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THE NEW WORLD OF MEDICAID AUDITS AND APPEALS IN THE AGE OF MANAGED CARE

HFMA NJ and Metro Philadelphia Chapters
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The Growth of Managed Medicaid in New Jersey

1995: Launch of New Jersey Managed Medicaid in the KidCare Program

Slowly expanded to include adults in the NJ Family Care Program

2011: Nearly 80% of Medicaid beneficiaries in NJ were enrolled in managed care

2014: Affordable Care Act further expanded program participation

October 2023: 97% of Medicaid enrollees were in Managed Medicaid

2026: Approximately 1.7 million New Jersey residents enrolled in Managed Care

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Traditional Medicaid v. Managed Care

Traditional Medicaid

- Generally, no preauthorization required for inpatient admissions
- Subject to utilization review audits by state contractors
- Governed by statutes and regulations

Managed Care

- Ordinarily require preauthorization for inpatient admissions
- Can the state audit and recover alleged overpayments on preauthorized claim?
- While statute and regulations are relevant, contractual provisions control

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Important Terms of MCO Contract

Provisions Relevant to Claims Against MCO

- Governing Law / Venue
  - What law will be applied
  - State/Federal Court
  - Arbitration
- Dispute Resolution
  - Are there conditions precedent to filing claims
- Time limits on Disputing Claims
- Incorporation of Law
  - Are additional requirements incorporated by reference

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Important Terms of MCO Contract

Other Important Provisions

- Obligations Following Termination
- Amendments
  - Prospective or retrospective
- Payment Rates
  - Does the contract set specific rates or incorporate Medicare/Medicaid rates
- Utilization Review
  - Is preauthorization required
  - Are retrospective audits / recoupment permitted

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New Jersey's Efforts to Audit and Recover on MCO Claims

- **2010:** DMAHS contracted with Permedion to conduct audits of inpatient hospital services
  - Included utilization review (UR), quality of care, DRG validation and billing audits
  - Limited to claims involving FFS NJ FamilyCare members
- **February 2020:** DMAHS expanded scope of Permedion's hospital UR audits to include MCO encounters
  - No formal rulemaking

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Threshold Issue:
Does New Jersey have authority to audit and recoup on claims that were preauthorized by an MCO?

- Remains an open question

- Relevant factors include:
  - Federal statutes and regulations
  - State statutes and regulations
  - DMAHS contracts with MCOs
  - MCO contracts with providers

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Federal Law: Medicaid RAC Audits

***42 C.F.R. § 455.500*, et seq. establishes the Medicaid Recovery Audit Contractor (RAC) Program**

- Requires states to contract with an eligible RAC to review provider claims and identify and recoup overpayments
- "States may exclude Medicaid managed care claims from review by Medicaid RACs." *42 C.F.R. § 455.506(a)(1)*
- New Jersey twice amended its Medicaid State Plan to suspend the RAC program
  - Stated reason: 97% of beneficiaries participate in managed care

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Federal Law: *42 C.F.R. Part 456*

- Obligates states to implement a utilization review plan for inpatient services
  - No specific methodology

- New Jersey fulfills obligation through *N.J.A.C. 10:52-1.15*
  - Sets forth requirements which must be met to entitle hospitals to reimbursement for services provided to Medicaid beneficiaries including provisions related to utilization review
    - Specifically (and repeatedly) references “Medicaid/NJ FamilyCare fee-for-services beneficiaries”
    - No reference to managed care

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Federal Law: *42 C.F.R. Part 438*

- Provides federal standards for states' managed care programs
- ***42 C.F.R. § 438.66***: Requires state to monitor utilization management in its managed care program
  - No reference to who is responsible for post-payment review and recoupment

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Relevant New Jersey State Law

- ***N.J.A.C. 10:74-3.1***
  - "Service utilization shall be controlled by the MCO through pre-certification programs and prior authorization for medical necessity."
- ***N.J.A.C. 10:74-13.1***
  - Requires MCOs to collect and analyze data for quality assurance, quality improvement, and utilization review and report to DMAHS
- ***N.J.A.C. 11:24-8.3(d)***
  - "An HMO shall not reverse a utilization management decision where the provider relied upon the written or oral authorization of the HMO or its agents prior to providing the service to the member, except in cases where there was material misrepresentation or fraud."

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DMAHS Contracts With MCOs

- Providers are not parties to the contract!
  - Controls relationship between state and MCO

- Relevant UR provisions
  - **Section 3.9.1F**: Inpatient Hospital Adjudicated Claim and Encounter Records
    - Provides that records are subject to review by state UR vendor
    - If there is an adverse determination by the UR vendor, the MCO provider contract "shall require the hospital to adjust the claim"

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DMAHS Contracts With MCOs: UR Provisions

- **Section 4.6.4A:** Utilization review assigned to MCO
  - Requires MCOs to develop written utilization review plan
  - If a claim is preauthorized “the specific standards, criteria or procedures used in the determination shall not be modified pursuant to retrospective review”

- **Section 4.7.1A:** DMAHS monitoring authority
  - DMAHS may monitor and evaluate on an ongoing basis via inspection, utilization review, and quality management reports.

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DMAHS Contracts With MCOs: UR Provisions

- **Section 7.24E:** Reporting requirements
  - MCO must collect and analyze data to implement quality assurance, utilization review, and peer review programs with provider participation

- **Section 2(N)(2):** Provider contract/subcontractor provisions
  - Requires MCOs to include NJUR audit obligations in provider contracts
  - Inpatient encounter records “shall be subject to review by NJUR Vendor”
  - If adverse determination issues, the hospital “shall adjust the claim . . . or appeal . . . utilizing NJUR appeal process”

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MCO Contracts with Providers

- Providers are not parties to contract between DMAHS and MCO
- Contract with MCO governs provider obligations
- Contract terms vary by provider and MCO
  - May not include UR provisions required by state
- Providers must review contracts closely to determine what UR audit and recoupment obligations are included

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MCO Contracts with Providers

What to look for in your contracts:

- Does the contract include express provisions permitting review and recoupment by state UR vendor?
- Does the contract require preauthorization or concurrent authorization?
- Does the contract guarantee payment for preauthorized claims?
- What time restrictions are imposed on the parties' ability to dispute claims?

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What Is The UR Vendor Looking At?

- Medical necessity
- Level of care
- Coding issues/DRG verification
- Quality of care

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Medical Necessity and Level of Care

- Most common basis for claim denials or adjustments to claims
- Concepts are interrelated
- Auditors rely on Milliman Criteria Guidelines in making decisions
- Can services be provided on outpatient or observation basis?
- Were alternative treatments attempted?
  - Oral v. I.V. medications
- If secondary diagnosis or abnormal test results led to an extended hospital stay, was the course of treatment adjusted to address those issues?

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Case Study: Laparoscopic Cholecystectomy

- Common focus of audits and retroactively denied claims
- Goal length of stay – ambulatory
  - Based on optimal recovery
- Extended stay permitted under certain conditions
  - Failure to meet recovery milestones and discharge criteria
  - Conversion to open procedure
  - Severe systemic infection delays surgery
  - Severe post-operative infection
  - Care for comorbidities
  - Complications of procedure

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Case Study: Laparoscopic Cholecystectomy

- Hospital claimed extended inpatient stay was required because:
  - Patient required Jackson-Pratt drain
  - Significant post-operative rise in WBC requiring IV antibiotics
  - Significant pain requiring IV pain medications.
- Rejected by Permedion and ALJ because:
  - Jackson-Pratt drain can be addressed on outpatient basis
  - No evidence of hospital attempting oral medications instead of IV
- Takeaways
  - Must attempt alternative treatments
  - Must clearly document attempts in medical record

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Alternative Recovery Efforts by State: Medicaid Fraud Division

- Charged with protecting the integrity of New Jersey's Medicaid program by detecting and recovering funds that are improperly used
- Recovered over $1B between 2014 and 2024 from overpayments and fraud or abuse
- Broad powers
  - Temporarily suspend payments during investigation based on "credible allegation of fraud" without disclosing the basis for the "credible allegation"
  - Can refer to Medicaid Fraud Control Unit in Office of Attorney General for criminal prosecution
- Investigations usually begin following third-party complaints

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Medicaid Fraud Division: Recent Investigations

- Nursing homes
  - Uncovered scheme by two south New Jersey nursing homes by which they diverted tens of millions to owners and other businesses while failing to provide adequate staffing for the residents at their facilities
- Clinical laboratories
  - Laboratory routinely overcharged Medicaid for lab tests and submitted claims for unnecessary tests
  - Resulted in laboratory's agreement to pay more the $2.9M to New Jersey and $10.3M to the federal government
  - Both laboratory and its owner were suspended from the Medicaid program

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Medicaid Fraud Unit: Recent Focus on ABA Services

- Medicaid spending on Applied Behavioral Analysis (ABA) services has significantly increased
- Federal investigations have been ongoing in numerous states
  - Investigators identified $77.8M in overpayments in Colorado and recommended the state return $42.6M to the federal government
  - Result is increased scrutiny on state level
- Focus of investigations: proper documentation of:
  - Treatment plans
  - Location of services
  - Parental consent forms
  - Qualifications of providers
- Best defense is clear and concise record keeping consistent with treatment plans

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Key Takeaways

- New Jersey is aggressively auditing and seeking to recover payments for inpatient admissions including those preauthorized by MCOs
- Providers must closely review their MCO contracts to determine whether they can challenge the State's authority to conduct such audits
- Beyond UR audits, recoupment of overpayments may still be conducted by the Medicaid Fraud Division
- Best defense is a good offense – keep clear and concise documentation of services provided and reasons for same

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Questions?





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