

IN THE MATTER OF DEFICIENCIES )  
FOUND IN THE OPERATIONS OF )  
AMERICHoice OF NEW JERSEY, INC., ) ORDER ASSESSING PENALTIES  
PURSUANT TO A COMPREHENSIVE )  
ASSESSMENT BY THE DEPARTMENT )  
OF HEALTH AND SENIOR SERVICES )

THIS MATTER having been opened by the Department of Health and Senior Services (Department) in accordance with the authority set forth at N.J.S.A. 26:1A-15, and N.J.S.A. 26:2J-1 et seq.;

WHEREAS, pursuant to the authority of N.J.S.A. 26:2J-18, the Department periodically performs an assessment of the policies, procedures and operations of each health maintenance organization (HMO) with a certificate of authority to engage in business in New Jersey;

WHEREAS, the Department performs a comprehensive assessment consistent with the procedures set forth at N.J.A.C. 8:38-2.4, as these rules relate to the requirements of the statutes at N.J.S.A. 26:2J-1 et seq. and N.J.S.A. 26:2S-1 et seq., and regulations governing HMOs generally at N.J.A.C. 8:38;

WHEREAS, AmeriChoice of New Jersey, Inc. (AmeriChoice), is an HMO in New Jersey, having been issued a certificate of authority by the Department in 1995 to engage in business, being known then as Managed Health Care Systems;

WHEREAS, the Department performed a comprehensive assessment evaluation of AmeriChoice's activities for calendar year 2002 through review of:<sup>1</sup>

1. Information obtained from interviews and observation of AmeriChoice personnel, including the President and Chief Executive Officer of AmeriChoice, Thelma Duggin, while

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<sup>1</sup> A complete list of the individuals and materials reviewed is set forth in the Appendix of the Final Report of AmeriChoice Comprehensive Assessment Review Final Report (Final Report), issued January 12, 2004. In addition, further background regarding the Department's position and findings are set forth in the Final Report. It should be noted that some material contained in the Appendix to the Final Report is confidential, and will be redacted.

Department personnel were at the offices of AmeriChoice in Newark, New Jersey on June 3, 4, 9, 11, 12 and 18, and subsequently at AmeriChoice's request on June 29, 2003;

2. Information regarding complaints about AmeriChoice received at the Department by consumers, health care providers and other state agencies;

3. AmeriChoice's Annual Supplement, required by N.J.A.C. 8:38-3.8 to be submitted annually on March 1 (or such later date as may be approved by the Department);

4. Documentation submitted by AmeriChoice specifically upon the request of the Department before, during and after the Department's on-site visit to AmeriChoice's offices, including AmeriChoice's corporate information, minutes of committee and subcommittee meetings, policies and procedures, credentialing files, complaint files, appeal files, customer service records, provider network information, and contracts for delegated services, among others; and

5. The most recent annual report of the Peer Review Organization of New Jersey (PRONJ), commissioned by the Department of Human Services (DHS) to evaluate AmeriChoice's operational compliance with the contract between DHS and AmeriChoice, in lieu of a report setting forth the findings of an external quality review organization (EQRO) commissioned by AmeriChoice, as is otherwise required pursuant to N.J.A.C. 8:38-7.2;<sup>2</sup>

WHEREAS, the Department found through its comprehensive assessment that

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<sup>2</sup> AmeriChoice contracts with DHS for the Medicaid managed care program established by DHS as an alternative means of delivering and financing the delivery of services to Medicaid recipients and certain other populations eligible to receive coverage of their health care needs through Medicaid waiver programs, Medicaid extension programs, the State Children's Health Insurance program and expansions thereof (known as NJ FamilyCare) and certain other programs administered by or through DHS, as may be appropriate from time to time. In addition, AmeriChoice offers Medicare+Choice products in a limited number of counties in New Jersey. AmeriChoice offers no commercial products, nor any administrative service products for public or private employer plans. Information regarding AmeriChoice's market and enrollment at the time that the comprehensive assessment was performed is available in the Final Report; more current information is readily available through the Department of Banking and Insurance's website at <http://www.nj.gov/dobi/managed.htm>.

AmeriChoice was deficient in multiple areas of its operations, and the Department required AmeriChoice to submit a Plan of Correction to address the deficiencies;<sup>3</sup>

WHEREAS, the Department reserved its right to impose separately other penalties and fines against AmeriChoice regarding the deficiencies found by the Department and related matters;

WHEREAS, the Department finds that certain deficiencies are evidence of a systemic problem in AmeriChoice's operations which limited or limit AmeriChoice's ability to deliver quality health care services to its membership, and/or have presented barriers to the Department's investigation of AmeriChoice's activities;

WHEREAS, N.J.S.A. 26:2J-18 requires that HMOs submit their books and records to examination by the Department, and N.J.A.C. 8:38-3.8 requires HMOs to submit information to the Department either upon a scheduled basis, upon request, or as it becomes available, as delineated at N.J.A.C. 8:38-3.8 or elsewhere in statute or regulation;

WHEREAS, AmeriChoice failed to provide the Department with all periodically required or specifically requested information, notably information relevant to the Department's comprehensive assessment of AmeriChoice, in a timely manner, to wit:

1. AmeriChoice was required to submit its 2002 Annual Supplement on March 1, 2003, but did not complete the submission until May 15, 2003, 51 days later;<sup>4</sup>

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<sup>3</sup> AmeriChoice submitted a Plan of Correction on February 27, 2004, which the Department rejected on April 19, 2004. AmeriChoice submitted a revised Plan of Correction on May 10, 2004, with supplemental information submitted on May 18, 2004. By a letter dated October 29, 2004, the Department accepted some portions of the May Plan of Correction, but rejected others. AmeriChoice submitted a revised Plan of Correction specific to the remaining issues on November 23, 2004, and the Department is reviewing it.

<sup>4</sup> Only days for which the State was open for business are counted.

2. AmeriChoice was required to submit its then-current member handbook on March 10, 2003, but did not provide it to the Department until the Department was on-site at AmeriChoice's offices, a delay in submission of 59 days;

3. AmeriChoice was required to submit an organizational chart of the company's utilization management department no later than March 10, 2003, but did not submit it to the Department until May 15, 2003, a delay in submission of 49 days;

4. AmeriChoice was required to submit a list of terminated providers for a certain period of time, including specified information, no later than March 10, 2003, but did not submit any information to the Department until April 22, 2003, a delay in submission of 29 days, and further, failed to submit complete data for this request prior to the end of the examination; and

5. AmeriChoice was required to submit its policies regarding complaints and appeals on March 10, 2003, but did not submit the information to the Department until March 13, 2003, and further, failed to submit complete information for this request prior to the end of the examination;

WHEREAS, N.J.A.C. 8:38-4.2(a)7 sets forth that the HMO shall, through the operation of a committee under the direction of the HMO's medical director, review and verify the credentials of all physicians and other providers performing health care services or related functions for the HMO;

WHEREAS, AmeriChoice's files indicate AmeriChoice's use, for at least 12 Stage 2 appeals in calendar year 2002 surveyed by the Department, of a consultant physician who was not credentialed by AmeriChoice, and who represented himself as being a Diplomate of the American Board of Surgery on certain Stage 2 appeals surveyed, but who appears to be certified only in internal medicine according to other AmeriChoice documentation;

WHEREAS, N.J.A.C. 8:38-7.1(a) requires HMOs to have a system-wide continuous quality improvement (CQI) program to monitor the quality and appropriateness of care and services provided to members, and to operate that program under the direction of the HMO's medical director and in accordance with a written plan;

WHEREAS, AmeriChoice failed to provide the Department with a copy of a written CQI plan for 2002 that had been approved by AmeriChoice's Board of Directors, instead providing the Department with a document entitled "Quality Management Program Description 2002 – Draft," which clearly was not a copy of a final document, being annotated throughout with question marks and highlighting as well as the word "Draft;"

WHEREAS, upon further inquiry from the Department as to whether the 2002 draft document had been approved by the Board of Directors, AmeriChoice provided the Department with a copy of a document entitled "2003 Quality Improvement Program Description (QIPD)," without further explanation;<sup>5</sup>

WHEREAS, N.J.A.C. 8:38-7.1(g) requires that an HMO maintain documentation of its CQI program,<sup>6</sup> including minutes of quality improvement committee meetings, and records of evaluation activities, performance measures, quality indicators and corrective plans and their results;<sup>7</sup>

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<sup>5</sup> As part of its Plan of Correction, AmeriChoice again stated that "Quality Management Program Description 2002 – Draft," was the written plan for 2002, and submitted another copy of the draft document, with mark-ups, but no proof of approval of the document by the Board of Directors. While acknowledging AmeriChoice's position in our response to AmeriChoice's second Plan of Correction, the Department relied upon the QIPD for purposes of evaluating the CQI program initially, and has not been persuaded by any subsequent information from AmeriChoice that an evaluation based on the draft document would have yielded a different outcome for the triennial assessment.

<sup>6</sup> As the Department understood the various documents presented to it, the Quality Management Committee was the umbrella organization within AmeriChoice with oversight of the general CQI functions. The Quality Management Committee had at least six subcommittees, four of which the Department reviewed: Service Quality Improvement, Health Quality and Utilization Management, Provider Affairs, and Pharmacy & Therapeutics.

<sup>7</sup> It may be noted that, while AmeriChoice finally provided proof that most of the subcommittees met as required by the QIPD, AmeriChoice did not do so until it submitted its *second* Plan of Correction – more than a year *after* the request for the documents. Accordingly, the Department's acceptance of the documentation (as set forth in the

WHEREAS, AmeriChoice either failed to operate its CQI program in accordance with any written policy provided to the Department, or failed to maintain appropriate documentation of the CQI program, as evidenced by production of minutes for only two of the quarterly meetings required of the Board of Directors for calendar year 2002, production of minutes for only eight of the at least ten monthly meetings required of the Quality Management Committee for calendar year 2002, and production of minutes for only six of the at least ten monthly meetings required of the Service Quality Improvement Subcommittee (SQIS) for calendar year 2002;

WHEREAS, AmeriChoice either failed to operate its CQI program in accordance with any written policy provided to the Department, or failed to maintain appropriate documentation of the CQI program, as evidenced by information provided to the Department regarding the Health Quality and Utilization Management (HQUM) subcommittee, which, according to various documents, was required to meet quarterly or bi-monthly, and as needed to accommodate expedited appeal requests, but which met as few as five or as many as eight times in 2002, depending upon the information reviewed;<sup>8</sup>

WHEREAS, AmeriChoice either failed to operate its CQI program in accordance with any written policy provided to the Department, or failed to maintain appropriate documentation of the CQI program, as evidenced by AmeriChoice's failure to provide proof that recommendations were made by the Quality Management Committee (as required by N.J.A.C.

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Department's response to the second Plan of Correction) does not alter the Department's belief that AmeriChoice failed to maintain appropriate documentation for the CQI program, including meeting minutes.

<sup>8</sup> The 2003 QIPD does not establish a meeting schedule for the HQUM, *per se*, but indicates that the Quality Management Committee should receive reports from the HQUM after each HQUM meeting, or quarterly, which is similar to what is stated in the 2003 Quality Management Workplan. However, the HQUM charter states that the subcommittee will meet bi-monthly or as needed to meet expedited appeal review requests. HQUM minutes indicate there were eight meetings of the HQUM in 2002, while the 2002 Annual Evaluation states that there were five HQUM meetings that year.

8:38-7.1(e)), or proof that the Quality Management Committee sought to monitor any planned or implemented corrective actions with respect to:

1. Mortality reports and the level of detail that should be included, which was first recognized as an issue at the February 13, 2002 meeting, but not discussed subsequently in 2002;
2. Deterioration in aspects of customer service related to AmeriChoice's then-vendor, ICT, which was brought to the attention of the Quality Management Committee at the September 18, 2002 meeting, but not discussed subsequently in 2002;<sup>9</sup>
3. Increasing complaints regarding inappropriate billing from members and payment issues from providers, which was brought to the attention of the Quality Management Committee at the September 18, 2002 meeting, but not discussed subsequently in 2002;<sup>10</sup>
4. A request that the Medical Director investigate ways to improve the pre-certification process, made by the Quality Management Committee at the February 13, 2002 meeting, but not discussed subsequently in 2002;

WHEREAS, N.J.A.C. 8:38-7.1(a) requires that the HMO's written CQI plan include specifications of standards of care, criteria and procedures for assessment of the quality of services provided and the adequacy and appropriateness of health care services utilized;

WHEREAS, AmeriChoice's policy, UM-ICM-P2, indicates that sentinel events will be tracked and addressed, but AmeriChoice failed to have an integrated system-wide process for consistently identifying and responding to "Sentinel Events," as evidenced by:

1. Lack of any definition of sentinel event;

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<sup>9</sup> The Department acknowledges that AmeriChoice did replace its call center vendor in 2003.

<sup>10</sup> The Department acknowledges that AmeriChoice did initiate or update a policy regarding action by AmeriChoice when made aware that a member has been put into collection (Member Services Policy MO-403 "Collection Agency

2. Lack of screening tools;<sup>11</sup>

3. Two separate, and in some instances, inconsistent sets of Sentinel Events Quality Indicators, one presented as Attachment B in AmeriChoice's 2002 Annual Supplement, and one found by Department personnel while reviewing AmeriChoice's Peer Review Policy and Procedure, which appeared to be the set of quality indicators used by the HMO in at least some of the cases reviewed by the Department;

WHEREAS, N.J.A.C. 8:38-7.1(a) requires HMOs to have a routine peer review and provider profiling system to support ongoing evaluation activities, with peer review including providers within the same discipline and area of clinical practice;

WHEREAS, AmeriChoice's subcommittee designated to perform peer review, the Provider Affairs Subcommittee (PAS), engaged in peer review activity for only 3 cases in 2002 because AmeriChoice's medical director reportedly personally reviewed each of the 805 cases identified in 2002 through the quality management program as meeting potential quality of care triggers, and determined that only 3 required consideration by the PAS;

WHEREAS, AmeriChoice's Peer Review Process Policy (QM9) did not require the inclusion of providers within the same discipline and area of clinical practice as appropriate to a case;

WHEREAS, AmeriChoice did not include a reviewer within the same discipline and area of clinical practice as the provider being reviewed for one of the three peer review cases presented to the PAS in 2002;

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Notice Resolution Process", effective February 3, 2003, but AmeriChoice appears not to have taken any more *affirmative* (preventative) action regarding the matter in either 2002 or subsequently.

<sup>11</sup> AmeriChoice information referenced use of Centers for Medicare and Medicaid screens, but AmeriChoice's staff was unable to provide information about such screens. Department personnel tried to locate the screens, searching through CMS quality assurance manuals, but could not find them.

WHEREAS, N.J.A.C. 8:38-7.1(b), requires that the HMO's Board of Directors be kept apprised of the HMO's CQI activities via regular written reports delineating quality improvements, performance measures used and their results, and demonstrated improvements in clinical and service quality;

WHEREAS, AmeriChoice's QIPD requires the Board of Directors to review minutes of the Quality Management Committee and provide feedback regarding the minutes, but the Board of Directors apparently only reviewed minutes from one Quality Management Committee meeting in 2002, and there is no indication of any feedback from the Board of Directors to the Quality Management Committee regarding any improvement initiatives;

WHEREAS, the minutes from the Board of Director meetings in 2002 reflect very little discussion – some of which arguably was misleading – about any claims payment problems, although AmeriChoice was experiencing wide-spread claims payment issues during this time period;

WHEREAS, N.J.A.C. 8:38-7.1(d) requires HMOs to monitor the availability and accessibility of services, among other things, on an ongoing basis;

WHEREAS, AmeriChoice had designated the SQIS committee with responsibility for reviewing an "Access and Availability Report," but the SQIS failed to perform this function in 2002 because, contrary to statements contained in the March through July SQIS minutes suggesting that the report was merely unavailable, AmeriChoice had no such reporting process in place, as was finally noted in the August 2002 minutes;

WHEREAS, N.J.A.C. 8:38-7.1(f) requires that CQI activities be coordinated with other performance monitoring activities, including utilization management, risk management and monitoring of member and provider complaints;

WHEREAS, AmeriChoice's CQI activities do not appear to be coordinated with other performance monitoring activities, as evidenced by:

1. AmeriChoice's failure to follow-up on a member complaint presented to the PAS by the Quality Member Advocate Team (QMAT) on April 10, 2002, despite having received more information from the health care provider in late June 2002;<sup>12</sup>

2. AmeriChoice's inability to present documentation of the coordination of CQI activities with other performance monitoring activities, notwithstanding documentation indicating that at least reports regarding member complaints were funneled into the CQI system;

3. In ten of ten complaint files reviewed by the Department, categorized by AmeriChoice as "member dissatisfaction with PCP services," AmeriChoice's failure to review any of the PCPs' individual files or any database maintained by the HMO to determine whether any of the PCPs had been the subject of any other member complaints;

WHEREAS, N.J.A.C. 8:38-4.2(a) requires that the medical director provide clinical direction and leadership to the CQI program;

WHEREAS, AmeriChoice's medical director failed to provide the required clinical direction and leadership, as evidenced by the medical director's failure to:

1. Assure compliance with AmeriChoice's own policies regarding peer review and monitoring of sentinel events;

2. Establish a system of ongoing evaluation activities, including individual case reviews and pattern analysis;

3. Establish a functional mechanism to monitor availability and accessibility;

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<sup>12</sup> When Department personnel inquired while on-site as to the status of the case, senior HMO medical staff downgraded the case to a Level #0, and annotated the case file accordingly, but did not present any indication that the PAS had made this recommendation.

4. Maintain appropriate credentialing activities; and,
5. Coordinate the CQI activities with other performance monitoring activities of the HMO;

WHEREAS, N.J.A.C. 8:38-8.1 requires that HMOs establish a comprehensive utilization management (UM) program under the direction of the HMO's medical director or his (physician) designee based on a written plan that is reviewed at least annually by the HMO, and available for review by the Department;

WHEREAS, AmeriChoice presented a written plan for its UM program, entitled "2002 Utilization Management Program Description,"<sup>13</sup> but the Department finds the written plan to have been inadequate because it failed to provide any comprehensible scope of UM activity, chain(s) of command, staffing for UM functions, or supporting documentation that would clarify the scope of activities, the chain of command or staffing for UM functions;

WHEREAS, the Department determined that AmeriChoice's written plan did not provide for mechanisms and/or systems as part of the UM program as appropriate to satisfy the requirements of N.J.A.C. 8:38-8.1(a)2, 3, 5, 6 and 8, or that AmeriChoice did not comply with the standards set forth in the written plan because AmeriChoice could not demonstrate that there were:<sup>14</sup>

1. Procedures to evaluate clinical necessity, access, appropriateness, and efficiency of services;
2. Mechanisms to detect underutilization and overutilization;

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<sup>13</sup> This document is erroneously referred to as the Utilization Management 2003 Program Description in the narrative portions of the AmeriChoice Final Report, but identified as the 2002 Utilization Management Program Description in the list of documents reviewed in the Appendix of the Final Report.

<sup>14</sup> The written plan discussed some issues that could have satisfied the requirements of N.J.A.C. 8:38-8.1(a)3 and 5, for instance, but AmeriChoice did not implement the procedures and mechanisms cited in AmeriChoice's written plan.

3. Mechanisms to ensure consistent application of review criteria and uniform decisions;
4. Outcome and process measures for evaluating the UM program; and
5. A mechanism to evaluate member satisfaction with the complaint and appeals systems, coordinated with the CQI program;

WHEREAS, N.J.A.C. 8:38-8.1 requires that HMOs establish a comprehensive UM program with procedures to evaluate clinical necessity, access, appropriateness and efficiency of services as well as ensure consistent application of review criteria and uniform decisions, among other things;

WHEREAS, AmeriChoice does not have procedures for evaluating the clinical necessity and appropriateness of certain formulary drugs, or application of review criteria is not performed uniformly, as evidenced by the apparently routine denial of requests for coverage for certain classes of drugs despite submission of appropriate and/or specifically requested information supporting the prescription, as evidenced in at least four of nine randomly selected pharmacy denial case files in which:

1. Oxycontin (a drug prescription frequently denied by AmeriChoice)<sup>15</sup> coverage was denied initially and at Stage 1 (but overturned at Stage 2), on the basis that the prescribing physicians failed to provide an appropriate medical diagnosis and then failed to provide additional information requested, but AmeriChoice's records indicate that both an appropriate diagnosis and the additional information were submitted no later than the Stage 1 appeal;

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<sup>15</sup> Three of the nine files reviewed involved Oxycontin. When asked about the prevalence of Oxycontin denials, AmeriChoice senior management seemed to justify the denials on the basis that too many drugs in certain classes, such as Oxycontin, are prescribed and abused by people and clients in specific counties and surrounding communities.

2. Additional information submitted by AmeriChoice with respect to three Oxycontin cases suggests AmeriChoice applied the criteria used for review of the requests inconsistently with AmeriChoice's own policies, and FDA standards;

3. A prescription for Adderall for an existing special needs member was denied on March 28, 2002 for failure to substantiate an adverse reaction to a generic alternative, and continued to be denied until May 7, 2002, despite Adderall having been added to AmeriChoice's formulary as of January 1, 2002;

WHEREAS, AmeriChoice indicates that it used both Milliman & Robertson (M&R) and Interqual during 2002, but did not specify the criteria to be used in instances of conflict between the two standards, resulting in an adverse determination in at least one cardiac care denial case surveyed by the Department in which the Interqual criteria were met, even though the M&R criteria were not met;

WHEREAS, N.J.A.C. 8:38-8.1 requires that the HMO's UM program include the development of outcome and process measures by which the HMO shall evaluate the UM program;

WHEREAS, the minutes of AmeriChoice's HQUM committee and the HQUM's 2002-2003 Program Plan have no review, discussion, recommendations or actions taken or intended to be taken that address outcome and process measures, nor any discussion in the minutes indicative of any outcome or process measures having been utilized to evaluate the UM program or to provide follow-up or closure on any UM issues;

WHEREAS, N.J.A.C. 8:38-8.3(b) requires that all determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician;

WHEREAS, AmeriChoice indicated that it has nurses who determine whether there is sufficient clinical information to enable a UM Physician Reviewer to render a UM decision, and that when the information is determined to be insufficient, the nurse automatically denies the service request, contrary to N.J.A.C. 8:38-8.3(b);

WHEREAS, N.J.A.C. 8:38-8.5 requires that HMOs establish an informal appeals process (Stage 1), with decisions on the appeals being rendered as soon as possible consistent with the medical exigencies of the case, not to exceed 72 hours for urgent or emergency care appeals, and five business days for all other appeals;

WHEREAS, the Department reviewed a total of 20 randomly-selected UM appeals,<sup>16</sup> and found that AmeriChoice did not consistently initiate appeals based on telephone contact, but instead required the appeal to be submitted in writing;

WHEREAS, AmeriChoice's procedure<sup>17</sup> for logging in receipt of appeals permitted for substantial lags in time between when an appeal was date-stamped as received at AmeriChoice and dated by the appellant (whether by regular mail or fax), being on average ten calendar days;

WHEREAS, even if the Department accepts that the date stamp represents the date on which AmeriChoice first became aware of all of the appeals reviewed, at least 40 percent of the Stage 1 appeals were not concluded timely;

WHEREAS, N.J.A.C. 8:38-8.6 requires that each HMO establish a formal (Stage 2) appeal mechanism whereby the appeal is reviewed by a panel of physicians and/or other health care professionals selected by the HMO (who were not involved with any prior determination on the appeal);

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<sup>16</sup> Ten of the appeals were Stage 1 appeals only, and the remaining ten involved both Stage 1 and Stage 2 appeals.

<sup>17</sup> The Department discerned that AmeriChoice lacked a uniform process for logging appeals.

WHEREAS, N.J.A.C. 8:38-8.6 requires that the Stage 2 appeal panel have available consultant practitioners who are trained or practice in the same specialty as would typically manage the case at issue, or such other licensed health care professional as may be mutually agreed upon by the parties (so long as neither the consultant or other health care professional has participated in any prior determinations regarding the appeal), who shall participate in the panel's review of the case, if requested by the appellant;

WHEREAS, AmeriChoice provided the Department with a list of 38 physician consultants with a broad range of specialties (though not psychiatry or nephrology), but only used two of the 38 physicians for review of Stage 2 appeals during 2002, with apparent disregard as to specialty requirements, inasmuch as the two reviewers both specialized in internal medicine;

WHEREAS, the ten Stage 2 appeals reviewed involved 4 cardiac cases, and one case each of the following: psychiatric; renal; pulmonary; neurosurgical; diabetes with dehydration, osteoporosis and depression; and, pulmonary and cardiac with gastroenterology issues;

WHEREAS, two of the ten appellants specifically requested specialist consultation, but neither case was reviewed by the requested specialists or anyone else in the appropriate specialty;

WHEREAS, N.J.A.C. 8:38-8.6 requires that within ten business days following the HMO's receipt of the appeal, the HMO acknowledge receipt of it in writing to the appellant;

WHEREAS, AmeriChoice failed to timely acknowledge receipt of the Stage 2 appeal in 7 of the ten Stage 2 appeals reviewed;

WHEREAS, N.J.A.C. 8:38-8.6 requires that HMOs conclude Stage 2 appeals in a timeframe consistent with the medical exigencies of the case, not exceeding 72 hours for urgent

or emergency care situations, or 20 business days otherwise, unless the HMO requests approval from the Department to extend the timeframe up to an additional 20 days, and the Department grants the request;

WHEREAS, AmeriChoice failed to timely conclude eight of the ten Stage 2 appeals reviewed;

WHEREAS, AmeriChoice did not make a request to the Department to extend the timeframe for completing the Stage 2 appeal for any of the ten Stage 2 appeals reviewed by the Department;

WHEREAS, N.J.A.C. 8:38-8.6 requires that, when issuing an adverse determination on a Stage 2 appeal, the HMO provide written notification of the right of the appellant to proceed to the Independent Health Care Appeals Program for an external review (Stage 3), including specific instructions as to how to apply for an external appeal, with inclusion of any forms required to initiate such an appeal;

WHEREAS, AmeriChoice provided inaccurate information with respect to who may pursue an appeal through the Independent Health Care Appeals Program, and how to initiate such an appeal, advising members dissatisfied with the resolution of both complaints and grievances that they may appeal to the Independent Utilization Review Organization, but providing inaccurate contact information;

WHEREAS, N.J.A.C. 8:38-9.1 specifies that members have the right to be free from balance billing by participating providers for medically necessary services authorized or covered by the HMO except as permitted for copayments, coinsurance and deductibles by contract;

WHEREAS, N.J.A.C. 8:38-15.2 requires HMOs to include a provision in the HMO's contracts with its participating providers prohibiting billing by the participating providers of the HMO members for costs that are the responsibility of the HMO;

WHEREAS, AmeriChoice's members were billed by participating providers, and AmeriChoice was aware that the problem of provider billing was significant and growing, as evidenced by AmeriChoice's own data, and recognition of the problem in certain meetings and reports;<sup>18</sup>

WHEREAS, the Department found no evidence during the comprehensive assessment that AmeriChoice had taken any corrective actions or developed a means for doing pattern analysis of provider billing complaints;

WHEREAS, pursuant to N.J.S.A. 26:2J-4, issuance of a certificate of authority to operate as an HMO is premised upon the Department determining that an applicant for a certificate of authority demonstrating the potential ability to assure that services will be provided in a manner that assures availability and accessibility of adequate personnel and facilities, and in a manner enhancing availability, accessibility and continuity of health care services;

WHEREAS, the Department has significant concern about the staffing and organizational structure of AmeriChoice, the failure of its Board of Directors to provide oversight of the CQI program, AmeriChoice's failure to have an adequate or compliant CQI program in place, AmeriChoice's failure to have an adequate or compliant UM program in place, and the lack of

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<sup>18</sup> Data from AmeriChoice's 2002 Quality Management Program Description, submitted with AmeriChoice's Annual Supplement, states that provider billing was the top reason for member complaints and grievances, and data for the year ending December 31, 2002 showed that 45% of the complaints filed (602/1318) and 45% of the grievances files (226/503) involved a member receiving a bill from a provider. The Department recognizes that not all of the providers who billed were necessarily participating providers, but believes that whether the billing is by participating or nonparticipating providers, either scenario suggests a need for corrective action by AmeriChoice.

responsiveness of AmeriChoice's provider relations – including provider complaint and network management programs -- to the issues of participating and nonparticipating health care providers;

WHEREAS, at the demand of the Department, AmeriChoice submitted a Plan of Correction on February 27, 2004, represented as addressing many of the deficiencies cited by the Department in the Final Report;

WHEREAS, the Department rejected the February Plan of Correction for failure to adequately address most of the deficiencies cited, and demanded submission of a revised Plan of Correction;

WHEREAS, AmeriChoice submitted a revised Plan of Correction on May 10, 2004, which the Department acknowledges to be an improvement in comparison to the prior Plan of Correction, but nevertheless, only conditionally approved;<sup>19</sup>

WHEREAS, AmeriChoice submitted a revised Plan of Correction on November 23, 2004, which the Department acknowledges to be an improvement in comparison to the prior Plans of Correction, but nevertheless, there are certain issues that remain outstanding;

NOW, THEREFORE, it is on this 1st day of February hereby ordered that:

1. AmeriChoice shall pay a fine of \$275,000 in one lump sum, made payable by check or money order to "Treasurer, State of New Jersey," no later than the date on which this paragraph becomes effective, to the Director of the Office of Managed Care, P.O. Box 360, Trenton, NJ 08625-0360, for the following:

a. \$55,000 for its failure to submit documents to the Department in a timely manner (\$250 multiplied by a total of 220 business days);

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<sup>19</sup> Although found to address some specific issues adequately, AmeriChoice's responses to several areas continued to be unacceptable. Those portions of the May 10, 2004 Plan of Correction found to be acceptable and unacceptable are set forth in a separate letter to AmeriChoice, with a demand for additional revisions with respect to those deficiencies the Department believes still have not been adequately addressed.

b. \$10,000 for each of the following violations, which exhibit a pattern of noncompliance with N.J.A.C. 8:38-4.2(a)7, for a total of \$20,000:

(1) use of at least one consultant physician in review of UM appeals who had not been credentialed or recredentialed by AmeriChoice;

(2) the failure of the Medical Director to provide clinical direction and leadership for the CQI program;

c. \$10,000 for each of the following violations, which exhibit a pattern of noncompliance with N.J.A.C. 8:38-7.1, for a total of \$70,000:

(1) AmeriChoice's failure to adequately establish policies and procedures regarding sentinel events;

(2) AmeriChoice's failure to have an appropriate peer review process generally; and

(3) AmeriChoice's failure to have peer review by practitioners in the same discipline;

(4) AmeriChoice's failure to keep its Board of Directors apprised of CQI activities, and failure of the Board of Directors to provide any feedback with respect to CQI activities;

(5) AmeriChoice's failure to implement a reporting process to monitor access and availability of services;

(6) AmeriChoice's failure with respect to the oversight activities of the Quality Management Committee;

(7) AmeriChoice's failure to maintain appropriate documentation of committee meetings, activities and reports related to the CQI program;

d. \$10,000 for each of the following violations, which exhibit a pattern of noncompliance with N.J.A.C. 8:38-8.1, for a total of \$40,000:

(1) AmeriChoice's failure to have a written UM plan;

(2) AmeriChoice's failure to clarify the which of two sets of UM criteria take precedence when inconsistencies between them arise;

(3) AmeriChoice's failure to have procedures to evaluate the clinical necessity and appropriateness of certain formulary drugs or consistent application of review criteria in this regard; and

(4) the failure of AmeriChoice's HQUM committee to address outcome and process measures to evaluate the UM program or provide follow-up on any UM issues;

e. \$10,000 for exhibiting a pattern of noncompliance with N.J.A.C. 8:38-8.3 for permitting denials of service requests to be performed by a nurse, rather than by a physician;

f. \$10,000 for each of the following violations, which exhibit a pattern of noncompliance with N.J.A.C. 8:38-8.5, for a total of \$20,000:

(1) AmeriChoice's failure to consistently provide for initiation of Stage 1 appeals via telephone;

(2) AmeriChoice's failure to process Stage 1 appeals in a timely manner;

g. \$10,000 for each of the following violations, which exhibit a pattern of noncompliance with N.J.A.C. 8:38-8.6, for a total of \$50,000:

(1) AmeriChoice's failure to have available or use consultants with appropriate specialties for the cases at issue;

(2) AmeriChoice's failure to timely acknowledge receipt of the appeals;

(3) AmeriChoice's failure to process Stage 2 appeals in a timely manner;

(4) AmeriChoice's failure to request extensions in the processing of Stage 2 appeals; and

(5) AmeriChoice's failure to provide appropriate information to members regarding their right to and the process for requesting review by the Independent Health Care Appeals Program; and

h. \$10,000 for exhibiting a pattern of noncompliance with N.J.A.C. 8:38-9.1 for failing to address provider billing complaints and thereby assuring that members would be free from inappropriate billing by health care providers and being subjected to collection services for bills not paid;

2. Obligations under this Order are imposed pursuant to the police powers of the State of New Jersey for the enforcement of law and the protection of public health, safety, and welfare and are not intended to constitute a debt or debts subject to limitation or discharge in a bankruptcy proceeding.

3. All numbered paragraphs of this Order, other than Paragraphs 1, shall be effective as of the date of this Order.

4. Paragraphs 1 shall not become effective until 30 days following the date of this Order, in accordance with N.J.A.C. 8:38-2.14(c), unless AmeriChoice files with the Department, prior to the end of the 30-day period, a written request for a hearing, and a written request to Stay the Order with respect to Paragraph 1 until an administrative hearing has been concluded and a final decision is rendered by the Department. A request for a hearing shall be accompanied by a written response to the violations set forth in this Order.

5. If AmeriChoice wishes to request an administrative hearing, AmeriChoice shall submit its request in writing no later than 30 days following the date of this Order to the Director

of the Office of Legal and Regulatory Affairs, P.O. Box 360, Trenton, NJ 08625-0360, or by fax at (609) 292-5333.

Questions regarding this Order should be submitted to Marilyn Dahl, Deputy Commissioner (609-984-3939), or Sylvia Allen-Ware (609-633-0660), Director of the Office of Managed Care.

FOR:

FRED M. JACOBS., ACTING COMMISSIONER  
NEW JERSEY DEPARTMENT OF HEALTH  
AND SENIOR SERVICES

BY:

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MARILYN DAHL  
Deputy Commissioner

*/s/ Marilyn Dahl*