Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

New Jersey Focused Program Integrity Review

Final Report

January 2016

Submitted By:
Todd Chandler, Review Team Leader
Michael Berry
Julian Isaacs
Andrey Marinovich
Joel Truman, Review Manager

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Objective of the Review

The Centers for Medicare and Medicaid Services (CMS) conducted a focused review to determine whether New Jersey's program integrity procedures satisfy the requirements of federal regulations that implemented the enhanced provider screening and enrollment provisions of the Affordable Care Act. Another purpose of the review was to determine the extent of program integrity oversight of the managed care program at the state level and assess the program integrity activities performed by selected managed care entities (MCEs) under contract with the state. The review also included a follow up on the state's progress in implementing its corrective action plan (CAP) that resulted from CMS's last program integrity review in November 2011.

Background: State Medicaid Program Overview

New Jersey's Medicaid program enrolled approximately 1.3 million beneficiaries in federal fiscal year (FFY) 2013 and had total computable Medicaid expenditures of a little over $11.1 billion (Federal share – approximately $5.6 billion). Ninety percent of all beneficiaries were enrolled in four risk-based MCEs under contract with the state, and managed care expenditures accounted for roughly 42% of total Medicaid spending. New Jersey is a Medicaid expansion state.

Methodology of the Review

In advance of the onsite visit, CMS requested that New Jersey and the MCEs selected for the focused review complete a review guide that provided the review team detailed insight to the operational activities of the areas that were subject to the focused review. A five-person team reviewed the responses and materials that the state provided in advance of the onsite visit.

During the week of July 28-August 1, 2014, the CMS review team met with staff from the Division of Medical Assistance and Health Services (DMAHS), which is part of the state Department of Human Services; the Medicaid Fraud Division (MFD), which is part of New Jersey's Office of the State Comptroller (OSC); and the Special Investigation Unit (SIU) of two MCEs selected for review. The team conducted interviews with numerous state agency and fiscal agent staff involved in program integrity, provider enrollment, and managed care. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate both New Jersey's and the selected MCEs' program integrity practices.

Results of the Review

The review of New Jersey program integrity activities found the state to be in compliance with many of the current program integrity requirements. However, the review team identified some areas of concern and instances of regulatory non-compliance in its program integrity activities, thereby creating a risk to the Medicaid program.

CMS will work closely with the state to ensure that all issues, particularly those that remain from the earlier review are satisfactorily resolved as soon as possible. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Affordable Care Act Provider Screening and Enrollment

Overview of the State's Provider Enrollment Process

In New Jersey, fee-for-service (FFS) provider enrollment and screening is handled by the state fiscal agent under the oversight of DMAHS. The OSC's MFD is a separate organizational component from State Medicaid agency and is responsible for providing site visits and background checks for high and moderate risk providers. DMAHS does not require any managed care network providers to be enrolled in the Medicaid program. Managed care network providers are enrolled by the individual MCEs. Although providers can be enrolled in both FFS Medicaid and MCE networks; enrollment in an MCE network does not automatically enroll the provider in FFS Medicaid.

42 CFR 455.410: Enrollment and screening of providers
The regulation at 42 CFR 455.410 requires that the State Medicaid agency: (a) screen all enrolled providers; and (b) enroll all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan as participating providers; and (c) the State Medicaid agency may rely on the results of the provider screening performed by any of the following: (1) Medicare contractors. (2) Medicaid agencies or Children's Health Insurance Programs of other states.
The state is in compliance with this regulation.
The state documented compliance through: • A provider news bulletin posted on the NJ Medicaid Management Information System (MMIS) website stating the requirement; • The state's use of an abbreviated enrollment form for ordering, prescribing and referring (OPR) providers; • MMIS screenshots which documented the enrollment of OPR providers; and • Sampling – the review team found a prescribing psychiatrist who had been sanctioned by Medicare and subsequently reinstated in the Medicaid program; however, the reinstatement was only approved after DMAHS conducted an executive review of the provider application.
Recommendations: • None

42 CFR 455.412: Verification of 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.

The state is not fully in compliance with this regulation.
DMAHS checks the licenses of all in-state providers and provider applicants from two neighboring states (New York and Pennsylvania). For other out-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 that the attestations are truthful and that no limitations exist on out-of-state provider licenses.
Recommendations: • 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.

42 CFR 455.414: Revalidation of enrollment
The regulation at 42 CFR 455.414 requires that the State Medicaid Agency (SMA) revalidate the enrollment of all providers regardless of provider type at least every 5 years. The deadline has been revised according to *Sub Regulatory Guidance for SMAs: Revalidation (2016-001)*. The purpose of this guidance is to align Medicare and Medicaid revalidation activities to the greatest extent possible. The new requirement is now a two-step deadline under which states must notify all affected providers of the revalidation requirement by the original March 24, 2016 deadline, and must have completed the revalidation process by a new deadline of September 25, 2016.
The state is potentially at risk of non-compliance with this regulation for both the March 25, 2016 and September 25, 2016 deadlines.
At the time of the review, DMAHS had just started the revalidation process on a rolling basis. The state indicated that in preparation for the revalidation process the fiscal agent had hired additional staff. A tentative reenrollment schedule had been drafted based on resources. The state indicated that the target date for re-enrolling all current providers was April 2016. The state is at risk of not complying with this regulation if all affected providers are not notified on or before March 25, 2016 and the revalidations are not completed on or before the revised deadline of September 25, 2016. DMAHS provided the team with detailed policies and procedures on how it plans to undertake the re-enrollment process. Provider enrollment staff also noted that DMAHS was treating reenrollment and revalidation as part of the same process.
Recommendations: • The state must closely monitor progress to ensure that the revalidation process is completed on or before September 25, 2016.

42 CFR 455.416: Termination or denial of enrollment
The regulation at 42 CFR 455.416 describes several conditions under which a State Medicaid agency must terminate or deny enrollment to any provider. These include situations in which the Medicare program or another state Medicaid or Title XXI program or state Children's Health Insurance Program has terminated a provider for cause on or after Jan. 1, 2011 unless the State Medicaid agency determines that denial or termination of enrollment is not in the best interests of the Medicaid program and documents that determination in writing.

The state is in compliance with this regulation.
DMAHS documented compliance with this regulation in several ways: • A review of CMS's termination database showed that New Jersey was regularly uploading Medicaid for-cause terminations. The state had uploaded 222 provider terminations from January 2011 to June 2014 that included 10 excluded providers. • The state's provider enrollment and screening policy and procedures addressed the pertinent requirements of 42 CFR 455.416. • Sampling – As described above, the review team found a prescribing psychiatrist who had been sanctioned by Medicare but subsequently reinstated in the Medicaid program. The reinstatement showed that the state had taken the regulatory requirements of 42 CFR 455.416 into account and approved the provider's reenrollment as being in the best interests of the program after a DMAHS executive review of the provider application. • Using data from CMS's provider termination database, the team did not identify any providers from New Jersey whose billing privileges had been revoked by Medicare but who were actively enrolled in the state Medicaid program.
Recommendations: • None

42 CFR 455.420: Reactivation of provider enrollment
The regulation at 42 CFR 455.420 requires that the State Medicaid agency, after denial or termination of a provider for any reason, require the provider to undergo rescreening and pay the associated application fees pursuant to 42 CFR 455.460.
The state is in compliance with this regulation.
DMAHS presented the review team with comprehensive provider enrollment policies and procedures that included a full screening process for providers who request to have their Medicaid status reactivated.
Recommendations: • None

42 CFR 455.422: Appeal rights
The regulation at 42 CFR 455.422 requires that the State Medicaid agency give providers terminated or denied pursuant to 42 CFR 455.416 any appeal rights available under State law or regulations.
The state is in compliance with this regulation.
DMAHS identified a section (10:49-9.14) in the New Jersey Administrative Code (NJAC) which required the state to offer providers appeal rights consistent with the regulation. The state also provided a sample copy of a provider application denial letter which contains information on appeal rights.
Recommendations: • None

42 CFR 455.432: Site visits

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 state is not fully in compliance with this regulation.
The state has incorporated the federal site visit requirement, along with the other requirements of 42 CFR 455 Subpart E into the NJAC, section 10:49-1.5. In consultation with one another, the MFD and DMAHS assign risk categories during the enrollment process based on provider type. Provider applications identified as high or moderate risk are forwarded to the MFD for site visits and background checks. However, state officials indicated that they do not conduct site visits to moderate or high risk out-of-state providers as part of the application process due to resource limitations. For example, there are some children placed in out-of-state group homes and some Medicaid beneficiaries who are approved for specialized drugs or biologicals that can only be furnished by out-of-state providers which are not subject to site visits. Other out-of-state providers who do not regularly serve New Jersey residents are typically authorized to bill Medicaid for only the date of service for which they submit claims. They are also not subject to site visits, although the limitations on their billing ability significantly reduces the state’s risk.
Recommendations: • Determine if those states which house New Jersey Medicaid beneficiaries in group homes or whose pharmacies provide rare drugs or biologicals have conducted the required pre-enrollment site visits to those providers. • Consult with the provider enrollment and screening workgroup of the Medicaid Technical Assistance Group for suggestions on how to complete out-of-state site visits.

42 CFR 455.436: Federal database checks
The 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 the U.S. Department of Health and Human Services-Office of Inspector General’s (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the Excluded Parties List System (EPLS) on the System for Award Management (SAM), the Social Security Administration Death Master File (DMF), the National Plan and the Provider Enumeration System (NPPES) upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.
The state is not fully in compliance with this regulation.

The state's fiscal agent checks all of the required databases at enrollment except the DMF. The fiscal agent uses an alternate website to check the death status of a provider in place of the DMF. The information contained on the alternate website is limited in that it only provides death records that are more than three years old. The use of information from the alternate website places the state at risk because the fiscal agent could enroll individuals who are posing as providers that have expired within the past three years.

Furthermore, the fiscal agent does not conduct monthly EPLS/SAM checks. During the interview, DMAHS noted that it had no way of doing automated data matches with the EPLS/SAM database and lacks the resources to check thousands of providers manually on a monthly basis. Additionally, the EPLS database on SAM is a public use file. It does not contain fields such as date of birth or Social Security number that can be used to identify debarred individuals with common names, so that researching "hits" on the system every month would be an arduous task. DMAHS supplied the review team with documentation detailing its efforts thus far to develop automated data checks with the EPLS/SAM database.

During the onsite discussion, the MFD also raised a question about how far down the employee chain a state must go in conducting the required database searches of managing employees at large institutional providers such as hospitals. The team indicated that generally speaking, the state database checks on managing employees apply to individuals at a high managerial level who are in a position to influence a provider's billing policies and practices. The team further referenced past CMS guidance in State Medicaid Director letter # 09-001, which noted that individual providers and facilities are responsible for doing exclusion checks on lower level employees.[1]

Recommendations:

- Consult with the provider enrollment and screening workgroup of the Medicaid Technical Assistance Group to work with states that have developed automated monthly EPLS/SAM database checks.
- Access and utilize the actual DMF during provider enrollment and reenrollment.

42 CFR 455.440: National Provider Identifier

The regulation at 42 CFR 455.440 requires that the State Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.

The state is in compliance with this regulation.

[1] See CMS State Medicaid Director Letter #09-001, dated Jan. 16, 2009, retrievable from the CMS website at http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD011609.pdf.

DMAHS uses industry-standard institutional and professional claim forms and demonstrated that edits were in place to detect the ordering or referring provider's NPI through:

- MMIS screenshots of claims that were rejected because the OPR NPI was not present; and
- a list of edit error codes used to reject claims when:
  - the ordering or referring provider's NPI is not present on the claim form,
  - the provider is not enrolled in the Medicaid program, or
  - The relationship between the NPI and provider identification number was not documented.

Recommendations:

- None

42 CFR 455.450: Screening levels for Medicaid providers

The regulation at 42 CFR 455.450 requires that the State Medicaid agency must screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of ''limited,'' ''moderate,'' or ''high.''

The state is not fully in compliance with this regulation.

DMAHS has set screening levels for high, moderate and limited risk providers. Risk levels are assigned to providers based on provider type during the initial enrollment. However, DMAHS does not adjust risk levels based on certain additional criteria set forth in the regulation. For example, it has no procedures in place to raise the risk level of an individual limited-risk provider who has an outstanding overpayment. DMAHS noted that there are other actions it may take that are just as effective as raising the risk level assigned to such providers. For instance, the state indicated that a provider with an existing overpayment would not be permitted to reenroll or be revalidated. Such policies and procedures mitigate the state's technical non-compliance with portions of this regulation.

Recommendations:

- Develop policies and procedures to adjust provider risk levels as required by the regulation.

42 CFR 455.460: Application fee

The regulation at 42 CFR 455.460 requires the States Medicaid agency to collect the applicable application fee prior to executing a provider agreement from certain prospective or re-enrolling Medicaid-only providers as stipulated in the regulation.

The state is in compliance with this regulation.

DMAHS provided the team with a list of 62 providers which had paid Medicaid application fees at the time of the review. The state also furnished a newsletter announcing the implementation of application fees upon enrollment and listing documentation with which provider applicants needed to substantiate that they had already paid the fee to Medicare or another state agency As one cross-check to ensure that the state was obtaining Medicaid application fees only from the appropriate providers, the team checked the PECOS database to determine if the 62 providers who had paid Medicaid application fees thus far were enrolled in Medicare at the time of their remittance. None of these providers were found in PECOS.
Recommendations: • None

42 CFR 455.470. Temporary moratoria
The regulation at 42 CFR 455.470 requires the State Medicaid agency to impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid program unless the SMA determines that imposition of a temporary moratorium would adversely affect beneficiaries' access to medical assistance.
The state is in a position to comply with this regulation if invoked.
The state has issued moratoria on its own initiative since 2006. More recently it complied with an HHS moratorium and stopped the enrollment of ambulance providers in three New Jersey counties that are in the Philadelphia suburbs. The state has also incorporated temporary moratorium authority in its Administrative Code at NJAC 10:29-1.5. DMAHS utilizes downloadable enrollment forms for different provider types on the state website. However, to ensure that the ongoing HHS moratorium is not breached, ambulance provider applications cannot be downloaded; and if a paper application is submitted, it will be denied by the fiscal agent.
Recommendations: • None

Provider Enrollment and Screening in Managed Care

In New Jersey as noted, managed care network providers do not have to be enrolled in the FFS Medicaid program. They are enrolled by the individual MCEs. As noted above although providers can be enrolled in both FFS Medicaid and MCE networks; enrollment in an MCE network does not automatically enroll the provider in FFS Medicaid.

During the interview with state managed care staff, the team asked whether there are provisions in the New Jersey Medicaid managed care contract that direct the MCEs to conform to the provider enrollment and screening regulations at 42 CFR 455 Subpart E. The CMS review team was particularly interested in whether managed care contracts require the reporting of for-cause terminations and the checking of federal databases for excluded parties. Likewise, CMS asked if different provider types are assigned different risk levels and subject to greater screening and site visits during the credentialing process when categorized at a higher risk.

State staff indicated that the baseline screening requirements for MCEs in New Jersey were in section B.7.2 of the state's model contract. Although the team did not find any language expressly directing MCEs to adhere to or implement the requirements of 42 CFR 455 subpart E, it did find catch-all language in section B.7.2. under the rubric "Compliance With Federal and State Laws and Regulations."

> *The provider/subcontractor agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.*

Both MFD and DMAHS staff pointed to this language as the state requirement that MCEs must adhere to/implement the regulations at 42 CFR 455 Subpart E. However, the same language is not included in the Non-Emergency Medical Transportation broker contract. State legal staff also directed the team to NJAC 10:49-1.5 which refers to the final 455 Subpart E regulations as they appear in the published February 2, 2011 edition of the Federal Register.

At the time of the review, New Jersey contracted with four MCEs for comprehensive Medicaid services. The team conducted onsite interviews with two of these MCEs: Horizon of New Jersey and United Healthcare. The interviews contained some questions about enrollment and screening procedures to determine if MCE practices were consistent with the general contract and NJAC requirements. Below are the team's observations:

- Provider Risk Levels: Both of the MCEs interviewed were not assigning risk levels to providers. They used uniform screening procedures for all providers of a given type in their credentialing process.
- Site Visits: Horizon reported conducting some site visits for certain providers such as adult medical daycare at the MFD's request during the provider enrollment process; while United said it would only conduct site visits if a major issue was identified during the enrollment process. Neither plan performed site visits on all provider types and individual providers/entities that would have been classified as moderate or high risk if operating in the FFS Medicaid environment.
- Federal Database Checks: A sampling of provider enrollment files showed that the screeners in Horizon used a checklist indicating that its staff performed the same database checks as required in the FFS Medicaid program. This was not the case with United, which acknowledged that it did not check the NPPES or the DMF. The team's sampling of 10 provider enrollment files confirmed this, although it was noted that in 3 of the 10 files, there was evidence that all the required database searches were performed. These 3 enrollment files were processed by the plan's vision care subcontractor.
- Provider Terminations: Both MCEs noted that they report for cause terminations to the state. The reporting of program integrity-related terminations is a potentially valuable practice because it gives the state an opportunity to warn all contractors about unscrupulous providers who may be operating in more than one plan. However, on closer examination, it was not clear to the review team how much information on

problem providers was actually being transmitted. United Healthcare indicated that it prefers to avoid for-cause actions when possible in favor of not renewing the contracts of undesirable providers since this does not trigger appeal rights. Such cases also do not have to be reported. This issue is discussed at greater length in the Managed Care Program Integrity section below. For its part, Horizon gave CMS a list of providers that it terminated, decredentialed, or disenrolled in the last four FFYs. The review team selected a sample of 10 cases in which the terminations appeared to be fraud or abuse-related. Based on a review of the samples, the team saw no indication that any of the 10 cases were reported to the state Medicaid agency; and only one of the ten for-cause terminations was listed in the CMS terminations database.

Section 2: Managed Care Program Integrity

Overview of the State's Managed Care Program

As noted already, New Jersey's Medicaid program enrolls approximately 1.3 million beneficiaries and in FFY 2013 had annual expenditures exceeding $12 billion. Of these totals, 90 percent of all beneficiaries are enrolled in risk-based MCEs under contract with the state, and managed care expenditures account for 42 percent of total Medicaid spending. All MCEs are paid a pre-determined capitation rate to manage virtually all enrolled beneficiary healthcare services; while providers in turn are paid on a capitated or FFS basis by the MCEs. The one service carved out of the managed care program is non-emergency medical transportation (NEMT). The state utilizes a transportation broker to deliver NEMT services to beneficiaries and reimburses the broker under a capitated arrangement.

Summary Information on the Plans Reviewed

During the week of July 28-August 1, 2014, the CMS review team met with staff from the SIU of two of the four contracted MCEs in New Jersey. Both of the selected MCEs are large contractors of long-standing in New Jersey. While they both served significant Medicare and commercial insurance populations, they also had large Medicaid enrollments. United Healthcare is a national plan that had over 400,000 New Jersey Medicaid enrollees at the time of the onsite visit. Horizon of New Jersey is a statewide contractor. Its Medicaid enrollment was over 700,000 at the time of the review. Both plans reimbursed some network providers on a capitated basis and some through FFS payments, while also offering different types of alternate incentive plans. Total Medicaid payments to each plan in the most recently completed FFY (2013) were nearly $1.6 billion and just over $2 billion, respectively.

State Oversight of Managed Care

DMAHS and the MFD are principally responsible for providing oversight of the managed care program. Contract oversight falls under the umbrella of DMAHS and its Office of Managed Health Care which include several sub-divisions, such as the Office of Quality Assurance, and the Office of Quality and Monitoring (which serves the Managed Long-Term Services and Supports program). Oversight of program integrity activities for the FFS and managed care programs is assigned to the MFD which is located in the OSC. All program integrity activities were transferred from DMAHS to the OSC through a Memorandum of Understanding between

the parties in 2011. The MFD is comprised of three units (fiscal integrity, investigations, and regulatory) with a total of 71 full-time equivalent (FTE) positions allocated to program integrity activities.

The MFD provides input on the state's managed care contract requirements. It also takes part in readiness reviews of new Medicaid managed care contractors. However, MFD staff are not involved in annual MCE reviews conducted by New Jersey's External Quality Review Organization. According to state officials, the annual reviews once had a small program integrity component but this was dropped. In general, oversight of program integrity activities in managed care could be improved with better tools to monitor compliance with contract requirements, and with better communication and coordination of information across the MFD, DMAHS, and the MCEs. The need for better communication and coordination is discussed in detail throughout this document.

MCE Program Integrity Activities

Investigations of Fraud, Waste, and Abuse

The MCEs are required to submit a *Notice of Investigation* (NOI) form to the MFD when an MCE wants to initiate a preliminary investigation. Information on NOI submissions is also summarized in quarterly reports to the MFD. The NOI process allows the MFD to determine whether or not the same provider is under investigation by the MFD or another MCE. It provides the MFD with an opportunity to approve a continuation of the MCE's investigation or to recommend that a joint investigation be undertaken. The MFD could also disapprove the MCE's request to investigate and begin an investigation of the provider without the assistance of the MCE. Per the state's managed care model contract, recoveries are determined by which party initiated the investigation and are shared between the MFD and the MCE when a joint investigation is initiated.

At the time of the review, most NOIs resulted in state investigations. The team was able to identify only one joint investigation. The actual operation of the NOI process could have negative consequences if MCEs are left out of the investigative process too often. United Healthcare expressed concerns about this during its interview. It maintained that if the MFD feels inclined to participate in an investigation, it should be done as a joint endeavor since the MCE has assumed the financial risk and will be time sensitive in its efforts to complete the investigation. While the MFD was able to support its judgments on individual NOI cases with well-founded arguments, the pattern of decisions has tended to give the state most of the responsibility for carrying out fraud investigations. United felt this might be hindering the development of those MCE fraud-fighting capacities which the state otherwise seeks to foster.

Both of the MCEs selected for review in New Jersey had SIUs which focused on fraud investigations. United Healthcare had 9 FTEs dedicated to fraud investigations and payment integrity in government programs (i.e. Medicaid). This staff was partially supported by a contractor that provided 18 FTEs for data analysis, claims review and audit functions. Other contractors for this plan investigated fraud and abuse in behavioral health and prescription drugs, respectively. Similarly, of the 32.6 SIU FTEs working on all lines of business, 11 FTEs in Horizon were assigned to Medicaid anti-fraud and abuse efforts. This staff was supported by claims analysts who were trained to review managed care encounter data for trends that may indicate fraud, waste, and abuse.

In response to the limited number of preliminary investigation requests from the MCEs and to assess the program integrity efforts of the MCEs, the MFD has used audits of the MCE SIUs as an effective tool. At the time of the review, audits of the two plans reviewed by the CMS team had been completed and an audit of a third plan was in progress.[2] The audits assessed whether specific contract requirements were met. For example, they determined if an adequate number of staff was assigned to program integrity activities and whether or not SIU personnel met specific

[2] See State of New Jersey, Office of the State Comptroller, Medicaid Fraud Division, *Compliance Audit: Horizon New Jersey Health's Special Investigation Unit*, Oct. 18, 2011, and State of New Jersey, Office of the State Comptroller, Medicaid Fraud Division, *Compliance Audit: United Healthcare Community Plan of New Jersey's Special Investigation Unit*, July. 31, 2013.

training requirements. The MFD also reviewed MCE subcontractor program integrity activities, compared overpayment recovery data in the plans' internal records with the amount of recoupments reported in the contractually required MCE quarterly reports, and ascertained whether case logs included instances of provider fraud that went unreported to the MFD.

The state's SIU audits have been responsible for significant improvements in the overall program integrity performance of the plans. For example, the level of SIU staffing dedicated to New Jersey fraud issues was far below the state's contract requirements when the first two audits were conducted. Horizon did not meet the minimum training requirements for 35 percent of its investigators in the first year of the audit period and did not satisfy the minimum requirements for 9 percent of its investigators in the second year of the audit period. United Healthcare had fully satisfied the training requirements for all investigators in both years but did not meet the training requirements for any of its claims examiners over the same time period. At the time of the CMS review, both MCEs met the staffing and training standards specified in the contract.

In addition, the audits helped to stimulate an increase in MCE fraud and abuse investigations. The original audit results showed that United Healthcare contracted with 4 vendors that in turn reviewed 3,280 providers in the first year of the audit period and 3,716 in the second year of the audit period but made no referrals to the SIU. Horizon had only nine provider cases during the two year audit period, of which five resulted in recoveries. This began to change as the results came out.

For example, in the three full fiscal years prior to this review, the number of fraud cases handled by United rose from 40 in FY 2011 to 92 in FY 2012 and 180 in FY 2013. This pattern clearly shows growth in United Healthcare's case investigation activities. The increase in investigations was accompanied by a decrease in referrals to the New Jersey Medicaid Fraud Control Unit (MFCU), a trend the plan attributed to greater caution on the part of providers. In addition, the plan's behavioral health contractor, which handled fraud and abuse investigations separately, reported an additional 14 cases between FY 2011 and FY 2013, two of which were referred to the MFCU.

Likewise, Horizon with its strong statewide presence tripled the number of investigations it conducted from FY 2010 to FY 2011 and held steady in the 115-122 range over the next two fiscal years. Also, while it averaged a little over $50,000 in recoveries in FY 2010-2011, it collected an average of $414,763 per year in FY 2012-2013.[3] United Healthcare too showed an upward trend in post-payment fraud and abuse recoveries. While it averaged $89,471 per year in post-pay fraud and abuse recoveries from July 2010 through June 2012, the annual average for the next two year period rose almost nine-fold to $784,182.[4]

Nevertheless, the MFD considered the progress made by the MCEs to be limited in scope. It was not satisfied with the overall increase in fraud investigation notices received. And although the reported fraud and abuse recoveries rose significantly, they still lagged far behind the returns that were expected in FFS Medicaid programs. The State of Idaho, for example, with only 221,000 Medicaid beneficiaries, averaged $2.1 million in annual recoveries in FFY 2010 and 2011. This

[3] Based on data reported in a [Horizon] spreadsheet listing recoveries in response to MCE-37 of the CMS Review Guide.
[4] Based on a [UHC] spreadsheet listing recoveries in response to MCE-37 of the CMS Review Guide.

was three to five times greater than the largest recovery totals subsequently reported by United or Horizon.[5]

The audits of the SIUs might be enhanced if the MFD and DMAHS put a process in place to ensure that all corrective actions are implemented by the MCEs. However, other constraints also affect the state's ability to audit and monitor the managed care program in a more thoroughgoing way. For example, the MFD observed that existing resource limitations can affect the number of managed care network providers it has the capacity to audit. In addition, although MFD officials documented the use of both managed care encounter data and FFS data in state-initiated provider investigations, they indicated that the ability to audit individual MCE providers is sometimes hindered by encounter data formatting issues.

Overpayment Recoveries

While MFD officials had detailed knowledge of MCE fraud investigations, in interviews, they seemed less aware of other plan audit and recovery activities. While the data furnished by Horizon did not provide a clear picture of this, the review team obtained documentation from United showing that it performed extensive billing audits as well as pre and post-payment reviews in cases that were not defined as fraud-related. The plan recouped substantial overpayments from network providers as a result of these activities.

United, for example, had a Payment Integrity Program supported by various contractors which was heavily engaged in "waste and abuse" activities. These included data analytics, algorithm development, provider verifications, and frequent auditing of improper payments. United claimed to have recouped $17.8 million as a result of "audit and recovery" activities in the period July 2013-June 2014.[6] It said this was reported to the state, but the MFD did not mention these figures. It is possible that such figures were contained in reports to DMAHS that were not circulated. The same plan also claimed to have saved several times the recoupment amount through various types of prospective claims review and cost avoidance techniques which were not reported to the state.[7]

In New Jersey, the MCEs do not return overpayments to the state unless a joint investigation was initiated between the MFD and the MCE. This does not typically occur as noted above. The MCEs stated that overpayments were credited to the overpaid claim, but no evidence was provided that state performed any look-behind activities to ensure that this was occurring. The state should implement a process to review MCE compliance whereby overpayments are credited to ensure that total MCE expenditures are not inflated.

The example of United suggests that there may be a great deal of MCE scrutiny given to improper payments that is not classified officially as fraud and abuse detection. Sometimes it is performed by audit components, data analysts, and/or contractors operating outside the SIU. The MFD and DMAHS should ensure that they have a complete overview of all anti-fraud, waste, and abuse activity taking place at the MCE level. They should have information on all types of

[5] DHHS/CMS Medicaid Integrity Program Idaho Program Integrity Review Final Report, June 2011, pp. 1-2.
[6] Based on a [UHC] spreadsheet listing recoveries in response to MCE-37 of the CMS Review Guide.
[7] Same as above.

recoveries to ensure that these are factored into the rate-setting process where appropriate. They should review the audit activity of the MCEs in particular to ensure that potential cases of fraud and abuse are identified and addressed appropriately, for example through MFCU referrals.

Terminated Providers and Adverse Action Reporting

The state's contract with the MCEs requires the reporting of terminated providers directly to the MFD. However, MCE provider terminations are communicated to DMAHS on a quarterly report and are not shared with the MFD. Nor is any action taken to share this information with other MCEs or to determine if the listed providers are enrolled in the FFS Medicaid program. Consequently, these terminated providers are seldom if ever reported to HHS-OIG or uploaded to the CMS database that houses information on providers terminated by state Medicaid programs or revoked by Medicare. United Healthcare indicated that it tries to avoid terminating providers in the middle of a contract period even if fraud and abuse is substantiated; in many cases, it allows providers to remain in the network until their contract is up for renewal. Per its provider agreements, use of this option allows the plan to remove the provider from the network without giving a reason and without triggering appeal rights or reporting obligations. However, this practice also institutionalizes the underreporting of problem providers. Providers who are quietly removed from one plan may be creating fraud and abuse in other plans and the FFS program.

The reporting practices of the other MCE were less clear cut. Based on lists submitted by Horizon of terminated, decredentialed or disenrolled providers in the last four FFYs, the CMS team selected a sample size of ten cases for review. The results suggested a tendency toward underreporting. Although the sample contained some likely for-cause terminations, only one of the ten cases was posted on CMS's termination database. This case had been referred to MFD by way of the NOI process. The provider had an inmate number, was incarcerated, and was listed on the HHS-OIG exclusions database, so that the state agency would have known about this termination in any case. Based on interviews, sampling, and review of other documents, the team concluded that Horizon was reporting at least some for-cause terminations to the MFD, but it was not clear if there were other unreported terminations that should have been called to the state's attention.

United had similar results. A review of the disenrollment and termination information it submitted showed that United averaged 1,873 disenrollments or terminations per year over the three year period from FY 2011 through FY 2013; but only 103 of those on average per year were listed as "for-cause" terminations. Given the plan's preference for using contract non-renewal as a tool for removing undesirable providers, it is also not clear how many unreported terminations were in fact program integrity-related.

The state should contractually require that MCEs report all fraud-related provider terminations directly to the MFD in a timely manner. It should further ensure that the information on such terminations is shared with other MCEs, the FFS program, HHS-OIG, and CMS.

MCE Compliance Plans

The MCEs are required by contract to have a compliance plan that meets the requirements of 42 CFR 438.608, but the state is not ensuring that such plans exist or that they are in compliance with the regulation. The MCEs submit the compliance plans to the State Department of Banking and Insurance, which in turn sends them to DMAHS, but the compliance plans are not routed to the MFD for review. The review of MCE compliance plans was formerly a part of the External Quality Review Organization's annual MCE assessment. The MFD agreed to assume responsibility for the review and monitoring of these after CMS allowed the External Quality Review Organization to dispense with this function. The MFD should develop a policy and procedure to perform an annual review of each MCE's compliance plan and incorporate monitoring activities to ensure that MCEs are complying with their plan.

Payment Suspensions

In New Jersey, the managed care contract requires MCEs to suspend payments at the direction of the state Medicaid agency. The contracts also provide that MCEs will report credible allegations of fraud directly to the MFCU, with copies to the MFD. Although there was no evidence of MCE non-compliance with payment suspension orders by the state, at the time of the review, payments were not being suspended in the case of MFCU referrals that came directly from the MCEs. As long as the state does not say otherwise, the MCE contract does not require the plans to suspend payment. The results of the team's sampling of fraud investigation cases confirmed this picture. The cases reviewed by the team from each plan revealed no instances in which payment suspensions were taken, although the MCEs found credible allegations of fraud in several of the sampled cases. Although payment suspensions may not be advisable in situations where they can jeopardize a law enforcement investigation, the state should consider whether suspensions are warranted on a case by case basis and provide more direction to the plans in this area.

Meetings and Training

In documentation provided for the review, both Horizon and United documented the provision of substantial program integrity training to their SIU personnel. New Jersey state regulations require nine hours of such training annually per person; and compliance with these requirements was stressed after the MFD's audits of the MCEs found deficiencies in these areas. The bulk of the training was provided by outside organizations, such as the National Health Care Anti-Fraud Association and the Association of Certified Fraud Examiners, but some training sessions were provided by the plans' respective corporate headquarters; and on one occasion training by the MFD was listed.

Yet while the MFD has conducted some training and has frequent informal communications with the MCEs, recurring meetings with all MCEs to discuss and share program integrity activities or to review cases were not taking place at the time of the review. Nor was there regularly scheduled program integrity training. According to the MFD, the first meeting of any kind took place in June 2014, but the meeting was informal with no agenda or meeting minutes, and not all MCEs were in attendance. Additionally, no regularly scheduled meetings or trainings were taking place between the MFCU and the MCEs. One of the MCEs recently reached out to the MFCU and noted that it was receptive to setting up meetings in which cases could be discussed.

The MFD, MFCU, and each MCE (and potentially DMAHS) should establish recurring meetings to enhance and formalize communications on program integrity issues and to share and discuss case information. The MCE staff responsible for program integrity activities would also benefit from periodic training by the MFD and the MFCU.

Summary of Managed Care Recommendations:

- Improve communications across the MFD, DMHAS and MCEs on MCE data and financial reporting. Develop and implement policies and procedures for involving the MFD in the program integrity components of MCE readiness reviews.
- Increase the scope of the MFD's MCE audits to include all overpayments recovered by other divisions or sections within the plans.
- Consider the use of more collaborative provider fraud investigations with the MCEs.
- Develop and implement procedures to confirm that the full range of improper payments and costs avoided by MCEs are reported to DMAHS and the MFD to ensure that reported MCE expenditures are not inflated.
- Contractually require that MCEs 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 MCEs, the FFS program, HHS-OIG, and CMS.
- Develop and implement policies and procedures for periodic MFD review of all MCE compliance plans and ongoing monitoring of MCE adherence to these plans.
- Provide training to contracted MCEs on the circumstances in which payment suspensions are appropriate pursuant to 42 CFR 455.23.
- Establish regularly scheduled meetings on program integrity issues with the Medicaid MCEs, and conduct periodic training on Medicaid fraud, waste and abuse topics for MCE SIU staff.

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:

- Consult with other states on methods of conducting out-of-state site visits to provider applicants. Consider using other available state, county, and local government resources to assist in the provider screening process in order that the state can comply with the requirements of 42 CFR 455.432 listed in Section 1.
- Consult CMS's Medicaid Payment Suspension Toolkit at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html to develop a payment suspension process that is consistent with federal regulations and guidance. CMS can also refer New Jersey to states that are further along in this process to address risks identified is Section 2.
- 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 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 concerns identified in this report. Courses that may be helpful to the state based on its identified risks include those related to provider enrollment and oversight of managed care. More information can be found at http://www.justice.gov/usao/training/mii/training.html.
- 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.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states.
- Work with the assigned CMS State Investigations & Audits Lead to discuss program integrity issues and request technical assistance as needed.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately. However, CMS supports New Jersey's efforts and encourages it to look for additional opportunities to improve overall program integrity.

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 plan should identify those corrections as well.

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

Review of New Jersey's Corrective Action Plan

As part of the focused review, on July 31, 2014, the CMS review team interviewed staff from DMAHS, the MFD, and New Jersey's fiscal agent about corrective actions the state had taken and any open issues related to its CAP from the last CMS comprehensive program integrity review of November 2012. The state's original CAP response reasonably addressed the issues found in the 2012 review. The CMS review team sought to determine if corrections envisioned after the comprehensive review had been fully implemented or were on pace to be made. The state responded as follows to the CMS review team's questions:

1. ***The State does not refer all cases of suspected fraud to the MFCU –*** The MFD provided the review team with policy and procedure documents numbered 213 and 214. Document 213 outlined the MFD responsibility to refer cases of suspected fraud to the MFCU in line with 42 CFR 455.21. Document 214 detailed MFD procedures for suspending payments in cases where there is a credible allegation of fraud pursuant to 42 CFR 455.23. The team reviewed both policies and procedures and found them acceptable. The MFD also presented the team with an updated Memorandum of Understanding (MOU). The executed version of November 5, 2012 MOU was provided to CMS on July 25, 2014. The team noted that the MOU is not in full compliance with 42 CFR 455.23 based on the fact that the state does not suspend payments when there is evidence of a credible allegation of fraud (CAF). Instead the case is sent to the MFCU which determines if payments should be suspended. Although the new MOU states that the MFCU will respond to the MFD within ten days of receipt, the regulation states that the state must suspend payments before sending cases of CAF to the MFCU. The team suggested that the state consider informal consultation with MFCU so that payments can be suspended or good cause exception filed at time the CAF is made and case is referred to the MFCU.

   The MFD also provided the team with updated numbers of referrals to the MFCU:

   - FY12 – 19 referrals to MFCU
   - FY13 – 26 referrals to MFCU
   - FY14 – 29 referrals to MFCU

   The Investigations Branch Chief said this includes FFS cases only. Managed care referrals come in with quarterly reports but are not tracked. There is a separate tab for such referrals. In New Jersey, MCEs can make referrals directly to the MFCU with a copy to the MFD.

2. ***The State does not suspend payments in cases of credible allegations of fraud –*** The MFD reported forty-six payment suspensions. The state could not answer whether this figure included good cause exceptions. The team stressed the need for New Jersey to provide updates to CMS in accordance with the regulation's annual reporting requirements. The state said nearly all MFCU cases involve requests not to suspend payments. The team noted that there may be providers billing a lot of dollars who know they are under investigation. Stopping payments would not tip them off and a lot of dollars are at risk. The team referenced Connecticut as a state that was particularly aggressive in trying to taking administrative actions against fraudulent billers. We stressed the need to review cases on a case by case basis. We also stressed that the final decision to suspend payments or file good cause exception rest with the State Medicaid agency. The same applies to quarterly certifications. While the State Medicaid agency can ask the MFCU to certify that the state should keep the payment suspension in effect, the final decision continues to rest with the state, and the Medicaid agency could decide in some circumstances to impose a suspension if there was a pressing need to "stop the bleeding."

3. ***Capturing ownership and control disclosures from disclosing entities –*** New Jersey provided a copy of the language that is now incorporated in the contract for its NEMT broker. It contained the full text of the regulation at 42 CFR 455.104. However, the team

pointed out the 455.104 language in the state's on-line application and model managed care contract reflects an outdated version of the regulation and should be changed. The provider enrollment supervisor from DMAHS said he would do an update. The team also noted that there was outdated 455.104 language in the managed long term services and support contract and spoke to a state supervisor on the managed care side about the need for revisions.

4. ***The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid –*** New Jersey provider enrollment staff stated that effective December 2011, all provider applicants, including professionals and individuals with a 5% or more ownership in an entity, are screened against the EPLS database. Any positive findings are shared with the Office of Provider Enrollment in DMAHS for review and an enrollment decision. Applicants are screened using NPI, date of birth or Social Security number. The EPLS database is updated monthly and also used systemically to screen healthcare claims. In addition, applicants are screened using the DMF and the NPPES.

   The state reiterated that it is having trouble doing automated checks on a monthly basis. One MFD manager indicated that his office can document discussions with the federal government, including the Treasury Department's Do Not Pay Initiative, about its efforts to achieve compliance. The team suggested that New Jersey get attestations from anyone that has a common name that they cannot eliminate through an automated data match with the EPLS public use file on SAM. The state representatives understood the usefulness of this but said it would be a very labor intensive process. As mentioned in the ACA section of this report, compliance with required DMF checks also remains an issue because provider enrollment staff uses an alternate website in lieu of the official DMF for death matches.

5. ***The State does not comply with its State plan regarding False Claims education monitoring –*** DMHAS legal staff provided the team with an abundance of information and documentation to show that the state is in compliance with the False Claims Act education monitoring requirements.

Official Response from New Jersey
July 2016

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ELIZABETH CONNOLLY
Acting Commissioner

MEGHAN DAVEY
Director

July 21, 2016

Laurie Battaglia
Acting Director
Division of State Program Integrity
Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Program Integrity
7500 Security Boulevard, Mail Stop AR-21-55
Baltimore, Maryland 21244-1850

Dear Ms. Battaglia:

This letter is in response to your January 21, 2016 correspondence concerning your Department's focused review of New Jersey's Medicaid program integrity procedures and processes.

The objective of the focused review was to determine whether New Jersey has fully implemented the requirements of federal regulations at 42 CFR 455 Subpart E that implemented the enhanced provider screening and enrollment provisions of the Affordable Care Act. The focused review identified areas of concern and instances of regulatory non-compliance in the State's provider enrollment and managed care program integrity activities.

Attached is New Jersey's Corrective Action Plan for each of the recommendations which follow the Corrective Action Plan Development Tool that was provided in your letter.

Let me know if you have any questions and I will arrange to have the appropriate person from DMAHS, MFD or MFCU respond to you.

Sincerely,

Richard H. Hurd
Chief of Staff

cc. Peter Sepulveda, Director, MFCU
Josh Lichtblau, Director, MFC
Michael Melendez, Associate Regional Administrator, DMCHO
Jackie Garner, Consortium Administrator, CMCHO
Meghan Davey, Director, DMAHS