

STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION

COMPLIANCE AUDIT
HORIZON NEW JERSEY HEALTH'S
SPECIAL INVESTIGATIONS UNIT

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COMPTROLLER

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EXECUTIVE SUMMARY

As part of its oversight of the Medicaid and New Jersey FamilyCare programs, the Medicaid Fraud Division of the Office of State Comptroller (OSC) conducted an audit of Horizon NJ Health (HNJH), the largest of the four Medicaid health maintenance organizations (HMOs) in the state of New Jersey. HNJH receives \$1.3 billion from the state annually. The audit pertained specifically to HNJH's compliance with the program integrity provisions of HNJH's contract with the state. In its audit, OSC found multiple areas of non-compliance.

For example, OSC determined that HNJH's investigative arm, tasked with investigating fraud and abuse within its HMO network, did not consistently coordinate with the state to maximize recovery opportunities, or consistently enforce the yearly training requirements for its investigators. In addition, HNJH does not have a methodology for calculating the number of its employees dedicated to investigating fraud and abuse. As a result, HNJH cannot substantiate that it has allocated contractually required resources based on the number of enrollees in its network. OSC also found that HNJH did not ensure that pharmacy audits conducted by its vendor were referred to HNJH's investigators for further investigation even though our review indicated that further investigation was warranted for many of those audits.

Further, OSC determined that over the two-year period reviewed, HNJH reported only 14.1% of its fraud and abuse recoveries to the state Department of Human Services. The underreporting of recoveries results in the state paying an artificially high premium rate to HNJH and the other three Medicaid HMOs with whom the state contracts. Specifically, OSC found that HNJH's underreporting of recoveries led to the state paying approximately \$162,000 more in premiums to the Medicaid HMOs than it should have. OSC recommends that the state seek to recover these funds.

In total, HNJH recovered only \$188,207 in improper payments from its network providers and enrollees and actively investigated only nine providers during the two-year period reviewed. These figures raise questions regarding the aggressiveness with which HNJH is pursuing fraud and abuse recoveries in the Medicaid program.

BACKGROUND

The Medicaid program provides health insurance to qualifying parents and dependent children, as well as individuals who are aged, blind or disabled. The program pays for hospital services, doctor visits, prescriptions, nursing home care and other healthcare needs.

New Jersey FamilyCare is a health insurance program for uninsured children whose family income is too large for them to qualify for Medicaid, but not large enough to be able to afford private health insurance. Combined, the Medicaid and New Jersey FamilyCare programs serve more than one million New Jersey residents.

The Division of Medical Assistance and Health Services (DMAHS) within the Department of Human Services serves as the state's Medicaid agency and contracts annually with a number of HMOs to provide healthcare services to New Jersey's Medicaid and FamilyCare population. The largest of these HMOs is HNJH, a wholly owned subsidiary of Horizon Blue Cross Blue Shield. HNJH serves more than 470,000 Medicaid enrollees in all 21 New Jersey counties.

The state pays HNJH approximately \$1.3 billion annually to provide healthcare services to qualifying New Jersey residents through its HMO network providers. HNJH's contract with the state requires it to maintain within its operations a distinct fraud and abuse unit, dedicated solely to the detection and investigation of fraud and abuse by HNJH Medicaid and FamilyCare enrollees and healthcare providers within its network.

This distinct unit, known within HNJH as its Special Investigations Unit (SIU), recovers improper payments from healthcare providers and enrollees based on its investigations. HNJH is obligated to report such recoveries to the state so that the state can factor those recovery amounts, along with other actuarially driven factors, into its premium payments to HNJH. Specifically, the more money the SIU and similar units within the other Medicaid HMOs recover and report to the state, the lower the premium payments the state pays to those entities. OSC audited HNJH's adherence to the program integrity provisions of its contract with the state to ensure that the state is receiving the level of service for which it contracted.

OBJECTIVE AND SCOPE

The objective of OSC's audit was to evaluate the SIU's compliance with the fraud, waste and abuse requirements of HNJH's contract with DMAHS for the period of January 1, 2009 through December 31, 2010. OSC also audited the SIU's compliance with the staff training requirements set forth at N.J.A.C. 11:16-6.5.

The audit examined reports submitted by the SIU to the state from January 1, 2009 through December 31, 2010 for accuracy and completeness. In addition, we reviewed compliance with contract requirements pertaining to the SIU's investigative staff, such as requirements concerning staff employment experience, training, and the number of employees dedicated to investigating fraud and abuse within the HNJH network.

This audit was conducted under the State Comptroller's authority as set forth under the *Medicaid Program Integrity and Protection Act*, N.J.S.A. 30:4D-53 *et seq.*, and N.J.S.A. 52:15C-23.

REVIEW OF QUARTERLY REPORTS

Section 7.38 of the contract between HNJH and DMAHS (the Contract) requires the SIU to submit to OSC and DMAHS all identified instances (proven or

suspected) of fraud and abuse within HNJH's provider network. The Contract also requires the SIU to report to OSC on a quarterly basis the monetary amounts recovered from any entity engaged in fraudulent or abusive activities. The SIU is further required to provide notice to and receive approval from OSC before initiating an investigation or seeking a recovery.

The specific areas of our review concerning the quarterly reports, and our corresponding findings and recommendations, are set forth below:

1. Reporting of Dollars Recovered

The SIU is contractually required to report to OSC those cases that result in financial recoveries by the SIU. These recoveries are to be reported in the quarter they are received by the SIU and should include only Medicaid recoveries (i.e., they should not include recoveries from non-Medicaid providers and recipients). OSC reviewed the quarterly reports submitted by HNJH to determine whether all relevant recoveries were reported to OSC. During the two-year period under review, HNJH reported a total of five Medicaid-related recoveries. We obtained and reviewed HNJH's underlying documentation for those five recoveries and compared the information therein to the information submitted in the quarterly reports. After our audit fieldwork was complete, HNJH submitted amended quarterly reports that reflected larger recoveries in those five instances. HNJH subsequently provided OSC with additional documentation and OSC ultimately was able to obtain support from HNJH for the recoveries HNJH listed on its amended quarterly reports.

Separately, HNJH's Finance Division is contractually required to provide a number of reports to DMAHS's Office of Managed Health Care. Unlike the quarterly reports previously discussed, these reports are not sent to OSC as a matter of course. Included among these reports is a report entitled "Table #10 - Third Party Liability and Fraud/Abuse Collections" (T10). The relevant section of T10 for purposes of this audit sets forth HNJH's fraud and abuse recoveries on a quarterly basis. These recoveries listed on T10 are a factor in determining the

state's premium payments to HNJH and the other Medicaid HMOs. Specifically, the larger the recovered dollars listed on T10, the smaller the premiums the state pays.

OSC compared the recoveries listed on T10 to the amounts listed as recoveries on the corresponding quarterly reports submitted by HNJH to OSC. Table 1 below reflects the amounts reported on the quarterly reports in comparison to the amounts reported on T10.

Table 1

Quarter	Amount Reported on Quarterly Reports	Amount Reported on T10	Difference
1Q2009	\$28,953	\$619	\$28,334
2Q2009	\$83,385	\$1,105	\$82,280
3Q2009	\$47,682	\$973	\$46,709
4Q2009	\$5,076	\$4,361	\$715
1Q2010	\$5,969	\$255	\$5,714
2Q2010	\$5,714	\$2,656	\$3,058
3Q2010	\$5,714	\$9,174	(\$3,460)
4Q2010	\$5,714	\$7,398	(\$1,684)
Totals	\$188,207	\$26,541	\$161,666

Findings

During the period of January 1, 2009 to December 31, 2010, there was a \$161,666 difference between the recovery amounts reflected on the quarterly reports and the recovery amounts reported on T10, resulting in HNJH reporting to DMAHS only 14.1% of its total Medicaid recoveries. The state overpaid \$161,666 in premiums to the Medicaid HMOs due to HNJH's underreporting of recoveries on T10. OSC separately notes that the \$188,207 in total fraud and abuse recoveries in this \$1.3 billion program raises questions regarding the aggressiveness with which HNJH is pursuing such recoveries.

Recommendations

HNJH's Finance Division and the SIU should reconcile differences between what was reported on T10 and what was reported in the quarterly reports. T10 should

reflect the total amount of Medicaid recoveries. OSC recommends that the state seek to recover the premiums that it overpaid.

2. **Approval to Investigate**

Pursuant to section 7.38.2 of the Contract, the SIU is required to submit written notification to OSC requesting approval to open an investigation. That section states in pertinent part, “Written notification must be sent by the contractor to the [OSC] within five (5) business days of the contractor’s intent to conduct an investigation, and approval must be obtained by the contractor from [OSC] prior to conducting the investigation.” During the period covered by this audit, there were 64 SIU provider cases and 75 enrollee cases reported on the quarterly reports.

Findings

Of the 64 provider cases, only four included adequate documentation demonstrating that OSC had granted approval for the SIU to investigate. Our inquiries further revealed that the SIU actively worked on only nine provider investigations in total (including the four with adequate documentation) over the audit period. The remaining cases listed merely reflected inquiries from various third parties seeking information for their own investigations or otherwise required only de minimus investigative work on the part of the SIU. The small number of provider cases being actively investigated raises questions as to whether adequate resources have been allocated to the SIU.

The remaining 75 cases were enrollee cases. For enrollee cases, the Contract does not require the SIU to seek approval from OSC prior to initiating an investigation. Accordingly, OSC did not perform audit testing on the enrollee cases.

Recommendations

The quarterly reports should reflect only actual investigations. Listing cases that do not involve substantive investigative work on the part of the SIU provides a misleading picture of the work the SIU is performing. OSC recommends that the

Contract be amended to require the SIU to list responses to inquiries from third parties in a separate category. For consistency purposes, the Contract also should be revised to include reporting requirements for enrollee cases.

3. Approval to Recover Funds

Section 7.38.2 of the Contract also provides that “[w]ritten notification must be sent by the contractor to [OSC] within five (5) business days of the contractor’s intent to recover funds, and approval must be obtained by the contractor from [OSC] prior to the collection of those funds.” The purpose of this contractual requirement is to allow OSC to conduct a review to ensure that the SIU is maximizing the recovery potential in the cases it settles. As noted previously, larger recoveries made by the SIU result in lower premium payments by the state on a yearly basis. For purposes of this audit, we reviewed the five provider cases in which the SIU obtained a recovery to determine whether the SIU received approval from OSC for the recovery.

Findings

The SIU did not have documentation indicating OSC’s approval for the recoveries in four of the five provider cases.

Recommendations

HNJH shall abide by the terms of the Contract with regard to issues such as obtaining approval to recover funds.

VENDORS/SUBCONTRACTORS

HNJH contracts with six vendors, in addition to its provider network, to offer comprehensive healthcare services to its enrollees. The vendors perform a variety of services on behalf of HNJH, including providing vision care, dental care, lab services, and behavioral health services, adjudicating prescription drug claims, and monitoring a customer complaint hotline. The vendors’ contracts with HNJH permit the vendors to enter into subcontracting agreements with other healthcare providers. There are more than 3,500 subcontractors that work with HNJH’s

vendors. The subcontractors are obligated to adhere to the contractual stipulations between the vendor and HNJH.

HNJH management (Management) informed us that the oversight and monitoring of the vendors and subcontractors is the responsibility of the HNJH Delegate & Vendor Oversight Subcommittee (Subcommittee). According to Management, the Subcommittee meets regularly with the vendors to assess their performance and identify issues for referral to the SIU. HNJH's vendors and their subcontractors are required to report potential fraud and abuse issues to the SIU when they encounter them.

OSC reviewed HNJH documentation to determine the number of referrals made by HNJH's vendors and their subcontractors to the SIU during the audit period. Table 2 below illustrates the results of that review.

Table 2

Vendor	Number of Subcontractors in 2009	Number of Subcontractors in 2010	Number of Referrals to the SIU from Jan. 2009 through Dec. 2010
1	300	304	1
2	873	964	6
3	0	0	0
4	2,367	2,367	0
5	0	0	1
6	0	0	15
Total	3,540	3,635	23

Findings

There were 23 documented referrals from HNJH's vendors and subcontractors to the SIU during the audit period. The vendor with the largest number of subcontractors did not refer any cases to the SIU during the audit period. The lack of referrals by HNJH's vendors and subcontractors to the SIU raises questions concerning oversight and monitoring by HNJH's Subcommittee in ensuring that potential fraud and abuse by providers and enrollees is being addressed.

In addition, the referrals listed on HNJH's internal vendor referral documents do not reconcile with the referrals separately identified on the quarterly reports. HNJH provided no explanation for this discrepancy.

Recommendations

HNJH shall provide OSC with an action plan outlining the steps to be taken to enhance the detection of fraud and abuse in its vendor and subcontractor relationships. HNJH shall further provide OSC with an accurate reconciliation of its referral documentation.

ON-SITE PHARMACY AUDITS

HNJH also contracts with a vendor that conducts on-site audits of HNJH network pharmacies. The vendor conducts approximately 400 audits of HNJH pharmacies annually. During on-site audits, prescriptions are reviewed to evaluate the integrity of billed prescription claims and to identify fraudulent or suspicious matters. According to Exhibit D of the contract between HNJH and the audit vendor, if the audit identifies certain patterns of suspicious billing activity, the audit vendor is required to refer the audit to HNJH's Pharmacy Network Manager. After receiving this referral, the Manager is required to refer the case to the SIU for further investigation.

The contract between HNJH and its pharmacy providers states that any overpayments found during the audits will be offset against future payments to the pharmacy until the overpayment is satisfied. In addition, any audit which results in the pharmacy owing HNJH more than \$5,000 in any given year requires that pharmacy to be audited again the next year.

Our review of HNJH's quarterly pharmacy recovery reports revealed that the audit vendor performed 431 on-site audits in 2009 with recoveries totaling \$530,025, and 392 on-site audits in 2010 with recoveries totaling \$410,817. In 2009, the audit vendor found that 21 pharmacies owed HNJH more than \$5,000. In 2010, the audit vendor found that 13 pharmacies owed HNJH more than \$5,000. As part of our audit sampling, we reviewed 12 audits from 2009 with

recoveries totaling \$133,714 and 10 audits from 2010 with recoveries totaling \$96,899.

Findings

Of the 22 audits reviewed, OSC identified 19 audits in which the audit vendor documented deficiency patterns which should have resulted in a referral to the SIU from HNJH's Pharmacy Network Manager, but no referral was made. Some examples include:

- A federally excluded HNJH provider wrote 65 different prescriptions.
- Six prescriptions, at three different pharmacies, were identified as having been altered.
- In many audits, the original prescriptions were missing. Specifically,
 - o In two audits, 30 or more of the original prescriptions were missing.
 - o In one audit, 21 of the original prescriptions were missing.
 - o In five audits, from 10 to 19 of the original prescriptions were missing.

The failures to refer potential instances of fraud and abuse to the SIU bring into question HNJH's degree of oversight in managing its pharmacy network.

Recommendations

The 19 audits in which the audit vendor documented deficiency patterns should be referred to the SIU for further investigation.

DISTINCT UNIT REQUIREMENT

Section 7.38.2 of the Contract states, "The contractor shall establish a distinct fraud and abuse unit, solely dedicated to the detection and investigation of fraud and abuse by its New Jersey Medicaid and NJ FamilyCare beneficiaries and providers The unit can either be a part of the contractor's corporate structure, or operate under contract with the contractor." To satisfy this requirement, HNJH created the SIU.

The SIU is contractually required to have "an investigator-to-beneficiary ratio for the New Jersey Medicaid/NJ FamilyCare enrollment of at least one investigator

per 60,000 or fewer New Jersey enrollees, or a greater ratio as needed to meet the investigative demands.” This provision is designed to ensure that the SIU allocates appropriate resources to address fraud and abuse on the part of providers and enrollees.

Pursuant to the Contract, the requirement of one investigator per 60,000 enrollees can be satisfied by the use of “full-time equivalents” rather than dedicated investigators. Full-time equivalents (FTEs) represent individuals whose job responsibilities may be split into different areas; however, when combined with other individuals, they represent one fully dedicated individual responsible for a particular task. For example, if three individuals each spend one-third of their time on the SIU function, those three individuals combined would represent one full-time equivalent person dedicated to SIU responsibilities.

Pursuant to the Contract, HNJH must submit to OSC, on a quarterly basis, documentation demonstrating that at least one FTE investigator per 60,000 enrollees is being devoted to fraud and abuse cases. HNJH Management explained that they utilize full-time equivalent statistics (rather than dedicated investigators) in calculating their investigator-to-beneficiary ratio.

Table 3 below summarizes HNJH’s quarterly investigator-to-beneficiary ratio reports for the audit period. HNJH provided upwardly revised information regarding FTE hours after our audit fieldwork had been completed. That revised information is included in the Table. In addition, Table 3 indicates OSC’s calculation of the required quarterly FTEs based upon enrollment statistics provided by HNJH.

Table 3

Employee	Title	1Q2009	2Q2009	3Q2009	4Q2009	1Q2010	2Q2010	3Q2010	4Q2010
J.C.	Investigator	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
L.B.	Investigator	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25
E.O.	Data Reporting Analyst	0.50	0.50	0.50	0.50	0	0	0	0
J.W.	Investigator	0.25	0	0	0	0	0	0	0
W.C.	Investigator	0.50	0.50	0.50	0.50	0.50	0.50	0.50	0.50
J.M.	Director	0.25	0.25	0.25	0.25	0.25	0.25	0.25	0.25
M.L.	Investigator	0	0.25	0	0	0	0	0	0
J.O.	Investigator	0	0	0	0	0.25	0.25	0.25	0.25
D.T.	Data Reporting Analyst	0	0	0	0.25	0.50	0.50	0.75	0.75
L.E.	Assistant Counsel	0.15	0.15	0.15	0.25	0.15	0.15	0.25	0.15
P.E.	Senior Investigator	0	0	0	0	0	0	0	0.25
No employee listed	Pharmacy Lock in Program Initiative	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
No employee listed	Fraud and Abuse Work Group Initiative	1.00	1.00	1.00	1.00	2.00	1.00	1.00	1.00
No employee listed	Investigator Collaboration for Commercial/Medicaid Investigations	0.50	0.50	0.50	0.50	1.00	2.00	2.00	2.00
TOTAL REPORTED FTEs		6.40	6.40	6.15	6.50	7.90	7.90	8.25	8.40
TOTAL REQUIRED FTEs		6.34	6.60	6.86	7.16	7.49	7.76	7.77	7.83

Given HNJH's reliance on FTE statistics, OSC requested that HNJH provide its methodology for determining the amount of time individuals were dedicating to the SIU function. HNJH explained that it does not have such a methodology. Accordingly, OSC cannot assess whether the FTEs reported by HNJH are accurate.

In addition, section A.7.2(C) of the Contract Appendix requires HNJH to report the above data on an employee-by-employee basis. However, as related in Table 3, HNJH reported a total of 34 FTE hours by listing initiatives or collaborative investigations without specifying the employee(s) assigned to those tasks. OSC cannot assess the validity of HNJH's FTE reports when specific employees are not listed for the reported hours.

Findings

Reported SIU staffing levels were below the minimum required for three of the four quarters in 2009, but satisfied Contract requirements in 2010. However, OSC lacks confidence in the validity of the reported hours because of the methodology concerns referenced above. HNJH has not adequately established that it is devoting appropriate resources to address fraud and abuse within its provider and enrollee network.

Recommendations

The Contract should be amended to provide for monetary sanctions for failure to comply with SIU staffing requirements. HNJH should not be permitted to report its investigator-to-beneficiary ratios on an FTE basis until it provides its methodology for calculating such FTEs.

STAFF TRAINING REQUIREMENTS

SIU personnel must meet minimum staff training requirements as set forth by state regulatory law. Specifically, N.J.A.C. 11:16-6.5(iii) states, “The Basic Entry Level Training shall be no less than nine hours of classroom instruction. The Continuing Education Training shall be no less than nine hours of training per year for SIU personnel and four hours per year for claims and underwriting personnel.”

We reviewed training-related documentation provided by the SIU for each SIU investigator. This documentation included in-house training provided by HNJH, as well as symposiums sponsored by outside vendors. The majority of training received by the SIU investigators was sponsored by the National Health Care Anti-Fraud Association (NHCAA). Because of discrepancies in the information we initially obtained from HNJH, we requested training-related documentation directly from NHCAA for the SIU investigators. The NHCAA electronically maintains records of attendees for their courses. In determining whether the SIU investigators satisfied state requirements concerning minimum hours of training, we added together their hours of training from both NHCAA and non-NHCAA courses.

Findings

For 2009, 35% of the investigators did not satisfy state requirements concerning the minimum hours of training. For 2010, 9% of the investigators did not satisfy those requirements. SIU management is not consistently exercising adequate oversight to ensure its investigators are meeting the training requirements. As a result, the public lacks assurance that SIU investigators are properly trained to address fraud and abuse within HNJH's provider network.

Recommendations

SIU management should implement a monitoring process to ensure that all SIU investigators obtain the training required by the New Jersey Administrative Code.

REPORTING REQUIREMENTS

We provided a draft copy of this report to HNJH officials for their review and comment. Their comments were considered in preparing the final report and are attached as Appendix A. We address HNJH's response to two areas of our report in Notes set forth in Appendix B.

The Medicaid Fraud Division of the Office of the State Comptroller is required by statute to monitor the implementation of our recommendations. N.J.S.A. 30:4D-60(a); N.J.S.A. 52:15C-23. To meet this requirement, HNJH and DMAHS shall report periodically to this Office on what steps have been taken to implement the recommendations contained herein, and if not implemented, the reasons therefore.



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September 2, 2011

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Re: Horizon NJ Health Response to the Medicaid Fraud Division's
Compliance Audit Report of Horizon NJ Health - Special Investigations Unit

Dear Mr. Anderson:

Thank you for this opportunity to present our response to the Medicaid Fraud Division ("MFD") of the Office of the State Comptroller ("OSC") Compliance Audit Report ("Report") of Horizon NJ Health ("HNJH")— Special Investigations Unit ("SIU"). In this letter we set forth our specific concerns and rebuttals to the Report. It is our hope that the responses will clarify and/or correct some of the facts and Findings of the audit, which will result in strengthening and improving the processes and procedures of the HNJH fraud, waste and abuse program and our SIU. Where improvements can and should be made, Horizon Blue Cross Blue Shield of New Jersey ("Horizon") and HNJH are committed to making them. HNJH believes that the Report contains inaccuracies as we set forth in our response below.

By way of background, HNJH has participated in the New Jersey Medicaid Managed Care Program since its inception in 1993. Its fraud, waste and abuse program is supported by the SIU of Horizon. Since the inception of the Medicaid Managed Care Program, HNJH has been audited by the Department of Human Services, Division of Medical Assistance and Health Services ("DMAHS"), which included a review of the plan's compliance with the provisions of the contract ("State Contract") between DMAHS and the Medicaid managed care plans (including HNJH). One of the elements of the audit is compliance with the fraud, waste and abuse provisions set forth in the State Contract. HNJH has consistently achieved a score of 100% for the fraud and abuse element of the audits.

Our response sets forth comments on specific items in the Report and includes suggestions on the Report's Recommendations. As noted above, we have found that certain Findings and/or assertions within the Report appear to be factually incorrect, missing supporting facts and/or that the information supplied was misunderstood. Our comments are listed in the same order as they appear in the Report and provide reference to the page numbers where the issues can be found.

EXECUTIVE SUMMARY

HNJH strongly disagrees with the finding that “underreporting of recoveries results in the state paying approximately \$162,000 more in premiums to the Medicaid HMOs than it should have.” As more fully set forth below in Section 1, OSC has misunderstood the relationship between a Medicaid Managed Care Plans’ Quarterly Report (“Quarterly Report”) and Table 10 (“T10”) reporting of recoveries to the establishment of premiums.

The recoveries reported on T10 do not equate to a one to one dollar impact on premiums. DMAHS has advised the Medicaid Plans and MFD that the recoveries reported on T10 are reviewed for recovery trends. Premiums are set for a State Contract fiscal year prior to that fiscal year. In setting premiums, DMAHS utilizes a compilation of all financial reports, audited financial statements, and information found on the HMO reported encounter data in the rate setting process, not only T10 as this Report implies. Premiums are set for a State Contract fiscal year prior to that fiscal year. At the July 25, 2011 and August 17, 2011 meetings with MFD, DMAHS, DOBI, and the Medicaid Managed Care Plans, DMAHS advised that it will be revising the Medicaid Contract Financial Reporting Manual and the methodology for T10, in order to capture fraud and abuse recovery trends for the purposes of rate setting.

REVIEW OF QUARTERLY REPORTS

1. Reporting of Dollars Recovered (Pages 4-5)

HNJH disagrees with the assumption implied by the Findings in the Report that the recovery dollars listed in T10 should equal the amount reported in the Quarterly Reports.

The State Contract neither requires that T10 reconcile to the Quarterly Report, nor make any correlation between the two reports. DMAHS has stated, in response to this issue, that T10 was never intended to reconcile with the Quarterly Reports. In fact, during the July 25, 2011 and August 17, 2011 meetings with all the Medicaid Managed Care Plans, representatives of DMAHS, DOBI, the Director of MFD and the Chief Investigator of MFD (“Work Group”), DMAHS clearly stated that T10 and the Quarterly Reports cannot be reconciled because they reflect different time periods.

The information contained in T10 and the Quarterly Report reflect different time periods, making it difficult, if not impossible, to reconcile the two reports. T10 is a financial report of the previous 12 months of financial activity, while the Quarterly Report, required by Section A.7.2B of the State Contract, is strictly a report of the status of all open fraud, waste and abuse cases for the specific quarter. Fraud, waste and abuse cases are rarely, if ever, approved by OSC, investigated, resolved, and funds recovered in the same quarter. Therefore, it is not possible to reconcile a report that reflects a rolling 12 month period to a report that is quarterly. Due to the different time frames required for each report (T10 and the Quarterly Report), HNJH would not expect OSC to be able to reconcile recovery amounts.

Comptroller
Note 1

HNJH further disagrees with the statement in the Report that “Specifically, the larger the recovery dollars listed on T10, the smaller the premiums the state pays.” During the August 17, 2011 Work Group, DMAHS clearly stated that T10 is reviewed for recovery trends and that DMAHS utilizes a compilation of all financial reports, audited financial statements, and information found on the HMO reported encounter data in the rate setting process.

Comptroller
Note 2

Based on the above, HNJH disagrees with the Finding in the Report that “the state overpaid approximately \$161,666 in premiums to the Medicaid HMOs due to HNJH’s underreporting of recoveries in T10.” As HNJH has stated, there is not a dollar for dollar reduction in premium amounts based on the amount of recoveries reported on T10. Rather, T10 is reviewed for recovery trend in the rate setting process. Therefore, there could not have been an overpayment of premiums by \$161,666. HNJH respectfully requests that OSC remove the Recommendation that “the state seek to recover the premiums it overpaid.”

2. Approval to Investigate (Pages 5- 6)

Prior to the advent of the Office of Medicaid Inspector General (“OMIG”), now MFD, which first became operational in March of 2009, the Medicaid managed care plans worked with the Bureau of Program Integrity (“BPI”) unit at DMAHS and the Medicaid Fraud Control Unit (“MFCU”) at the Office of Insurance Fraud Prosecutor (“OIFP”) regarding potential fraud, waste and abuse cases. Cases were discussed, and information was requested and exchanged at quarterly meetings with MFCU, the plans and the BPI. Requests to investigate were generally handled through email between the plans and BPI or at the quarterly MFCU meetings. It was not until the MFD began meeting with the Medicaid Managed Care Plans on a regular basis in July of 2009, that a formal process for obtaining permission to investigate and recover was developed. Admittedly, prior to July of 2009, the BPI process was more informal, and, at times, email notifications to and from the BPI may have been delayed or an SIU Investigator received verbal approval from the BPI, which when given, may not have always been documented in writing. Horizon and HNJH are committed to working with MFD to develop a formal process and adhering to that process.

Comptroller
Note 3

HNJH disagrees with the Finding that “the SIU actively worked on only nine provider investigations in total...over the audit period. The remaining cases listed merely reflected inquiries from various third parties...or otherwise required only de minimus investigative work on the part of the SIU.” OSC is assuming, incorrectly, that because certain cases may require less work than other cases, they should not be reported.

HNJH disagrees with the Recommendation in the Report that the Fraud Quarterly Reports “should reflect only actual investigations.” Further, HNJH disagrees with the statement that “listing cases that do not involve substantive investigative work on the part of the SIU provides a misleading picture of the work the SIU is performing.” HNJH finds these statements troubling and certainly not in compliance with the requirements of the State Contract. What defines an actual or substantive investigation? The implication by OSC is that de minimus investigative work should not be reported, as somehow, these types of reviews do not rise to the level of an actual or substantive investigation.

Pursuant to Section A.7.2 of the State Contract, a contractor is required to submit to the MFD and DMAHS, on a quarterly basis, **all** identified instances (proven or suspected) of provider, subcontractor and enrollee fraud, waste and abuse (with supporting documentation) in accordance with Section 7.38 of the State Contract regarding the Quarterly Reports. This provision does not draw a distinction between substantive and non-substantive or de minimus investigations. The requirement in the FY 2011 State Contract is more expansive than the language of the Findings and Recommendations in the Report, and, if HNJH limited itself to supplying only the information requested in the Report, we would not satisfy the requirements of the State Contract.

3. Approval to Recover Funds (Page 7)

The Findings indicate the SIU did not have documentation of OSC's approval for recoveries in four of the five provider cases. HNJH agrees that it did not obtain permission to recover funds in two of the cases and will take corrective action to ensure that permission to recover funds is made where applicable, and as required by the State Contract.

As noted above, prior to July of 2009, with respect to both investigations and recoveries, the process with BPI was more informal, and, at times, email notifications to and from the BPI may have been delayed or the SIU received verbal approval to recover from the BPI, which when given, may not have always been documented in writing. Horizon and HNJH are committed to working with MFD to develop a formal process and adhering to that process.

VENDORS/SUBCONTRACTORS (Pages 7-9)

HNJH disagrees with the assertion in the Findings regarding the oversight and monitoring of the HNJH Delegate and Vendor Oversight Committee, based on the "lack of referrals" to the SIU. Fraud, waste and abuse is just one aspect of our oversight on our vendors. HNJH prides itself on its diligent oversight of its vendors. In addition, the HNJH vendors and their subcontractors have, and are required to have, fraud, waste and abuse programs.

HNJH disagrees with the Recommendation that it "should provide OSC an action plan outlining steps to be taken to enhance the detection of fraud and abuse in their vendor and subcontractor relationships." As noted, the vendors and their subcontractors reviewed by MFD during the audit period have fraud, waste and abuse policies and/or programs, including HNJH's policy on the False Claims Act as required by federal and state law. We believe that the vendors' policies and programs, together with our own oversight of the vendors are sufficient to detect potential fraud, waste and abuse. However, in HNJH's commitment to improving the HNJH fraud, waste and abuse program, we will work closely with our vendors to strengthen these programs.

HNJH disagrees with the Recommendation that it "should provide OSC with an accurate reconciliation of its referral documentation." The Quarterly Report format specified at

Section 7.38.3 of the State Contract does not include a field to report referral sources. However, going forward, HNJH will work with MFD and the other Medicaid managed care plans in the Work Group to develop a revised Quarterly Report that can include referral sources.

ON-SITE PHARMACY AUDITS (Pages 9-10)

HNJH has a very proactive Pharmacy Department, including with respect to its audit program and in monitoring fraud, waste and abuse, from both the provider and enrollee side. As the only Medicaid managed care plan with an in-house pharmacy program, it has been the only plan that is able to work effectively with both MFCU and MFD in promptly providing data and generating leads for potential fraud, waste and abuse. The HNJH Pharmacy Department works closely with ACS, its contracted pharmacy auditor, to review audit results and determine which pharmacies, enrollees or providers should be referred to the SIU.

With respect to the Recommendation that HNJH should refer to the SIU, for further investigation, the 19 audits, in which the audit vendor documented deficiency patterns, HNJH agrees that its pharmacy team analysts, together with the SIU, will review the audits to determine appropriate referrals. Going forward, HNJH will be more proactive in reporting pharmacies, providers and enrollees to the SIU for investigation.

DISTINCT UNIT REQUIREMENT (Pages 10-13)

HNJH does not agree with the Recommendation that the State Contract should be amended to include monetary sanctions against HNJH for failure to comply with SIU staffing requirements. As a point of clarification, the State Contract is a generic document for all Medicaid Managed Care Plans in New Jersey and not specific to an individual plan. Any amendments or changes would not be specific to one plan. HNJH believes it is unnecessary to include language for additional sanctions. However, in the alternative, HNJH suggests that the OSC can make recommendations to DMAHS to include specific contract language for monetary sanctions against a contractor for failure to comply with SIU staffing requirements.

HNJH disagrees with the Recommendation that it “should not be permitted to report their investigator to beneficiary ratios on an FTE basis, until it provides its methodology for calculating such FTE’s.” Going forward under the new State Contract language being developed by the Work Group, HNJH agrees that it will submit its FTE methodology to MFD for review and approval. Additionally, Horizon and HNJH are currently strengthening the Medicaid SIU team with the addition of new staff, and will only rely on the FTE methodology to supplement the expanded program.

STAFF TRAINING REQUIREMENTS (Pages 13-14)

HNJH and the Horizon SIU disagree with the statement in the Findings that "the public lacks assurance that SIU investigators are properly trained to address fraud and abuse within HNJH's provider network." With some exceptions (including medical leave, disability or termination), the majority of the SIU investigators met or exceeded the requirement for the minimum number of training hours. Additionally, the Horizon SIU has received awards and recognition for the work it has accomplished in the fraud and abuse arena. The public can be assured that the SIU investigators are well-trained professionals.

Going forward, HNJH agrees to strengthen its monitoring process to ensure that all SIU investigators obtain fraud, waste and abuse training as required by law.

HNJH and the Horizon SIU appreciate the opportunity to participate with MFD, DMAHS, DOBI and the other Medicaid Managed Care Plans in the Work Group, established under the FY 2012 State Contract to develop and finalize contract issues regarding Medicaid fraud, waste and abuse programs in managed care. We believe this is an excellent opportunity to develop a workable, comprehensive program that coordinates MFD with the Medicaid Managed Care Plans, and we look forward to working with you.

Thank you again for the opportunity to respond to the Report and your attention to our reply. For the foregoing reasons, HNJH and the Horizon SIU respectfully request that the OSC consider this response in revising and amending the Report. Should you have any questions, please do not hesitate to contact me.

Very truly yours,



Karen L. Clark

Vice President, Horizon Blue Cross Blue Shield of NJ, President of Horizon NJ Health

cc: Linda W. Eynon, Esquire, Legal Counsel, Horizon NJ Health
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Joseph Manger, Director Regulatory Affairs, Horizon NJ Health
Robert Graves, Medicaid Fraud Division
Michael McCoy, Medicaid Fraud Division

APPENDIX B

COMPTROLLER NOTES ON AUDITEE RESPONSE

- 1) The information contained in the current quarter section of T10 and the Quarterly Reports do not reflect different time periods. Further, we confirmed with DMAHS that the current quarter section on T10 should equal the amount that HNJH sets forth on its Quarterly Reports. As an additional test, OSC conducted a cursory review of the reports filed by another Medicaid HMO to determine whether the current quarter T10 information reconciled to the information provided on that HMO's Quarterly Reports. Those amounts did reconcile with each other.
- 2) We confirmed with DMAHS that if a Medicaid HMO underreported its financial recoveries on T10 during our audit period, there was a dollar for dollar premium impact causing DMAHS to aggregately overpay all of the Medicaid HMOs that amount.
- 3) Our review of case files and discussions with HNJH SIU personnel confirmed that there were only nine active provider investigations over the audit period, and that the other listed cases merely required HNJH SIU personnel to relay information to other external agencies.
- 4) OSC is not suggesting that HNJH violate the Contract, but rather is recommending that the Contract be amended to ensure that the information reported is meaningful to the public.