 of the managed care contract was amended to require that the MCOs check the EPLS and LEIE databases no less frequently than monthly. CMS approved this contract change in May 2012.

7. Finding: The State does not comply with its State plan amendment regarding False Claims education monitoring.

Recommendation:

Implement policies and procedures to monitor compliance of all providers and contractors in accordance with the State Plan amendment.

State Response:

As of April 26, 2012 all entities required to comply with Section 6032 have submitted certification forms for CY 2010 and CY 2011.

Robb Miller
August 9, 2012

VULNERABILITIES

1. Vulnerability: Not having adequate written policies and procedures.

Recommendation:

Develop, compile, implement, and update as necessary, written policies and procedures addressing all program integrity functions related to FFS and managed care services pursuant to 42 *CFR* §455. 13.

State Response:

The MFD has written policies and procedure addressing all program integrity functions related to FFS and managed care services pursuant to 42 CFR §455.13.

2. Vulnerability: Not verifying with managed care enrollees whether services billed were received.

Recommendation:

Develop and implement procedures to verify with MCO enrollees whether services billed by providers were received.

State Response:

Section 7.38.38 of the MCO contract was amended, effective January 1, 2012, to require the MCOs to verify with their enrollees that services billed by providers were received.

3. Vulnerability: Not capturing ownership and control disclosures from network providers.

Recommendation:

Modify the managed care contract to require, or ensure that managed care provider enrollment forms require, the disclosure of *complete ownership, control, and relationship information from all managed care network providers. Include contract language requiring MCOs to notify the State* of *such disclosures on* a *timely basis.*

State Response:

See response to Issue 3 above.

4. Vulnerability: Not adequately addressing business transaction disclosures in network provider contracts.

Recommendation:

Modify the managed care contract to require disclosure upon request of the information identified in 42 *CFR* § *455.105(b).*

Robb Miller
August 9, 2012

State Response:

See response to Issue 4 above.

5. Vulnerability: Not capturing criminal conviction disclosures from network providers.

Recommendation:

Modify the managed care contract to require, or *ensure that managed care provider enrollment forms require, the disclosure of health care-related criminal convictions on the part of persons with an ownership* or *control interest,* or *persons who are agents* or *managing employees of network providers. Include contract language requiring managed care entities to notify the State of such disclosures on* a *timely basis.*

State Response:

See response to Issue 5 above.

6. Vulnerability: Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

Recommendation:

Amend the contract to require the appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a *direct* or *indirect ownership interest of* 5 *percent* or *more,* or *who is an agent* or *managing employee of the disclosing entity,* or *who exercises operational* or *managerial control over the disclosing entity Require the contractor to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing* or *re-credentialing of network providers, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons* or *entities.*

State Response:

See response to Issue 6 above.

7. Vulnerability: Not reporting all adverse actions taken on provider participation to the HHS-OIG.

Recommendation:

Require contracted MCOs to notify the State when they take adverse action against a *network provider for program integrity-related reasons. Develop and implement procedures for reporting these actions to HHS-OIG, and modify MCO contracts to require proper reporting to the State.*

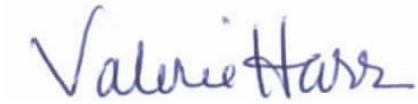
Robb Miller
August 9, 2012

State Response:

Section 3.2 of the MCO contract was amended, effective January 1, 2012 to add new subsection (e), requiring the MCOs to report any providers denied participation for cause to the MFD. This amendment was approved by CMS in May 2012. The MFD will propose a further amendment to this section for the new July 1, 2012 contract amendment to include requiring the MCOs to inform the MFD about any adverse action taken against a network provider for program-related reasons. MFD will report this information to the HHS-OIG.

Thank you for the opportunity to comment. If you should have any questions, please contact Mark Anderson at 609-292-4350 or by e-mail at Mark.Anderson@osc.state.nj.us or Richard H. Hurd at 609-588-2550 or by e-mail at Richard.H.Hurd@dhs.state.nj.uus .

Sincerely,



Valerie Harr
Director – DMAHS

Mark Anderson
Director – MFD

c: Richard Hurd