



**New Jersey State Legislature  
Office of Legislative Services  
Office of the State Auditor**

---

**Department of Human Services  
Division of Medical Assistance  
and Health Services  
Managed Care Provider Networks**

October 1, 2008 to December 31, 2009

---

**Stephen M. Eells  
State Auditor**

LEGISLATIVE SERVICES COMMISSION



ASSEMBLYMAN  
JOSEPH J. ROBERTS, JR.  
*Chairman*

SENATOR  
THOMAS H. KEAN, JR.  
*Vice-Chairman*

SENATE

ANDREW R. CIESLA  
RICHARD J. CODEY  
NIA H. GILL  
ROBERT M. GORDON  
SEAN T. KEAN  
JOSEPH M. KYRILLOS, JR.  
LORETTA WEINBERG

GENERAL ASSEMBLY

PETER J. BIONDI  
JON M. BRAMNICK  
JOHN J. BURZICHELLI  
ALEX DECROCE  
ALISON LITTELL MCHOSE  
JOAN M. QUIGLEY  
BONNIE WATSON COLEMAN

OFFICE OF THE STATE AUDITOR  
(609) 292-3700  
FAX (609) 633-0834

STEPHEN M. ELLS  
*State Auditor*

THOMAS R. MESTEROLI  
*Assistant State Auditor*

# New Jersey State Legislature

## OFFICE OF LEGISLATIVE SERVICES

OFFICE OF THE STATE AUDITOR  
125 SOUTH WARREN STREET  
PO BOX 067  
TRENTON NJ 08625-0067

ALBERT PORRONI  
*Executive Director*  
(609) 292-4625

The Honorable Chris Christie  
Governor of New Jersey

The Honorable Stephen M. Sweeney  
President of the Senate

The Honorable Sheila Y. Oliver  
Speaker of the General Assembly

Mr. Albert Porroni  
Executive Director  
Office of Legislative Services

Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, Managed Care Provider Networks for the period of October 1, 2008 to December 31, 2009. If you would like a personal briefing, please call me at (609) 292-3700.

Stephen M. Eells  
State Auditor  
May 5, 2010

## Table of Contents

	<b>Page</b>
Scope .....	1
Objectives .....	1
Methodology .....	1
Background .....	2
Conclusions .....	2
Findings and Recommendations	
Dental Providers and Specialist Networks .....	3
Auditee Response .....	7

---

**Department of Human Services  
Division of Medical Assistance and Health Services  
Managed Care Provider Networks**

***Scope***

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services, Managed Care Provider Networks for the period October 1, 2008 to December 31, 2009. For the year ended December 31, 2009 New Jersey spent \$2.5 billion on managed care for approximately 1.1 million beneficiaries. This audit was performed in conjunction with our overall review of the Managed Care program. Several audit reports have been issued on selected topics related to the Managed Care program.

***Objectives***

The objective of our audit was to determine if the division had adequate procedures to properly monitor Managed Care Organization (MCO) provider networks. Our review focused on dentists and the following specialists: dermatologists, otolaryngologists (ear, nose, and throat), colorectal surgeons, and endocrinologists.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

***Methodology***

Our audit was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States.

In preparation for our audit, we studied legislation, the State Medicaid Plan, administrative code, the managed care contract, and policies of the agency. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our analysis of provider networks. We also interviewed agency personnel to obtain an understanding of the program and the internal controls. Dentists and selected specialists

listed in the managed care network directories on websites and electronic data files were sorted, analyzed, and judgmentally selected for testing.

### ***Background***

The Division of Medical Assistance and Health Services administer the state's Medicaid and NJ FamilyCare programs, which provide medical assistance to needy or uninsured individuals. A Managed Care Organization (MCO) receives a monthly payment for each Medicaid beneficiary enrolled in the plan and in return is responsible for ensuring enrollees have access to quality health care and needed medical services. During our audit period there were five MCOs participating in the state's Managed Care program which is intended to provide quality health care in a cost-effective manner.

MCO provider networks consist of physicians or groups of physicians, specialists, hospitals, pharmacies, and clinics that are contracted by an MCO to provide its enrollees with all of the health care services they may require. The success of an MCO often depends on how well the provider network is structured and how efficient and effective it is in responding to patient needs.

### ***Conclusions***

The division should continue to improve its monitoring over MCO networks. Our review found information reported to the division by MCO provider networks in their geographic accessibility reports was often inaccurate. In addition, we found that provider network information appearing on MCO websites was not always accurate or sufficient in helping beneficiaries select a health plan that meets their needs. The division should consider modifying its current contract to include additional reporting requirements to ensure adequate provider networks.

## Dental Providers and Specialist Networks

**The division should  
continue to strengthen  
its oversight of provider  
networks.**

Section 4.8.1 of the New Jersey managed care contract states that Managed Care Organizations (MCOs) “shall establish, maintain, and monitor at all times a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access . . . to all services covered under this contract.” MCOs should ensure there are enough participating providers that are geographically accessible to enrollees and that there are a sufficient number of providers available in each area of specialty practice to meet the needs of enrollees.

As part of the contract requirements, MCOs submit network files of general dentists to the division quarterly. The MCO must demonstrate its compliance with the division’s provider network requirements and how it will ensure enrollees access to all services covered under the contract. MCOs are required to prepare a separate geographical accessibility analysis for each county using Medicaid/FamilyCare eligibility data files. These reports show the percentage of beneficiaries who have access to dental providers at various distances. We selected three counties: Camden, Ocean, and Passaic for review. We reviewed the 2008 geographic accessibility (Geo Access) reports for general dentists in these counties. These reports did not provide detailed listings of dental providers to support the totals. After obtaining additional information from the MCOs, we found significant errors in the number of general dentists reported by four of the five MCO networks. For these four MCOs, there was an overall average of 32 percent (193 of 601) fewer dentists serving Camden and Ocean counties and 19 percent (72 of 389) fewer in Passaic County than what was reported in the Geo Access reports. Two MCOs had overstated the number of dentists in their networks by as much as 40 percent (51 of 128) in Camden and

Ocean counties. Our review identified the following errors. Primary care dentists were listed more than once, dental specialists were counted as primary care dentists, and dentists who had more than one office location were improperly counted multiple times.

In a separate test of Ocean County dental providers listed on MCO websites, we found that 40 percent (86 of 217) of the providers tested were not providing dental services at the location listed. Additionally, we found 25 percent (31 of 124) of the remaining provider locations tested were not accepting new patients. The division's contract requires MCOs to maintain and update their web-based provider directories every 30 days.

Our review of MCO websites indicate that beneficiaries may still encounter difficulties when selecting a MCO based on the provider network information posted on their website. At the time of our testing, two MCOs did not have their network specialists listed on their websites. In addition, we examined website resources and found that some of the information provided was difficult to access and use in selecting a MCO. For example, the websites use different formats for information about their providers. Some provide electronic lists while others use search engines requiring beneficiaries to conduct queries of specific providers or specialties. The search engines also may vary. Some require beneficiaries to input zip codes while others require a search by provider name or specialty type. As a result, it can be difficult and confusing for beneficiaries to select a health care plan, which can be of particular importance to beneficiaries who need specialty care to treat chronic conditions.

Our review of provider directories in six counties (Atlantic, Camden, Cape May, Essex, Hudson and Passaic) indicated a number of listed specialty providers were not available to serve beneficiaries. We obtained the provider

directories from websites for three MCOs and attempted to contact a sample of each of the listed endocrinologists, otolaryngologists (commonly known as ear, nose, and throat specialists, or ENTs), dermatologists, and colorectal surgeons to verify their service location, whether they were seeing Medicaid beneficiaries at that location, and whether they were accepting new patients. Our review found the following:

Specialist	Not at the location listed	Not seeing Medicaid patients	Not accepting new patients
Colorectal Surgeon	15%	26%	0%
Dermatologist	54%	12%	5%
Endocrinologist	25%	32%	11%
Ear, Nose, and Throat	21%	21%	5%

The above noted exceptions have a cumulative effect on physician availability. For example, of the 138 ENTs tested for the three MCOs, 29 doctors did not service the location listed, 23 were not seeing Medicaid patients, and four were not seeing new patients. As a result, 82 of the 138 ENTs tested would see new Medicaid patients at the locations listed.

The problems that the MCOs are having with maintaining accurate provider lists with sufficient information about provider accessibility is probably not restricted to dentists and specialists. Although our review and testing focused on specialists, our findings may also be applicable to primary care physicians as well.

We recognize the division maintains a centralized database for receiving and tracking complaints. Grievance reports provide aggregate information about the total number of grievances that a plan receives. The reports identify the number of complaints specifically related to problems with accessing primary or specialty health care professionals. While this oversight activity may assist the division concerning network adequacy and accessibility, beneficiaries experiencing

access problems may choose not to file a complaint.

The division relies on MCOs reporting accurate information on their provider networks. Without accurate information the division can not properly monitor these networks for deficiencies. Failure to monitor networks may result in “phantom networks”, where specific doctors are not at the location listed or are not accepting new patients.

***Recommendation***

The division should continue to strengthen its oversight over provider networks. To help ensure the networks meet beneficiary needs, the division should modify the reporting requirements to support the Geo Access reports. The division should utilize the National Provider Identifiers (NPI) and encounter data to enhance its monitoring of networks. This would allow the division to identify which providers participate in more than one plan and whether providers have the capacity to address the needs of beneficiaries in their area. The division needs to work with the MCOs in fixing the provider directories to ensure beneficiaries have accurate information to make informed decisions in choosing a health care plan.

»»<<««



## State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PO Box 712

TRENTON, NJ 08625-0712

CHRIS CHRISTIE  
*Governor*

KIM GUADAGNO  
*Lt. Governor*

JENNIFER VELEZ  
*Commissioner*

JOHN R. GUHL  
*Director*

May 3, 2010

Stephen M. Eells, State Auditor  
Office of Legislative Services  
Office of the State Auditor  
125 South Warren Street  
P O Box 067  
Trenton, NJ 08625-0067

Dear Mr. Eells:

This is in response to your letter of April 19, 2010 to Commissioner Velez concerning the Office of Legislative Services (OLS) draft audit report entitled "Department of Human Services Division of Medical Assistance and Health Services, Managed Care Provider Networks". Your letter provides an opportunity to comment on the draft audit report.

The objective of the audit was to determine if the Division of Medical Assistance and Health Services had adequate procedures to properly monitor managed care organization provider networks during the period October 1, 2008 through December 31, 2009. The auditor's conclusion, findings and recommendations and the Division of Medical Assistance and Health Services' responses are provided below:

### Conclusion

The auditor concluded the Division of Medical Assistance and Health Services (DMAHS) should continue to improve its monitoring over managed care organization (MCO) networks. The auditor found information reported to the Division by MCOs in their geographical accessibility reports was often inaccurate. The auditor also found that provider network information appearing on MCO websites was not always accurate or sufficient in helping beneficiaries select a health plan that meets their needs. The auditor suggests the Division increase the MCO reporting requirements to ensure adequate provider networks.

DMAHS concurs that continued improvements in monitoring MCO provider networks is useful to support informed beneficiary decisions in choosing a health care plan and to ensure their access to services. The Division increased its monitoring of MCO provider networks and assigned additional resources to this function. The Division has plans to further enhance this activity through increased review and analysis of MCO provider network reports and expanded contractual requirements, if necessary.

However, the available information indicates the provider networks maintained by the MCOs meet the applicable regulatory and contractual requirements and provide for appropriate access

Stephen M. Eells  
May 3, 2010  
Page 2

to services. The MCO networks would have sufficient providers to meet the applicable requirements even after the elimination of every provider questioned in the audit report. The enhancements suggested in the audit would support beneficiary access to information but will not directly expand MCO provider networks.

DMAHS formally reviews MCO provider networks twice each year based on the certified provider network report submitted by the MCO. The Division monitored this submission to ensure the minimum number of providers prescribed by contract and reported the results to the MCO for corrective action, if needed. During the audit period, the results of these reviews indicate the MCOs have consistently maintained adequate provider networks or have immediately implemented corrective action to assure access to needed services.

Recently added staff resources and data processing tools have enabled DMAHS to expand the MCO network monitoring function to include evaluations of other data supplied by the MCOs such as the sources referenced in the audit report. The location of providers is now considered through recently obtained Geo Access submissions and provider overlaps can be efficiently reviewed as a result of the recent implementation of National Provider Identification (NPI) numbers. These data sources are being integrated by DMAHS to enhance the monitoring of MCO network providers and provide accurate and timely information to enrollees. The Division will take immediate action including additional MCO reporting requirements if these efforts indicate any shortcomings in the MCO provider networks or deficiencies in their provider network publications. However, current MCO provider networks appear sufficient to assure access to services.

#### Finding:

The audit selected three counties and reviewed the geographical accessibility reports for general dentists. Since these geographical accessibility reports do not contain provider specific information, the auditor obtained additional information directly from the MCOs. The auditor's analysis of this information identified significant errors for four of the five MCOs. There were 325 fewer dentists serving Camden and Ocean Counties and 19% fewer dentists serving Passaic County than contained in these four MCO's geographical accessibility reports. Primary care dentists were listed more than once, dental specialists were counted as primary care dentists and dentists who had more than one office location were improperly counted multiple times.

A separate test of MCO websites indicated that 40% of dentists listed in Ocean County were not providing services at the location listed. Additionally, 25% of the remaining provider locations were not accepting new patients.

#### Response:

The Division is cognizant of the importance of access to primary dental care for Medicaid and Family Care clients. The Division maintains MCO contractual requirements for primary dental provider networks that exceed the State's regulatory specifications. Additionally, the Division performs stringent reviews of the separate MCO certified provider network reports biannually. Based on the certified MCO provider network reports, all of the MCOs maintain a surplus of primary dental providers in the Counties mentioned in the audit report. The primary dental

Stephen M. Eells  
May 3, 2010  
Page 3

provider networks range from 165% of the minimum requirement to nearly 15 times the minimum for one MCO in Ocean County. The exclusion of every provider questioned in the audit would not reduce any MCO's dental provider network below the minimum contractual requirements.

The Division is aware that some providers are currently at capacity and can not accept new patients. This is an anticipated occurrence and is considered in the evaluation of MCO provider networks. Primary care dental provider network requirements are reflective of the number of MCO enrollees which does not change precipitously. The MCOs are not expected to maintain excessive unused capacity in their provider networks. The financing of excessive numbers of providers operating below capacity would increase overall costs to the MCO and the State. Therefore, it is likely that at any given point in time, the network will include some providers who are not accepting new patients.

DMAHS is aware that some dental specialists are identified as primary care providers. Some occurrences may be attributed to primary care providers who become specialists subsequent to enrollment in an MCO provider network. Other occurrences may be the result of providers indicating in their credentialing documentation that they perform both specialty and primary care dental services. However, this identification is not always incorrect since some specialists continue to provide primary care. The Division intends to work with the MCOs to correct their provider listings to properly reflect the level of service provided by each dentist.

Duplicate listings of primary care providers are acceptable on the MCO certified provider network report as long as the MCO can demonstrate that the providers are meeting full time equivalency (FTE) requirements (20 hours per week delivering primary care) in each county listed. Duplicate listings of specialists are common because they are allowed to serve members residing within 45 miles of their location which is likely to encompass more than one county resulting in a listing for each county serviced by the provider. Another source of duplication would be specialists with offices in multiple counties. DMAHS has been working to address the issues related to providers operating from multiple locations and being listed more than once on the separate geographical accessibility reports. The Division is developing computerized applications to identify duplicate provider listings and locations. Likewise, the Division is working with the MCOs to obtain additional information to support this improvement.

Finding:

The separate test of MCO websites indicated several providers were not providing services at the locations listed or were not accepting new patients. The auditor noted the MCOs are required to maintain and update the web-based provider directories every 30 days. Also, the auditor noticed potential difficulties that could be encountered by beneficiaries using the MCO websites because of missing information, differing formats, listings and search engines.

The auditor noted exceptions to the MCO websites for provider listings for dentists, colorectal surgeons, dermatologists, endocrinologists and otolaryngologists. The draft report supposes the noted deficiencies may also be applicable to primary care physicians. Finally, the report notes that failure to monitor networks may result in "phantom networks", where specific doctors are not at the location listed or are not accepting new patients.

Stephen M. Eells  
May 3, 2010  
Page 4

Response:

DMAHS rigorously monitors MCO provider networks for compliance with contract requirements especially primary care providers. This review of MCO provider networks has focused on the separate MCO certified provider network submissions and the applicable contract specifications. The results of these monitoring activities indicate the MCOs maintain adequate provider networks and meet the applicable contract requirements. The Division has strengthened its monitoring functions and further enhancements are planned. Since the purpose of robust provider networks is to assure access to needed medical services, the Division has also judged the adequacy of provider networks through reviews of enrollee complaints and ongoing surveys of enrollee satisfaction. Therefore, the Division is confident the MCOs maintain provider networks that provide adequate access to all covered medical services.

In addition to the provider network oversight mentioned previously, the Division provides direct telephone access for MCO enrollees through each MCO, through a contracted Health Benefits Coordinator and a Division hotline. These telephone supports are available to assist enrollees with locating specific providers to meet their needs or any other needed assistance including enrolling in MCOs that include selected providers. The combination of oversight, enrollee contacts and enrollee telephone support provides the Division with a basis to ensure that adequate MCO provider networks are available to provide access to needed services.

While the Division believes it has responsibly focused the available resources on confirming the MCOs maintain adequate provider networks to ensure access to services, the audit report indicates additional attention to the geographical accessibility reports and MCO websites would provide more support to our clients. The Division has plans to improve the oversight of these reports including requiring additional information for provider locations and reviewing MCO websites. The Division will continue to implement these plans to support our clients' ability to more easily locate available providers.

Recommendation:

The Division should continue to strengthen its oversight over provider networks. To help ensure the networks meet beneficiary needs, the Division should modify the reporting requirements to support the Geo Access reports. The Division should utilize the National Provider Identifiers (NPI) and encounter data to enhance its monitoring of networks. This would allow the Division to identify which providers participate in more than one plan and whether providers have the capacity to address the needs of beneficiaries in their area. The Division needs to work with the MCOs to ensure beneficiaries have accurate information to make informed decisions in choosing a health care plan.

Response:

The Division has plans to implement the improvements recommended in the audit report. In addition to the other supports provided by the Division, these improvements will provide beneficiaries with more information to make informed decisions. The Division has already begun to implement the use of NPI numbers in its provider network monitoring processes. DMAHS plans to link specific provider locations with Geo Access reports to enhance oversight

Stephen M. Eells  
May 3, 2010  
Page 5

functions. The MCOs will be reminded of the requirement to maintain accurate website information and the Division will initiate monitoring of the provider listing on these websites.

If you have any questions or require additional information, please contact me or Richard Hurd at 609-588-2695.

Sincerely,

A handwritten signature in black ink that reads "John R. Guhl" with a stylized flourish at the end.

John R. Guhl  
Director

JRG:L

c: Jennifer Velez  
Richard Hurd