STATE OF NEW JERSEY

OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION

COMPLIANCE AUDIT

UNITEDHEALTHCARE COMMUNITY PLAN OF NEW JERSEY'S SPECIAL INVESTIGATIONS UNIT

A. Matthew Boxer
COMPTROLLER

July 31, 2013

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EXECUTIVE SUMMARY

As part of its oversight of the Medicaid program, the Medicaid Fraud Division of the Office of the State Comptroller (OSC) conducted an audit of UnitedHealthcare Community Plan of New Jersey (United), the second largest of four Medicaid health maintenance organizations (HMOs) operating in the State of New Jersey. United receives on average $848 million from the State annually. The audit pertained specifically to United's compliance with the program integrity provisions of United's contract with the State. In our audit, OSC identified multiple areas of non-compliance.

For example, OSC determined that United's Special Investigations Unit, which is charged with investigating fraud and abuse within United's HMO network, did not meet the contractually required minimum number of employees who should be dedicated to investigating fraud and abuse. Furthermore, OSC's review of training documents for United's personnel revealed that they did not receive the required minimum training for fraud, waste and abuse detection.

Additionally, OSC determined that no referrals were made by United's vendors or their subcontractors to the Special Investigations Unit during the entire audit period. OSC's review of United's quarterly reports further revealed inconsistencies, inaccuracies and incompleteness concerning the contractually required reporting of case activity data to the State.

Although United received approximately $1.7 billion in premium payments from the State during the period audited, United recovered only $1.6 million in improper payments from enrollees and providers, less than one tenth of one percent of premium payments it received. The lack of resources dedicated to investigating fraud, waste and abuse; the lack of referrals from vendors and their subcontractors; and insufficient training for analysts all appear to have contributed to the low percentage of recoveries.

United had an opportunity to respond to OSC's audit report and its response is attached as Appendix A. In all relevant respects, United has implemented or is in the process of implementing OSC's recommendations.

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 (DHS) 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 second largest of these HMOs is United, a subsidiary of United Health Group. United serves more than 350,000 Medicaid enrollees in New Jersey.

The State pays United on average $848 million annually to provide healthcare services to qualifying New Jersey residents through its HMO network providers. United'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 United's Medicaid and FamilyCare enrollees and healthcare providers within its network.

This unit, known as the Special Investigations Unit (SIU), recovers improper payments from healthcare providers and enrollees based on its investigations. United is required to report those recoveries to the State so that the State can factor those recovery amounts, along with other actuarially driven factors, into its premium payments to United.

OBJECTIVE AND SCOPE

The objective of OSC's audit was to evaluate the SIU's compliance with the fraud, waste and abuse requirements of United's contract with DMAHS (the Contract) 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, OSC reviewed compliance with Contract requirements pertaining to the SIU's investigative staff, such as employee experience, training, and the number of employees dedicated to investigating fraud and abuse within United's 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.

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." United created the SIU to satisfy this requirement.

The SIU is contractually required to have an investigator-to-beneficiary ratio of at least one investigator per 60,000 enrollees. This provision is designed to ensure that the SIU allocates appropriate resources to address fraud and abuse.

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.

United is contractually required to submit documentation to OSC on a quarterly basis that demonstrates that at least one FTE investigator per

60,000 enrollees is devoted to fraud and abuse cases. During our audit period, United's FTEs were comprised of SIU investigators, Quality Assurance Auditors (QAAs) and analysts from OptumInsight (OI). OI is a subsidiary of UnitedHealth Group.

OSC reviewed policies and job descriptions for each FTE classification referenced above. OSC also reviewed United's methodology and supporting documentation to determine the accuracy and reliability of its FTE computations. Our findings are as follows:

1. QAA FTEs

United submitted documentation that indicated that QAAs are part of United's FTE calculation under the "claims analysts" category. Including QAAs as part of its FTE calculation permitted United to report that it had met its FTE requirement. However, pursuant to section 7.38.2(B)2 of the Contract, to be included as part of United's FTE calculations, claims analysts must be involved in certain specified fraud and abuse activities. Specifically, they must meet the following criteria as stated in the Contract:

a) They must be specifically looking at claims for detection of fraud and/or abuse.

b) The criteria (i.e., processing) they are using to review claims must be geared toward detection of fraud and/or abuse.

c) They must demonstrate that they have had, and continue to have, training in fraud and abuse detection.

d) They must demonstrate the process by which they detect fraud and/or abuse.

e) They must demonstrate the process by which they refer detected cases of potential fraud and/or abuse.

f) They must be able to differentiate between fraud, abuse, misutilization and/or overutilization.

According to United's Fraud and Abuse Detection Manual, the QAAs' work is not primarily designed to ferret out fraud and/or abuse. QAAs

identify claims for procedural and financial accuracy; their work is intended to strengthen internal processes and increase the likelihood of compliance. Although the reviews may incidentally detect fraud and/or abuse, the QAAs do not specifically look at claims for the detection of fraud or abuse, and therefore do not meet the FTE requirements of the Contract.

Additionally, United was unable to provide OSC with any connection between the QAAs' reviews and the process by which cases of potential fraud and/or abuse are referred to the SIU. OSC further noted that no referrals were made to the SIU from the QAAs during the audit period.

Based on the deficiencies noted above, OSC disqualified QAAs as FTEs because they failed to meet the requirements of the Contract. Consequently, we have made an adjustment to the aggregate calculation of United's investigator-to-beneficiary ratio for the audit period.

2. OI FTEs

OI employs claims analysts who perform data analytics, fraud, waste, and abuse detection, and investigations. United utilizes OI's claims analysts to supplement its SIU FTEs.

United reported one FTE for OI on each of the quarterly reports submitted to the State during our review period, with the exception of the first quarter of 2010 when no OI FTEs were reported.

During the audit, United provided OSC with a revised FTE calculation from OI. OI reported a revised total of 2.08 FTEs for the entire audit period, which is equivalent to .26 FTEs per quarter.

In reviewing data to determine whether OI's claims analysts met contractual requirements to be considered FTEs, OSC found that United could not provide documentation to support some of OI's claims analysts FTEs. Consequently, OSC excluded the FTEs for these claims analysts and adjusted the quarterly FTE ratio accordingly. As a result, OI's FTE ratio changed from 2.08 to 1.07 for the audit period, which is equivalent to .13 FTE per quarter.

Both the revised calculation OI furnished during the audit and OSC's recomputation of FTEs revealed that the FTEs United initially had reported on quarterly reports for OI had been overstated.

3. SIU Investigators' FTEs

OSC tested the methodology United used to calculate FTEs for its SIU investigators to determine if it is a reliable measure of calculating FTEs. OSC has maintained the confidentiality of United's FTE calculation methodology as required by the Contract.

OSC determined that the methodology used to calculate FTEs did not accurately reflect when investigators were absent for extended periods of time. Further, the methodology did not account for instances in which fellow investigators absorbed the caseloads of absent investigators. Consequently, the methodology did not accurately reflect time spent on New Jersey cases. However, OSC's recomputation of FTEs for the audit period did not have any material impact on United's FTE submission for its SIU investigators.

4. Overall FTE Findings

In total, based on OSC's calculations, United's staffing levels were below the minimum required for all eight quarters in our audit period. Consequently, the investigator-to-beneficiary contractual requirement was not satisfied.

Table 1 below sets forth the OSC-adjusted quarterly investigator-to-beneficiary FTE figures. Additionally, Table 1 shows the required FTEs based upon enrollment statistics provided by United.

Table 1

	1Q2009	**2Q2009**	**3Q2009**	**4Q2009**	**1Q2010**	**2Q2010**	**3Q2010**	**4Q2010**
OI	0.13	0.13	0.13	0.13	0.13	0.13	0.13	0.13
SIU Investigators	1.66	2.08	1.98	2.14	2.14	2.48	2.41	2.89
QAAs	0	0	0	0	0	0	0	0
Total FTEs	**1.79**	**2.21**	**2.11**	**2.27**	**2.27**	**2.61**	**2.54**	**3.02**
Required FTEs	**4.28**	**4.48**	**4.61**	**4.75**	**4.97**	**5.83**	**5.85**	**5.92**
Difference	**-2.49**	**-2.27**	**-2.5**	**-2.48**	**-2.70**	**-3.22**	**-3.31**	**-2.90**

Recommendation No. 1

United should establish procedures to ensure that QAAs and OI claims analysts meet current and future contract requirements in order to be included in the investigator-to-beneficiary ratio.

Recommendation No. 2

United should revise the SIU FTE methodology it uses to ensure a more reliable measure of hours worked by investigators on New Jersey cases.

REVIEW OF QUARTERLY REPORTS

Pursuant to Section 7.38 of the Contract and Section A.7.2B of its appendices, United is required to submit quarterly reports to OSC and DMAHS. These reports provide a variety of information on both enrollee and provider cases that United has investigated. OSC reviewed all eight quarterly reports pertaining to our audit period.

1. Quarterly Report Summary

United is contractually required to summarize by month the number of provider and enrollee cases on the Quarterly Reports as well as case details for each of the individual cases. The Report Summary is divided into in two parts, Part A – Monthly Data Summary and Part B – Case Details. OSC noted that the total number of added enrollee cases was reported as zero in Part A for the quarter ending on June 30, 2009. However, when compared with the information in Part B, there were actually four enrollee cases that were added in the second quarter of 2009. This error was corrected on the subsequent September 30, 2009 quarterly report.

Additionally, OSC noted that for the quarter ending March 31, 2009, enrollee data for a closed case was reported as being closed in February 2009 on Part A, when in fact it was closed in March 2009.

2. Enrollee (Member) Cases

Section 7.38.1 of the Contract provides instruction to United for reporting enrollee cases to the State. It states that "proven cases" are to be referred to the State for advice and/or assistance. The Contract does not specify

what "proven cases" means. However, it is United's practice to refer to OSC enrollee cases for which an allegation has been substantiated. OSC reviewed all 20 of the enrollee cases reported on the quarterly reports for the years 2009 and 2010 to determine whether only proven cases were reported to the State in accordance with the Contract. Also, OSC reviewed the SIU's case tracking database to ensure that enrollee cases not reported to the State were not proven cases.

OSC noted that United did not always adhere to its practice of reporting enrollee cases with substantiated allegations because 10 of the 20 enrollee cases (50 percent) reported to the State did not have substantiated allegations, which created unnecessary follow-up work for the State.

3. Provider Cases

Pursuant to Section 7.38.2 of the Contract and Section A.7.2.B of the appendices to the Contract, United's SIU is required to provide written notification to OSC within five business days of its intent to investigate a provider and must receive approval from OSC prior to conducting an investigation. The purpose of this contractual provision is to provide oversight of United's investigations and ensure resources are being dedicated to fraud and abuse recoveries appropriately.

OSC reviewed 59 of the 71 provider case investigations on the Quarterly Reports to determine whether there was supporting documentation indicating that the SIU had provided written notification of its intent to investigate and that OSC had granted approval for the SIU to investigate.

OSC found that 45 of the 59 cases (76 percent) lacked adequate documentation of written notification of the SIU's intent to investigate, and 46 cases (78 percent) lacked adequate documentation demonstrating that OSC had granted approval to investigate. Thirty-four of the cases that lacked adequate documentation for request and approval from OSC concerned a special investigative project conducted by United.

As an additional test, OSC compared the Quarterly Reports submitted to the State for the audit period to the SIU's internal case tracking database for the same period to determine whether the information in the case tracking database was consistent with what was reported to the State on the Quarterly Reports.

OSC noted that 61 of the 71 cases reviewed contained at least one reporting error. Of the 61 cases with errors, 27 contained multiple errors. The errors included the following:

- the dates of notification for permission to investigate on the submitted Quarterly Reports did not reconcile to the dates in the SIU's case tracking system;
- the "Findings/Actions" reported on the Quarterly Reports did not reconcile to the "Findings/Actions" in the SIU's case tracking system; and
- the dates of approval to investigate in the SIU's case tracking system did not reconcile with the dates submitted on the Quarterly Reports.

These multiple reporting errors raise concerns about the accuracy of the data being submitted to the State.

Recommendation No. 3

United should review the quarterly reports prior to submission to the State to ensure accuracy of the reported items as well as compliance with Contract requirements.

Recommendation No. 4

United should ensure that it refers only proven cases to the State in accordance with the Contract.

Recommendation No. 5

United should enhance its controls over reporting for provider cases to ensure that the data from its SIU database used on the quarterly reports is accurate and complete.

VENDORS/SUBCONTRACTORS

OSC reviewed United's contracts with four of its vendors that provide healthcare services to New Jersey Medicaid enrollees. Those contracts allow the vendors to enter into subcontracting agreements with other healthcare providers. In total, United's vendors have contracted with more

than 3,300 subcontractors. The subcontractors and vendors are required to comply with United's policies, the Contract and State and Federal laws. According to United policy, United's vendors and subcontractors are expected to refer fraud, waste and abuse to United by calling the SIU fraud hotline, through United's website or by mail.

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

Table 2

Vendor	Number of Subcontractors 2009	Number of Subcontractors 2010	Number of Referrals Made to the SIU During the Audit Period
A	772	917	**0**
B	1859	1973	**0**
C	438	500	**0**
D	311	326	**0**

The documentation provided by United revealed that there were no referrals from United's vendors and subcontractors to the SIU for fraud, waste or abuse during the audit period. United's policies and procedures thus appear to be ineffective in requiring vendors and subcontractors to detect and report fraud, waste and abuse.

Recommendation No. 6

United should take action to strengthen its policies and establish procedural guidelines to enhance its oversight over vendors and their subcontractors with regard to the detection and reporting of fraud, waste and abuse.

TABLE 10 REPORTS

United's finance department is contractually required to provide a number of reports to DMAHS' Office of Managed Health Care. Unlike the quarterly reports mentioned above, 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 the T10 for purposes of this audit sets forth United's fraud and abuse recoveries on a quarterly basis. The recoveries listed on T10 are a factor in determining the State's premium payments to United and 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 corresponding Quarterly Reports submitted by United to OSC. Table 3 below illustrates this comparison.

Table 3

Quarter	Amount Reported on Quarterly Reports	Amount Reported on T10	Difference
1Q2009	$805,625	$805,625	$0
2Q2009	$328,825	$328,825	$0
3Q2009	$158,839	$158,839	$0
4Q2009	$135,958	$158,838	($22,880)
1Q2010	$81,958	$81,958	$0
2Q2010	$30,250	$30,250	$0
3Q2010	$20,500	$20,500	$0
4Q2010	$10,870	$20,500	($9,630)
TOTAL	**$1,572,825**	**$1,605,335**	**($32,510)**

During two of the eight reporting periods, the total recoveries reported on the T10 did not agree with the total recoveries reported on the corresponding Quarterly Report.

Specifically, for the quarter ending December 31, 2010, the total recoveries reported on T10 were $20,500. However, the total recoveries reported on the Quarterly Report were $10,870. OSC determined through its audit work that the amount reported on the Quarterly Report was the correct recovery amount for the reporting period. The reporting error on T10 resulted in recoveries being overstated by $9,630 for the period.

For the quarter ending December 31, 2009, the total recoveries reported on T10 were $158,838. However, the total recoveries reported on the Quarterly Report were $135,958. OSC determined through its audit work that the recovery amount reported on the Quarterly Report was the correct amount for the reporting period. The reporting error on the T10 resulted in recoveries being overstated by $22,880 for the period. According to DMAHS, because of the small amount of this overstatement, it did not affect the premiums paid by the State.

OSC noted that the T10s prepared by United's SIU initially contained the correct recovery amounts. However, as part of its internal reporting structure, the SIU is required to submit these reports to United's finance department. The finance department is then responsible for submitting the T10s to the State. It appears that for the 4th quarter of 2009 and 2010, the finance department used the previous quarter's recovery amounts, resulting in the findings noted above.

OSC separately notes that the approximately $1.6 million in total fraud and abuse recoveries by United during this audit period when compared to the approximate $1.7 billion in total premium payments raises questions regarding the aggressiveness with which United is pursuing such recoveries.

Recommendation No. 7

United should establish procedures involving the SIU and United's finance department to ensure that information required for T10 reporting is accurate.

STAFF TRAINING REQUIREMENTS

SIU investigators and specialists, as well as other United claims adjusters and underwriters, are required to satisfy the minimum training requirements set forth in N.J.A.C. 11:16-6.5(a)(2)(iii). That regulation states in pertinent part, "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. The four hour continuous education training provided to non-SIU personnel shall emphasize the responsibility of all employees to identify

and report indications of internal and external fraud to the proper authority." SIU investigators, OI employees and United's QAAs are all required to satisfy this annual training requirement.

OSC's review of SIU training records determined that all 17 SIU investigators that we tested satisfied the minimum training requirements during the audit period. Similarly, for OI employees, only 3 of 44 OI employees failed to meet the four-hour continuing education requirement for non-SIU personnel in either 2009 or 2010.

However, OSC's review of QAA training records revealed that none of the 34 QAAs tested met the training requirements during the audit period. On average, QAAs completed approximately 33 minutes of the four-hour annual continuing education training requirement.

Recommendation No. 8

United should ensure that all employees subject to training requirements satisfy the annual requirements set forth in the New Jersey Administrative Code.

RECOVERIES

United is contractually required to report to OSC cases that result in financial recoveries. The 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).

During the two-year period under review, United reported a total of 41 completed investigations on its Quarterly Reports. OSC reviewed all 41 investigations and compared the underlying documentation to the Quarterly Reports to ensure that the results of the SIU's investigations were reported to the State in accordance with the Contract. Additionally, OSC reviewed the SIU's case tracking database in determining whether all completed investigations and relevant recoveries had been reported to the State.

Section 7.38(A)(4) of the Contract requires the reporting of investigation results to OSC within 20 business days of the completion of an investigation. OSC found that 21 of the 41 completed investigations

contained errors, including, for example, no documentation to support that the investigation results had been reported.

Section 7.38.2(A)(1) of the Contract states that written notification must be sent by United to OSC within five business days of United's intent to recover funds, and approval must be obtained by United from OSC prior to the collection of those funds. OSC noted that 17 of the 41 completed investigations resulted in recoveries. OSC reviewed documentation to determine whether all recoveries were supported by proper documentation (e.g., settlement agreements); whether stated recovery amounts were accurate and reported to the State on a timely basis; and whether approval had been obtained from the State prior to the recovery of the funds.

There was no documentation to support that written requests to recover funds were sent to the State for 4 of the 17 cases that resulted in recoveries. However, United did subsequently report to the State all of the recoveries themselves.

Recommendation No. 9

United should abide by the terms of the Contract with regard to timely and accurate reporting of investigations.

June 5, 2013

David Couture, Supervising Auditor
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RE: SIU Audit – Revised Final Draft Report Response

Dear Mr. Couture:

Thank you again for the opportunity to provide comments on the revised Special Investigations Unit ("SIU") Audit Draft Report and also for your continued partnership in the endeavor of preventing and recovering on fraud, waste and abuse perpetrated against the NJFamilyCare/Medicaid program in New Jersey.

As the content of the prior report has not changed significantly, please allow us to restate our prior comments with some minor corrections to page references, etc.

First, I would like to address the scope of the SIU audit and the executive summary included on page one. As you know, UnitedHealthcare Community Plan of New Jersey (UHCCPNJ) and its parent UnitedHealthcare Inc., maintains a comprehensive fraud, waste and abuse program that includes both prospective and retrospective activities aimed at not only recovering on fraud, but preventing it from occurring in the first place. While I understand the State's primary focus is retrospective recoveries, I would be remiss not to point out that United's prospective identification and prevention efforts are an integral and important part of the overall program.

Findings (pgs. 4 – 6): Non-Compliance with Distinct Unit and FTE requirements

UHCCPNJ understands the Medicaid Fraud Division's ("MFD") position on the Distinct Unit requirements in the NJFamilyCare/Medicaid Contract and the FTE Calculation Methodology employed by UHCCPNJ during the audit period. However, UHCCPNJ obtained the appropriate approval of its FWA program, including the FTE methodology, through the regulator that owned oversight of the FWA requirements in the NJFamilyCare/Medicaid program at the time. Upon notice from the MFD, however, UHCCPNJ initiated staffing changes to ensure compliance with the Distinct Unit requirements, as interpreted by MFD.

Finding (pg. 9 - 10): Vendors and Subcontractors did not identify or understand the process to identify potential fraud waste and abuse within UHCCPNJ's network as required by UHCCPNJ's policies and website

UHCCPNJ established its policies, procedures and provider/subcontractor communications to comply with CMS requirements. However, as a result of MFD's finding and recommendation, UHCCPNJ will integrate subcontractor FWA reminders into its delegate vendor oversight

functions as a standing agenda item at the Service Quality Improvement Subcommittee ("SQIS"); where vendors and delegates are present. It is our intent to further increase visibility around these responsibilities and the reporting mechanisms, which will in turn lead to an increase in referrals.

Finding (pg. 10 - 11): Discrepancies found between SIU reports and Table 10 Financial Report

UHCCPNJ agrees with MFD's finding and recommendation in this area. While the quarterly SIU report was accurate and there were no missing funds, UHCCPNJ recognizes human errors were made on the Table 10 reports that caused the discrepancies and corresponding confusion. Additional scrutiny on the quarterly SIU reports and the corresponding Table 10 reports will be employed to ensure both reports tie appropriately.

Findings (pgs. 4 – 7 & 12): Non-Compliance with training requirements for SIU personnel and other individuals involved in the FWA Program

This issue has been resolved by establishing the practice that all investigative activities will be conducted by trained SIU investigators. The current training protocols for SIU investigators satisfy applicable requirements. In the event that UHCCPNJ decides, in the future, to use FTEs in place of investigators, we will ensure all training requirements are complied with and that any calculation methodologies used to satisfy the "distinct unit" requirement are approved by the Medicaid Fraud Division.

Finding (pg. 13 - 14): Non-Compliance with Intent to Investigate Requirements

UHCCPNJ acknowledges the lack of adequate documentation of notification to and approval from the BPI DMAHS to investigate NJ cases. The contract has since changed and the current contract now requires that either the SIU Manager or their designee will submit all Notification of Investigation (NOI) requests to the NJ MFD Chief of Investigations or their designee. The UHCCPNJ SIU has a designee as does the NJ MFD. As a result of the contract change, the UHCCPNJ SIU designee maintains an Excel tracking list of all NOI activity between SIU and NJ MFD (request and approval) which ensures compliance with this contractual provision. In addition to the designee tracking the NOI activity, we developed edits specific to NJ business in our SIU Case Tracking Database. Investigative staff are required to document in the Case Tracking Database the dates of NOI notice to and approval from NJ MFD. The above measures are also cross checked at the time of quarterly reporting.

Finding (pg. 13 - 14): Reporting Inconsistencies in Quarterly SIU Reports

UHCCPNJ acknowledges the error in Part A with regard to the number of cases reported. The format of the Quarterly DMAHS report has since been changed and no longer requires this section be completed. Accordingly, no corrective action is necessary. However; UHCCPNJ SIU has automated the production of the quarterly report to avoid similar data entry errors which occurred when the report was produced manually.

Finding (pg. 13 – 14): Non-Compliance with internal UHCCPNJ policy and inaccuracies in Enrollee Case Reporting

UHCCPNJ acknowledges the error in submitting more cases to the BPI DMAHS than was required. We contend that this was due in part because of conflicting language in the contract with regards to reporting 'suspect' member cases. The current contract language with regards to the Notice of Investigation will avoid any inappropriate referrals to the state on member cases that do not require their intervention.

Finding (pg. 13 - 14): Reporting Inaccuracies in Provider Case Reporting

UHCCNP NJ acknowledges that there were errors in reporting provider cases on the quarterly reports. Many of the errors could be attributed to inconsistent directives provided by BPI DMAHS with regards to what data should be captured on the quarterly reports. Some of the errors can be attributed to data entry errors in either the database or the quarterly report. The contract has since changed and the current contract now requires that either the SIU Manager or their designee submit a Notification of Investigation (NOI) to the NJ MFD Chief of Investigations or their designee. UHCCPNJ SIU has appointed a designee to perform this function.

The UHCCPNJ SIU designee maintains an Excel tracking list of all NOI activity (NOI requests and approvals) between SIU and NJ MFD. This list is used to cross check the Quarterly Report data for accuracy.

UHCCPNJ has automated the production of the Quarterly Report from its Case Tracking Database. The automated report is generated from specific case data in the Case Tracking Database. The automation of the report will eliminate data entry errors (dates as well as case summary information) which could occur when the report was produced manually.

The UHCCPNJ SIU designee is required to review the Quarterly Report for accuracy before its submission. The report is cross checked against the Excel tracking list of NOI Activity and it is reviewed to detect any omitted information.

UHCCPNJ SIU has modified the Case Tracking Database to ensure that an investigation does not progress to an active status in the Case Tracking Database without documentation of the date of written approval to proceed with an investigation from NJ MFD. UHCCPNJ SIU Case Tracking Database has been locked down for changes and therefore any changes to the dates of notification and approval cannot be performed without approval from SIU Management.

Finding: (pg. 13 - 14) Non-Compliance Intent to Recover requirements and recovery reporting time frames

UHCCPNJ SIU modified the Case Tracking Database. This modification ensured that when an investigation was closed a notice was sent to the BPI DMAHS. The current contract no longer requires such reporting. Therefore additional corrective action is not necessary.

Again, UHCCPNJ appreciates the opportunity to provide the above comments on the draft SIU Audit Report. I look forward with renewed vigor to our continued partnership in combating Fraud, Waste and Abuse in the NJFamilyCare/Medicaid and Medicare Advantage Dual Special Needs Programs in New Jersey.

If you have any questions relating to the information in this letter or the comments provided, please contact my office directly. Thank you.

Sincerely,

Richard Munson
Vice President of Investigations

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Compliance Officer

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