Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

New Jersey Focused Program Integrity Review

Final Report

March 2020

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) is committed to performing program integrity reviews with states in order to identify risks and vulnerabilities to the Medicaid program and assist states with strengthening program integrity operations. The significance/value of performing onsite program integrity reviews include: (1) assess the effectiveness of the state's program integrity efforts, including compliance with certain Federal statutory and regulatory requirements, (2) identify risks and vulnerabilities to the Medicaid program and assist states to strengthen program integrity operations, (3) help inform CMS in developing future guidance to states and (4) help prepare states with the tools to improve program integrity operations and performance.

The CMS conducted a focused review of New Jersey to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing corrective actions related to CMS' previous comprehensive program integrity review conducted in calendar year 2014.

During the week of June 10, 2019, the CMS review team consisting of three persons, visited the offices of New Jersey's single state Medicaid agency, Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) and the New Jersey Office of the State Comptroller, Medicaid Fraud Division (MFD). The MFD is responsible for the program integrity oversight. The team conducted interviews with key staff. In addition, the CMS review team conducted sampling of program integrity cases investigated by the MCOs special investigations units (SIUs), as well as other primary data in order to validate the state and the selected MCOs program integrity practices.

Summary of Recommendations

The CMS review team identified a total of 12 recommendations based upon the completed focused review modules and supporting documentation, as well as discussions and/or interviews with key stakeholders. The recommendations were in the following areas: State Oversight of Managed Care Program Integrity Activities, MCO Investigations of Fraud, Waste, and Abuse, Encounter Data, Payment Suspensions, and Terminated Providers and Adverse Action Reporting. The recommendations will be detailed further in the next section of the report.

Overview of New Jersey Medicaid

- The Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) is the single state agency responsible for providing oversight of the Medical Assistance plans in New Jersey.
- The New Jersey Office of the State Comptroller, Medicaid Fraud Division is the organizational unit responsible for the overall program integrity operations.
- In FFY 2017, New Jersey's Medicaid expenditures exceeded $15 billion. The Federal Medical Assistance Percentage matching rate was 59.5 percent.

Overview of Managed Care in Missouri

- In FFY 2017, New Jersey Managed Care expenditures were approximately $9,758,901,028. This figure includes both Medicaid and Children's Health Insurance Program (CHIP).
- In FFY 2017, New Jersey has approximately 1,461,806 (excluding CHIP/ MCHIP) beneficiaries or 95 percent of the Medicaid population, were enrolled in four MCOs.
- During the onsite review three out of the five operating MCOs were interviewed; Amerigroup, United Health Care and Well Care. Table 1 and Table 2 below provide enrollment/SIU and expenditure data for each MCO.

Table 1.

	Amerigroup New Jersey Inc.	**United Health Care**	**WellCare**
Beneficiary enrollment total	167,903	387,339	77,535
Provider enrollment total	29,191	24,836	72,957
Year originally contracted	02/01/1996	10/01/2000	12/01/2013
Size and composition of SIU	14	9	10
National/local plan	National	National	National

Table 2.

MCOs	**FFY 2016**	**FFY 2017**	**FFY 2018**
Amerigroup New Jersey, Inc.	$1,025,161,692	$1,021,031,668	$1,010,064,086
United Health Care	$2,330,984,341	$2,493,522,608	$2,678,522,608
WellCare	$397,107,992	$513,396,477	$616,380,109

*Expenditure data reported above were submitted by each of the MCOs.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible. These issues and CMS' recommendations for improvement are described in detail in this report.

State Oversight of Managed Care Program Integrity Activities

The Division of Medical Assistance and Health Services (DMAHS) administers the state's Medicaid program referred to as NJ Family Care. NJ FamilyCare provides comprehensive health benefits to eligible beneficiaries through MCOs. The DMAHS is responsible for providing oversight of the MCO contracts. The New Jersey Office of the State Comptroller, Medicaid Fraud Division (MFD) is responsible for Medicaid program integrity. The MFD serves as the watchdog over both providers

and recipients of Medicaid services in order to ensure that those services are delivered in a quality manner and only to those who qualify for them. The MFD is comprised of three units: Fiscal Integrity, Investigations and Regulatory. The Fiscal Integrity Unit performs functions related to conducting audits and reviews of Medicaid providers' billings to confirm compliance with program requirements and recoupment of overpayments if necessary. They also perform data mining to detect aberrant patterns in claims reimbursement from providers in order to identify potential audit or investigations targets and third party liability to determine if Medicaid beneficiaries may have other health insurance coverage that should be billed before Medicaid. The Investigations Unit analyzes and examines various provider types to determine if any activity may indicate fraud, waste, and abuse, which would then be investigated. The Regulatory Unit recovers overpayments that are identified by the MFD auditors and investigators and determines when to exclude a Medicaid provider from the program.

All three MCOs had compliance plans that met the minimum requirements set forth in 42 CFR 438.608. However, none of the MCOs were able to provide the review team with a customized and detailed statewide fraud, waste, and abuse plan that addresses the fluid nature of the state's program integrity environment.

The CMS review team identified concerns with the limited oversight provided by DMAHS related to the managed care contractual requirements for program integrity. Based upon the significant penetration and enrollment of beneficiaries in Medicaid managed care in New Jersey, the program integrity roles and responsibilities for MCOs should be clearly defined in the managed care contracts. Under the current structure Medicaid program integrity is the primary responsibility of the New Jersey Office of the State Comptroller, MFD. Therefore, the communication between MFD and the state is critical to ensure that program integrity requirements are consistently being performed by the MCOs.

Recommendation #1- The state should ensure the managed care contractual language and relatable policies and procedures provides clear and concise guidance related to roles and responsibilities in the performance of program integrity activities.

Provider Screening and Enrollment

Pursuant to 42 CFR 438.608 Provider screening and enrollment requirements the state through its contracts with a MCO, PIHP, PAHP, PCCM, or PCCM entity must ensure that all network providers are enrolled with the state as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of part 455, subparts B and E. As of January 29, 2020 the state reports that 79.16% of the MCO providers are enrolled. The state reports the following actions will be implemented in order to work towards 100 percent compliance with provider screening and enrollment requirements as follows: (a) OMHC continues to communicate the importance of compliance to the MCOs, and encourages ongoing outreach attempts to their remaining MCO; (b) MCOs are currently required to submit weekly self-reports of their specific compliance, along with their outreach metrics, to DMAHS; (c) Providers not enrolled or registered in NJ FFS program cannot be counted toward MCOs network

adequacy benchmarks and (d) NJ FamilyCare is planning to redistribute the May 2018 NJFC Newsletter (Volume 28, number 6) addressing the need for FFS enrollment of MCO providers.

Recommendation#2- The state should ensure that actions are taken to attain full compliance with the provider enrollment and screening requirements in 42 CFR 438.608.

The DMAHS checks the licenses of all in-state providers and provider applicants from two neighboring states (New York and Pennsylvania). For other out-of-of state providers, the state requires a hardcopy of the out-of-state license and an attestation from the provider assuring good standing in the Medicaid program. However, the state does not check websites or use other means of verification to confirm the attestations are truthful and that no limitations exist on out-of-state provider licenses. The regulation at 42 CFR 455.412 requires that the State Medicaid agency: (a) have a method for verifying that any provider purporting to be licensed in accordance with the laws of any state is licensed by such state; and (b) confirm that the provider's license has not expired and that there are no current limitations on the provider's license. This is a repeat finding from the 2014 program integrity review.

Recommendation#3- The state should develop policies and procedures to check out-of-state provider licensing boards for the purpose of verifying if there are limitations on out-of-state provider licenses.

The state does not report adverse actions related to provider applications to Health and Human Services Office of Inspector General (HHS-OIG) and the MCOs are not consistently informing the state of the provider's adverse actions related to MCO provider credentialing. The state indicated if they were to deny a provider's enrollment due to program integrity concerns, they do not notify HHS-OIG. The regulations at 42 CFR 1002.3(b) and 1002.4 require reporting to HHS-OIG any adverse actions a state takes on provider applications for participation in the program.

Recommendation#4- The state should develop and implement procedures for reporting to HHS-OIG program integrity-related adverse actions on a provider's participation in the Medicaid program. In addition, the state should 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.

The regulation at 42 CFR 455.432 requires that the State Medicaid agency conduct pre-enrollment and post-enrollment site visits of providers who are designated as ''moderate'' or ''high'' categorical risks to the Medicaid program. The MCOs interviewed indicated that they are not conducting site visits, nor were they contractually required to conduct site visits. In addition, the MCOs have set screening levels for high, moderate and limited risk providers. Risk levels are assigned to providers based on provider type during the initial enrollment process. However, the MCOs are not re-assessing or adjusting risk levels based on certain additional criteria set forth in 42 CFR 455.432. For example, the MCOs have no procedures in place to raise the risk level of an individual limited-risk provider who has an outstanding overpayment.

Recommendation#5- The state should require their MCOs comply with all requirements set forth in 42 CFR 455.432. Therefore, the MCOs should develop and implement policies and procedures related to conducting site visits for providers designated as moderate or high categorical risks to the Medicaid program, as well as develop policies and procedures to adjust provider risk levels as required by the regulation.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral and reporting of suspected fraud, waste, and abuse by providers and MCOs.

New Jersey's Medicaid contracts with its MCOs states, the MCO program integrity program, "shall include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of fraud, waste and abuse in the administration and delivery of services under this contract."

The MFD conducts quarterly meetings with the MCOs and other stakeholders to discuss pertinent program integrity issues pertaining to fraud, waste, and abuse matters and relevant contractual concerns. Since suspected provider fraud referrals are made to the New Jersey Medicaid Fraud Control Unit (MFCU), they are also a major stakeholder. The CMS review team has concerns related to the following: (1) limited number of MCO provider investigations and referrals and (2) low amounts of overpayments and terminations reported by the MCOs. The MFD, the MCOs, and the (MFCU would benefit from meeting more frequently to discuss the status of investigations, referrals and reporting of suspected fraud, waste, ands abuse by providers. Some of the meetings could be designated as training sessions on various Medicaid program integrity topics. The opportunity for education related to Medicaid program integrity referral, overpayment and termination policy and procedures is a proactive action that may yield positive benefits for all partners.

The CMS review team confirmed that each of the MCOs interviewed have SIUs. The SIU staffing levels reported by all three national plans ranged between 9 to 14 full-time equivalents. The program integrity efforts of the reviewed SIUs in terms of provider referrals and investigations appears to be minimal in relation to the total annual Medicaid expenditure amounts of all three plans.

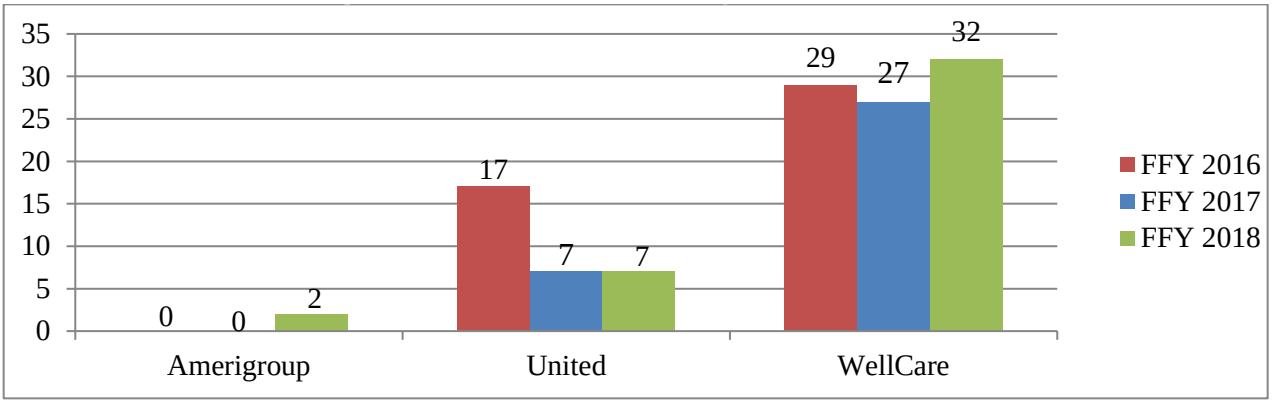
Recommendation #6- Given the limited number of provider investigations and referrals by the MCOs along with the low number of overpayments and terminations that the MCOs reported, the state should ensure that the MCOs are allocating sufficient resources to the prevention, detection, investigation and referral of suspected provider fraud.

According to MFD, the MCOs are authorized to refer cases directly to the MFCU pursuant to contractual language 7.36.5(C). However, the review team was unable to determine the effectiveness of the referral process without any formalized referral system in place. The state tracks the MCO referrals to the MFCU through the quarterly MCO reports submitted to the state. In addition, the MCOs will file a Notice of Investigation (NOI) and a Notice of Audit (NOA) form for the purpose of

de-confliction with MFD and the MFCU. The CMS review team has concerns with the MCOs referring directly to the MFCU given the fact that the referrals are not tracked in a formalized referral system. Therefore, the CMS review team suggests the state require its MCOs to submit all referrals simultaneously to both the MFCU and the state/MFD. The state would have first-hand knowledge of all the referrals submitted to the MFCU and could have an opportunity to evaluate the quality of the content of the referrals. Furthermore, federal regulation stipulates the state determine whether a credible allegation of fraud exists when referring cases to the MFCU prior to initiating appropriate actions against a participating provider such as a payment suspension action.

Recommendation #7- The state should consider requiring the MCOs to submit all provider referrals simultaneously to both the MFCU and the state/MFD in order for the state to have instant knowledge as to the quality of the referral and whether the referral warrants a credible allegation of fraud.

Table 3



As stated previously, the MCO provider case referrals of the reviewed SIUs appears to be minimal in relation to the total annual Medicaid expenditure amounts, along with the beneficiary enrollment totals and total number of providers reported for all three plans in FFY2016-2018. The state should incorporate a specific referral policy and procedure that provides a description of the MCOs internal procedures for the SIU to identify and report suspected fraud, waste, and abuse by providers to MFD. Presently, the MFD should consider utilizing a customized New Jersey fraud referral form for reporting purposes. The referrals should include an investigative report identifying the following: (1) the allegation; (2) the relevant statutes and regulations violated or considered; (3) the results of investigation; (4) the covered conduct, i.e., time period at issue; (5) the estimated identified overpayment; (6) summaries of completed interviews; (7) the encounter data submitted by the provider during the time period at issue; and (8) all supporting documentation obtained associated with the investigation.

Recommendation #8 - The state, in conjunction with the MFCU when possible, should work with the MCOs to develop and provide program integrity training on a routine basis to enhance case referrals from the MCOs. The state should ensure that MCO staff, primarily the SIU and/or compliance officer, is receiving adequate training in identifying, investigating, referring, and reporting potential fraudulent billing practices by providers.

Table 4-A

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2016	144	64	$4,231,652.63	$1,640,145.17
2017	128	49	$2,727,381.55	$1,006,752.19
2018	13	67	$208,039.94	$1,352,479.37

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2016	261	147	$2,487,893.89	$548,679.07
2017	287	174	$2,486,713.10	$613,314.17
2018	176	159	$85,590.82	$33,146.98

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2016	11	32	$3,410.00	$3,410.00
2017	14	31	$62,296.30	$20,674.51
2018	8	33	$285,166.70	$26,766.78

Overall, the amount of overpayments identified and recovered by the MCOs appears to be exceedingly low. Further, although MCOs may not be required to return overpayments from their network providers to the state, it is important that the state obtain a clear accounting of any recoupments, in order for these dollars to be accounted for in the annual rate setting process. Without these adjustments, MCOs could be receiving inflated rates per member per month.

Recommendation #9-The state should ensure that its MCOs are being proactive in identifying and collecting overpayments and accurately reporting all overpayments to the state. The state should ensure that the MCOs develop and maintain the appropriate overpayment identification /collection /reporting policies and procedures.

Encounter Data

The state's encounter data from each of the MCOs is collected electronically by DXC Technology on

a weekly basis. The data is utilized by DMAHS and the Encounter Data Monitoring Unit (EDMU) for capitation payment analysis, financial activities and cash disbursement auditing. The MFD Data Mining Unit (DMU) analyzes the validated encounter data for aberrant practices or trends and the MFD Investigations or Audit units' conducts further analysis and/or investigation.

Recommendation #10- The state should implement proactive audits of validated managed care encounter data.

Payment Suspensions

In New Jersey, Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The MCO Contract Section 7.36.2.D requires plans to suspend payments to a network provider on notice that the state determined a credible allegation of fraud in accordance with 42 CFR 455.23. Suspension of Payments must be implemented immediately and applies to any and all Medicaid claims (fee for service and encounter/managed care based) submitted by the provider.

The regulation at 42 CFR 455.23(a) requires that when the State Medicaid Agency determines that there is a credible allegation of fraud, it must suspend all Medicaid payments to a provider, unless the agency has a good cause not to suspend payments or to suspend payment only in part. The MCOs sends fraud referrals to the MFCU and awaits the MFCU's determination as to whether a credible allegation of fraud exists. The review team discovered that the MFCU rejects a substantial portion of the MCO referrals.

The MFCU expressed satisfaction with the quality of the MCO referrals, which in their opinion met the credible allegation of fraud threshold.

While CMS encourages states to communicate frequently with the MFCU and does not limit who a state may consult with in order to determine that an allegation of fraud is credible, the regulation at 42 CFR 455.23(a) requires that upon the State Medicaid Agency determining that an allegation of fraud is credible, the state 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. The use of alternative sanctions, such as prepayment review, may be part of a good cause exception, but should be documented as such in the case files.

The CMS review team identified concerns with the current payment suspension referral process. Currently the MCOs are referring directly to the MFCU instead of directly to the state/MFD in order for the referral to be evaluated for credible allegations of fraud as required by 42 CFR 455.23. The state is not able to delegate the determination of the credible allegation of fraud to another entity.

Therefore, the MCOs should be referring suspected fraud, waste, and abuse provider referrals to the MFD either before sending referrals directly to the MFCU or simultaneously to both. Since, the MFD is the state entity responsible for Medicaid program integrity, they are responsible for determining if the MCO referral constitutes a credible allegation of fraud. Ultimately, this would also alleviate the MFCU from the burden of receiving referrals that have not received the appropriate state program integrity vetting. Additionally, the MFCU expressed the willingness to provide payment

suspension training to the MCOs, who expressed education and training related to the payment suspension process would be beneficial.

Recommendation#11- The state should ensure that the current payment suspension process is in compliance with all the requirements at 42 CFR 455.23 and the state should provide the payment suspension policy and procedure to all contracted MCOs. Furthermore, this payment suspension policy should be referenced and outlined within the state and MFCU memorandum of understanding. This will allow all partners to be fully informed of the entire referral and payment suspension process.
Terminated Providers and Adverse Action Reporting.

The MCO contract does not address terminated providers and adverse action reporting. Therefore, the MCO is not required to provide written notice of termination to the state and there are no timelines for this procedure. However, the state expressed that although the contract does not express it, the MCOs do provide this information. The review team found evidence during a sampling of case files that this information is not being provided as efficiently as possible. When termination or adverse action information is shared with the state, the state reports that it shares this information with other plans and the expectation is that each plan would act on the information. It was also noted, that before taking any action themselves, plans rely on the state to notify them of actions taken at the state level against providers.

Table 5:

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated for Cause in Last 3 Completed FFYs	
Amerigroup	2016 2017 2018	1,284 1,211 1,213	2016 2017 2018	40 63 74
United	2016 2017 2018	22 74 159	2016 2017 2018	0 0 0
Well Care	2016 2017 2018	36 112 24	2016 2017 2018	0 0 0

Overall, the number of providers terminated for-cause by the plans appear low, compared to the number of providers enrolled with the MCOs and compared to the number of providers disenrolled or terminated for cause.

In addition, the MCOs do not seem to have a clear understanding of what constitutes a for-cause action versus a non for-cause action. The majority of these cases do not involve program integrity, quality or fraud. Accordingly, the CMS review team determined that additional education is warranted in order to ensure provider adverse actions are handled appropriately.

Recommendation #12 - The state should ensure that for-cause terminations are identified and

reported appropriately within its managed care program, and educate the MCOs on what constitutes a for-cause versus a not for-cause action in provider terminations.

Status of Corrective Action Plan from Year 2014 Review

New Jersey's last CMS program integrity review was in July, 2014 and the report for the review was issued in January, 2016. The report contained twelve recommendations relative to Enrollment and screening of providers, Verification of provider licenses, Revalidation of Enrollment, Termination of denial or enrollment, Reactivation of provider enrollment, Appeal rights, Site visits, Federal database checks, National Provider Identifier, Screening levels for Medicaid providers, Application fee, Temporary moratoria. During the onsite review in June 2019, the CMS review team conducted a thorough review of the corrective actions taken by New Jersey to address all issues reported in calendar year 2014. The findings from the 2014 review have not all been satisfied by the state.

Risk Areas-

1. A risk was identified in the state not verifying provider licenses.

   Status of the time of the review: Uncorrected.

2. A risk was identified in Revalidation of Enrollment.

   Status of the time of the review: Corrected.

3. A risk was identified in the state not conducting Site Visits.

   Status of the time of the review: Partially Corrected. The state is still not conducting site visits at group homes or conducting site visits at out of state pharmacies.

4. A risk was identified in the state not conducting Federal Database Checks.

   Status of the time of the review: Corrected

5. A risk was identified in the state not setting Screening levels for Medicaid Providers.

   Status of the time of the review: Uncorrected.

6. A risk was identified in improved communication across the MFD, DMAHS and the MCOs on data and financial reporting.

   Status of the time of the review: Corrected.

7. A risk was identified in no collaboration of provider investigations.

   Status at time of the review: Corrected.

8. A risk was identified in having procedures to confirm that the full range of improper payments and costs avoided by the MCOs are reported to DMAHS and the MFD to ensure that reported MCO expenditures are not inflated.

Status at time of the review: Corrected

9. A risk was identified that the MCOs were not contractually required to report all fraud-related provider terminations directly to the MFD in a timely manner and ensure that the information on such terminations is shared with other MCOs.

   Status at time of the review: Corrected.

10. A risk was identified in not having policies and procedures for periodic MFD review of all MCO compliance plans and ongoing monitoring of MCO adherence to these plans.

    Status at time of the review: Corrected.

11. A risk was identified in the state not providing training to contracted MCOs on the circumstances in which payment suspensions are appropriate pursuant to 42 CFR 455.23.

    Status at time of the review: Uncorrected.

12. A risk was identified in the state not providing regularly scheduled meetings on program integrity issues with the Medicaid MCOs and conducting periodic training on fraud, waste and abuse topics for MCO SIU Staff.

    Status at time of the review: Corrected

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for New Jersey to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to New Jersey are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as tool to identify effective program integrity practices.
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.
- Access the Toolkits to Address Frequent Findings: Payment Suspension Toolkit website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdfAccess the Toolkit to Address: State Toolkit for Validating Medicaid Managed Care Encounter Data at https://www.medicaid.gov/medicaid/downloads/ed-validation-toolkit.pdf.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

CMS looks forward to working with New Jersey to build an effective and strengthened program integrity function.