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State Comptroller audit finds Horizon NJ Health failing to aggressively investigate and recover misspent Medicaid dollars for the state

An audit released today by the Office of the State Comptroller (OSC) found the state's largest Medicaid health maintenance organization has done a poor job of pursuing and reporting fraud and abuse recoveries that would lower insurance costs paid by the state.

According to the audit, Horizon NJ Health (HNJH) recovered only \$188,207 in improper Medicaid payments to its network providers and enrollees in 2009 and 2010. Those recoveries represent less than one-tenth of one percent of the \$1.3 billion HNJH receives annually from the state.

HNJH's contract with the state requires it to maintain a special investigations unit dedicated solely to the detection of fraud and abuse by providers and enrollees within its network. All recoveries of improper payments are required to be reported to the state Department of Human Services and result in lower premium payments the state must pay to its four Medicaid health maintenance organizations (HMOs).

"Horizon NJ Health needs to step up its efforts in investigating Medicaid fraud and abuse and recovering misspent Medicaid dollars," State Comptroller Matthew Boxer said. "As the state now transitions its Medicaid program to a managed care system, it is becoming even more crucial for Horizon to meet its obligations as the state's partner in the fight against Medicaid fraud."

The OSC Medicaid Fraud Division audit found HNJH actively investigated only nine health care providers during the two-year period reviewed and made a total of five recoveries of improper Medicaid payments. It also found that even with the small amount of recoveries, only 14.1 percent of those recoveries were actually reported to

the state as required. As a result of the underreporting, the state overpaid \$161,666 in premiums to the four Medicaid HMOs, according to the audit. OSC recommends the state seek to recover the overpayments.

The audit further found HNJV did not consistently coordinate its efforts with the OSC, often failing to obtain required approvals for both its investigations and its recoveries. The approval process, which is dictated by HNJV's contract with the state, was designed to enable OSC to ensure that HNJV is maximizing its recoveries in the cases it pursues.

Insufficient staffing of HNJV's investigations unit raises further concerns about HNJV's dedication to addressing fraud and abuse within its network, the audit found. HNJV's contract with the state requires it to have at least one full-time investigator for every 60,000 of its New Jersey Medicaid enrollees. OSC could not determine precise HNJV investigative staffing levels because the information HNJV provided to OSC lacked sufficient detail. Even based on HNJV's own summary calculations, however, the staffing levels fell below the minimum required for three of the eight quarters covered in the audit.

"The bottom line is we pay a lot of money as a state to Horizon and the state is getting less than what it bargained for in its contract," OSC Medicaid Fraud Division Director Mark Anderson said.

A review of HNJV's pharmacy network raised further questions about HNJV's degree of oversight in fighting fraud and waste within its network. OSC reviewed 22 audits of HNJV network pharmacies conducted by an outside vendor. Of the 22 audits, OSC identified 19 in which the audit vendor documented deficiency patterns that should have resulted in a referral to HNJV's investigations unit from HNJV's pharmacy network manager, yet no referral was made. One audit found, for example, that a healthcare provider who the federal government had excluded from the Medicaid program was still writing prescriptions for Medicaid recipients. Other audits identified pharmacies at which prescriptions had been altered or where original prescriptions were missing.

HNJV serves more than 470,000 Medicaid enrollees in all 21 New Jersey counties. HNJV is a wholly owned subsidiary of Horizon Blue Cross Blue Shield.