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Centers for Medicare & Medicaid Services

Medicaid Integrity Program

New Jersey Comprehensive Program Integrity Review

Final Report

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TABLE OF CONTENTS

Introduction....1

The Review....1
- Objectives of the Review....1
- Overview of New Jersey's Medicaid Program....1
- Program Integrity Section....1
- Methodology of the Review....2
- Scope and Limitations of the Review....2

Results of the Review....3
- Effective Practices....3
- Regulatory Compliance Issues....5
- Vulnerabilities....6

Conclusion....9

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 Office of the Medicaid Inspector General (OMIG) and the Division of Medical Assistance and Health Services (DMAHS). The review team also met with the Medicaid Fraud Control Unit (MFCU).

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

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 DMAHS administers the New Jersey Medicaid program. In the State fiscal year (SFY) ending June 30, 2008, the program served a total of 894,861 beneficiaries, 668,827 of whom were enrolled in 5 managed care organizations (MCOs). Total Medicaid expenditures during SFY 2008 were $9,276,450,628. This figure includes nearly $1,500,000,000 in payments to MCOs. The State had 32,549 fee-for-service (FFS) enrolled providers and 20,900 MCO providers. During Federal fiscal year 2008, the Federal medical assistance percentage for New Jersey was 50 percent.

Program Integrity Section

In New Jersey, the OMIG is the organizational component dedicated to fraud and abuse activities. The OMIG is an independent agency located in New Jersey's Office of the State Comptroller. Established by State legislation in 2008, the OMIG started up as a separate organizational entity in March 2009. Many of its initial staff was transferred from DMAHS. At the time of the review, OMIG had 33 full-time equivalent staff focusing on Medicaid program integrity. The table below presents the total number of investigations, identified overpayments, and amounts recouped in the past four SFYs as a result of program integrity activities undertaken prior to the establishment of OMIG.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected
2005	431	125	$5,359,376	$8,325,015
2006	433	75	$11,664,359	$16,534,771
2007	433	50	$3,885,007	$ 4,352,405
2008	498	30	$1,045,556	$11,528,152

*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.

The discrepancy between overpayments identified and overpayments collected reflects additional dollars coming to the State from interest, treble damages, false claim penalties, and national settlements.

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, managed care, and the MFCU. A five-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of June 8, 2009, the MIG review team visited the OMIG, DMAHS and MFCU offices. The team conducted interviews with numerous OMIG and DMAHS officials, the State's provider enrollment contractor, and the MFCU director. Finally, to determine whether MCOs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed DMAHS staff. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of five MCOs. In addition, the team conducted sampling of provider enrollment applications, FFS and managed care case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of OMIG and DMAHS as they relate to program integrity but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care and non-emergency medical transportation.

New Jersey operates both a Medicaid expansion and stand alone Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act. The expansion program operates under the same billing and provider enrollment policies as New Jersey's Title XIX program. The same findings, vulnerabilities, and effective practices discussed in relation to the Medicaid

program also apply to the expansion CHIP. The stand alone program operates under the authority of Title XXI and is beyond the scope of 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 OMIG and DMAHS provided.

RESULTS OF THE REVIEW

Effective Practices

The State of New Jersey has highlighted several practices that demonstrate its commitment to program integrity. These practices include the use of a Special Projects Unit to screen high-risk providers, effective controls on one-time and inactive providers, and frequent and regular communications on program integrity issues among State, MFCU, and MCO staff.

High-risk provider screenings by the Special Projects Unit (SPU)
The OMIG maintains an SPU which performs background checks on provider types known to be high risk for fraudulent activities or most readily able to submit "thin air" billings. Such provider types include pharmacies, durable medical equipment suppliers, laboratories, partial care providers (independent mental health clinics), and adult medical day care centers. The SPU reviews all new applications and change of ownership requests. After its review, the SPU recommends to DMAHS whether to enroll a given provider in the program. While DMAHS has the final say on approving enrollments, the activity of the SPU allows the State to protect the integrity of the Medicaid program through an extensive pre-enrollment screening of potentially problem providers. It also provides a vehicle for program integrity staff input into the provider enrollment process that is missing in many States.

Effective policies on one-time providers and controls on inactive providers
The DMAHS has developed a one-time provider enrollment policy which allows it to reimburse out-of-state providers (or non-certified in-state providers) for emergency medical services provided to New Jersey Medicaid recipients. The policy controls the potential for fraud and abuse by only allowing date-specific reimbursement. The Medicaid agency has also developed effective methods of restricting inactive providers. It deactivates any provider's Medicaid number after 18 months of inactivity and requires all providers to reapply to the Medicaid program if they want to start billing after 24 inactive months.

Frequent and regular communications on program integrity issues with the MFCU and MCOs.
The OMIG participates in frequent and regular meetings on fraud and abuse cases with all parties involved in program integrity activities. For example, it meets on a monthly basis with representatives of DMAHS and the MFCU in order to discuss potential fraud and abuse cases in the FFS program. The OMIG also takes part in quarterly MFCU-sponsored meetings with representatives of DMAHS and all contracted MCOs. These meetings

include discussions of fraud and abuse cases, offer MCOs guidance in developing cases, and provide opportunities for training on current fraud and abuse issues and fraud schemes. The OMIG director indicated that he would like to conduct these meetings on a monthly basis. The MCO representatives stated that the meetings offer them a chance to share information and coordinate cases among themselves.

Additionally, the MIG review team identified four practices that are particularly noteworthy. The CMS recognizes New Jersey's efforts to publicly post a consolidated State debarment list, to monitor excluded individuals through wage and labor database matches, and to promote regular program integrity reporting and communications from MCOs. The CMS also recognizes the State's use of broad regulatory and statutory authority to deal with problem providers.

Web posting of consolidated State debarment list

The New Jersey Department of Treasury maintains a list of individuals who are debarred or suspended from participating in, or contracting with, State programs. The consolidated State debarment list is publicly posted and used by the provider enrollment contractor during enrollment. It is shared with the neighboring States of New York and Pennsylvania in an effort to limit the opportunities for debarred providers to cross state lines. The practice of publicly posting the debarment list also facilitates compliance with CMS State Medicaid Director Letter (SMDL #09-001), issued on January 16, 2009, in that it makes it easier for all providers to check for excluded individuals among their employees.

Monitoring of excluded individuals through Operation X

Operation X is a New Jersey initiative in which program integrity staff match the Social Security numbers of excluded individuals against the New Jersey Wage and Labor database to identify those excluded individuals who continue to work for health care entities. The State obtains the Social Security numbers of the excluded individuals from the Medicare Exclusion Database which it receives every month from CMS. If a match is found, an investigator will contact the health care entity to determine if the individual is working directly or indirectly with Medicaid recipients. If a link is confirmed, the OMIG will initiate recovery actions from the health care facility/provider and notify the excluded individual and the U.S. Department of Health and Human Services-Office of Inspector General (HHS-OIG) of the pertinent findings. An OMIG representative reported that in SFYs 2008-09, New Jersey opened 11 Operation X cases, at least 1 of which has been completed and is being worked up for recovery of overpayments.

Effective oversight of MCO program integrity issues

The DMAHS requires each MCO to provide quarterly summaries of its fraud and abuse case investigations. The model MCO contract requires the reports to be completed in a uniform format with designated fields that include room for a short description of the case and outcome. A review of sample quarterly reports by the MIG team revealed that the MCOs described their cases in a short but informative way. During an interview, one senior OMIG staff member stated that daily conversations also took place between her office and the MCOs regarding incidents of suspected Medicaid fraud and abuse, and indicated that OMIG must give approval before the Special Investigative Units within the MCOs are permitted to initiate formal investigations.

Broad regulatory and statutory authority to deal with problem providers
The New Jersey State statutes and Administrative Code contain many provisions which allow the OMIG, in conjunction with DMAHS, to deal with provider fraud and abuse effectively and in nuanced ways. For example, the State can:

- deny a provider access to the Medicaid program for 23 different reasons which cover all possible prior infractions in health care or other types of previous employment;
- apply partial withholding of payments to providers who do not warrant exclusion from the program but would otherwise have to file bankruptcy;
- mandate that providers who are initially denied enrollment not be allowed to reapply to the program for the period of one year;
- suspend all Medicaid payments to egregious providers prior to a hearing; and,
- make use of permissive exclusions to disqualify providers from future participation in Medicaid.

These statutory and regulatory tools give the State a great deal of flexibility in dealing with different types of fraud, waste and abuse in the program. They allow intermediate sanctions against lesser offenders, while permitting the State to take swift and effective actions against providers whose actions represent the greatest risks to Medicaid dollars. The OMIG indicated to the review team that the providers listed on the New Jersey Consolidated Debarment List represented a mix of mandatory and permissive exclusions. The State routinely uses its discretionary authority to exclude providers based on program integrity-related indictments. It does not require convictions to remove problem providers from the program.

Regulatory Compliance Issues
The State is not in compliance with Federal regulations related to disclosure requirements.

The State does not capture all required ownership, control, and relationship information from its fiscal agents.
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person 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. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person 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. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing

entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

The State was unable to provide evidence that it is collecting from its fiscal agents (FAs) the names and addresses of each person with a 5 percent or greater ownership or control interest and information on their relationships before the State enters into or renews a contract with these entities. Although the FA that maintains the Medicaid Management Information System (MMIS) submitted ownership and control information prior to contracting, the disclosure form provided listed ownership stakes of 10 percent or greater and omitted mention of spouse/parent/child/sibling relationships. New Jersey also uses several FAs to service its home and community based waiver programs. Documents from these FAs likewise did not contain the required disclosures.

***Recommendations*:** Modify all contracts to capture the required ownership, control, and relationship information. Obtain necessary disclosures from the fiscal agents.

New Jersey's provider enrollment agreement does not require the disclosure of business transactions, upon request.
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. Providers must submit business information within 35 days of the date of a request by the Secretary or the Medicaid agency.

New Jersey's contracts with its five MCOs do not include a provision requiring the MCOs to disclose business transactions to the Secretary or the Medicaid agency, upon request, within the required 35 day timeframe.

Recommendation: Modify the MCO contracts/provider agreements to require disclosure upon request of the information identified in 42 CFR § 455.105(b).

Vulnerabilities
The review team identified five areas of vulnerability in New Jersey's program integrity practices. These included the failure to check provider exclusions on a monthly basis, the absence of an OMIG Memorandum of Understanding (MOU) with the MFCU, several issues relating to disclosures, and beneficiary service verifications in the managed care program.

Not checking exclusion databases on a monthly basis.
The Medicaid agency checks the List of Excluded Individuals/Entities (LEIE) maintained by the HHS-OIG when providers apply to the FFS Medicaid program. However, the agency does not continue checking on a monthly basis. The New Jersey fiscal agent maintains a web based database into which all provider applicant documents are scanned, including the names of any listed owners and managing employees. However, although this database retains computer files of scanned information organized by provider number, the information it contains on owners and

managing employees is not matched against the LEIE or Medicare Exclusion Database on a monthly basis. In addition, interviews with the MCOs revealed that two of five contracted health plans did not check the LEIE on a monthly basis.

This practice does not follow the directives on exclusion checking issued in SMDLs of June 12, 2008 (#08-003) and January 16, 2009 (#09-001). The former directed States to conduct monthly exclusion checks on providers, owners and managing employees within the FFS program, while the latter directed State Medicaid agencies to require their providers, including MCOs, to perform similar checks on employees within their businesses.

Recommendations: Develop and implement policies and procedures to perform monthly checks of the LEIE in the FFS Medicaid program. These should include the storage of information on providers and key affiliated parties in a searchable database where they can be checked for exclusions on a ongoing basis. Revise State-MCO contracts and MCO provider agreements to require monthly exclusion checks by MCOs and network providers.

Not incorporating OMIG's role in an MOU with the MFCU.
New Jersey has traditionally had an MOU between DMAHS and the MFCU. With the March 2009 creation of OMIG, most of the functions and responsibilities assigned to DMAHS in the MOU now fall to OMIG. However, while both MFCU and OMIG leadership indicated in interviews that they are considering a modification of the MOU to reflect the new organizational relationships, as of yet no steps have been taken to negotiate a new MOU. This would seem appropriate, in any case, because the current MOU in effect between DMAHS and the MFCU was signed in 2000 and needs review. Although New Jersey's reorganization is recent and many startup tasks are still being undertaken, failure to negotiate a new MOU that defines the role of OMIG could become a problem in the future if there is a loss of experienced staff with institutional memory.

Recommendation: Develop and implement an MOU that specifies the current roles and responsibilities of OMIG, the MFCU, and DMAHS.

Not collecting criminal conviction information from managing employees of MCO providers. Not requiring MCOs to report such information to the State.
New Jersey's MCOs do not collect health care-related criminal conviction information on managing employees who work for network providers. In addition, the model MCO contract contains no language requiring MCOs to collect the disclosures or to notify the Medicaid agency of criminal conviction disclosures. This does not allow DMAHS to notify HHS-OIG of such disclosures in the required 20 day timeframe.

Recommendations: Modify the managed care contract to require the disclosure of health care-related criminal convictions on the part of managing employees who work for the network provider. Include in the contract language requiring MCOs to notify the State of such disclosures on a timely basis.

Not requiring disclosure of business transaction information, upon request, in the managed care credentialing process.
New Jersey's MCOs do not require individual providers to agree to disclose the full business transaction information, upon request, which is required from FFS Medicaid providers. Managed care provider agreements and contracts also do not have language which requires providers to furnish the information to the Medicaid agency or the Secretary within 35 days of the request.

Recommendations: Modify the MCO provider contracts to require disclosure of the required business transaction information. Include in the contracts language requiring the MCOs to notify the Medicaid agency of such disclosures.

Not verifying whether managed care services billed by providers were received.
New Jersey's FFS Medicaid program uses a sample of Explanations of Medical Benefits to verify with beneficiaries that services billed by providers have actually been received. The State-MCO contract also requires MCOs to do some form of service verification with beneficiaries. However, at the time of the review, three of the five MCOs indicated that they did not do any form of service verification with beneficiaries except in the case of providers under active investigation. One plan indicated that it endeavored to verify services through a clinical review process, but this did not involve beneficiaries confirming the receipt of services listed in their records. The other two MCOs indicated that they did verify services with a targeted population as part of their care and case management program.

Recommendation: Develop and implement a method for monitoring MCO compliance with the contract requirement that all plans verify with beneficiaries whether billed services were received.

CONCLUSION

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

- public posting of a Consolidated State Debarment List on the State's website,
- monitoring of excluded individuals through wage and labor database matches,
- use of broad regulatory and statutory authority to deal with problem providers,
- high-risk provider screenings by the OMIG's SPU,
- effective controls on one-time and inactive providers,
- effective oversight of MCO program integrity issues, and
- frequent and regular communications with the MFCU

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

However, the identification of two areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, five areas of vulnerability were identified. The CMS encourages OMIG to closely examine each area of vulnerability that was identified in this review.

It is important that these issues be rectified 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.