Beware! New Jersey Medicaid Is Aggressively Auditing Inpatient Claims That Have Been Pre-Authorized By MCOs

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Over the past several decades there has been a significant shift from beneficiaries enrolled in traditional Medicaid to those enrolled in Managed Medicaid. The New Jersey Division of Medical Assistance and Health Service ("DMAHS") has indicated that as of October 2023, 97% of Medicaid/NJ Family Care beneficiaries participate in managed care plans. This shift raises questions about the State's ability to audit and seek recovery of amounts it contends are overpayments that were approved and paid by private insurance companies.

Under traditional Medicaid, hospitals are not generally required to seek preauthorization for inpatient admissions but are subject to utilization review audits which can result in subsequently denied claims and recovery of overpayments. Conversely, private Medicaid Managed Care Organizations ("MCOs") generally require hospitals to obtain preauthorization for all inpatient admissions and are prohibited from "reversing a utilization management decision where the provider relied upon the written authorization of the HMO or its agents prior to providing the service to the member, except in cases where there was a material misrepresentation or fraud."1

Despite these differences in the manner in which provider claims are authorized, the State of New Jersey has been aggressively auditing and seeking recoupment of paid claims that were preauthorized by an MCO based on the State's own interpretation of the appropriate level of care. These audits raise significant issues regarding the scope of, and authority for, the State's audits and recoupment efforts. Determining whether the State has the authority to audit and recover alleged overpayments on these pre-authorized claims is dependent on the nature of the audit as well as the terms of the provider contract with the specific MCO.

While there is little dispute that the State is permitted, and indeed required, by the Federal government to oversee MCO claims in an attempt to weed out fraud, a more complex question arises regarding the State's authority to audit and recoup payment of claims based medical necessity when the claim was preauthorized by an MCO. This is particularly true when the State does not claim the services were not provided, or completely unnecessary, but rather questions whether the appropriate level of care was provided, i.e., should the patient have been treated on an inpatient or outpatient basis.

Given the State's recent attempts to aggressively pursue such recoupments from New Jersey hospitals, it appears the State believes it has broad authority under federal law to conduct these audits and recoup alleged overpayments. However, a closer review suggests the State has either waived its right to conduct such audit and recoupment efforts or delegated that authority directly to the MCOs and cannot now assume the role of "Auditor-in-Chief."

Federal regulation2 provides States with broad authority to use Recovery Audit Contractors ("RAC") to identify and recoup overpayments. However, the same regulation authorizes State's to specifically "exclude Medicaid managed care claims from review by Medicaid RACs." The State of New Jersey has not specifically excluded MCO claims from review. Rather, for the years 2022-2025 it has amended its Medicaid State

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Plan to suspend the use of Medicaid RACs in its entirety with the stated reason being, among other things, that "97% of all Medicaid/NJ FamilyCare beneficiaries participate in managed care." Thus, for those years, it may be argued that the State has waived its authority under 42 C.F.R. § 455.506, not only to audit MCO claims, but to use RACs in general.

Similarly, utilization review requirements imposed on States by the Federal government could authorize them to conduct such audits and recoup alleged overpayments. 42 C.F.R., Part 456 obligates States to have a utilization review plan for inpatient services. 42 C.F.R. 438.66 requires States to monitor MCO utilization management. Notably, neither of these regulations specifically define how, or by whom, this oversight is to be conducted. In fact, 42 C.F.R. 438.66's reference to monitoring MCOs demonstrates that States may delegate such authority to the MCO if it monitors the MCO's activities. A review of New Jersey's own regulations strongly suggests that that is exactly what the State of New Jersey has elected to do. N.J.A.C. 10:74-13.1(e) obligates MCOs to "collect and analyze data to implement effective quality assurance, quality improvement and utilization review programs." Similarly, N.J.A.C. 10:74-3.1(c) provides "service utilization shall be controlled by the MCO through pre-certification programs and prior authorization for medical necessity." When read together and in the absence of material misrepresentations or fraud, these provisions, along with N.J.A.C. 11:24-8.3(d)'s prohibition on reversing utilization management decisions, demonstrate that despite the State's current attempts to audit and recover on these MCO claims, it has delegated the authority to do so directly to the MCOs and cannot reinsert itself in the audit process.

Nevertheless, the State has attempted to retain its right to conduct these audits by including in its contracts with the MCOs provisions that would authorize them. These provisions include requirements that encounter records are subject to review by the New Jersey Utilization Review vendor. The State also requires MCOs to include in their contracts with providers a provision requiring "the hospital to adjust the claim pursuant to the adverse determination or appeal the decision utilizing the NJUR appeal process." Such provisions suggest the State intended to retain authority to audit and recover alleged overpayments even if they were preauthorized by the MCO.

However, a review of various MCO provider contracts demonstrates that despite the State requiring the MCO to include such provisions in their provider contracts, at least on certain occasions, the MCOs have failed to do so. To the contrary, those contracts require concurrent review for all inpatient admissions, limit the time periods where the parties can dispute claims, and guarantee payment where admissions were preauthorized or concurrently approved.

In short, where the MCO has failed to include provisions in its provider contracts that subject the providers to audit and recoupment by the State, it is highly questionable that the State can impose additional requirements on providers that were not agreed to by the provider or included in the contracts they negotiated with the MCO. Indeed, this issue is currently being litigated by several New Jersey hospitals. An initial decision on the issue is likely in late 2026 or early in 2027.

Given that the parties' rights in a Medicaid Managed Care contract, like all contracts, are controlled by the express terms of the agreed upon contract, all providers should carefully review each of their MCO contracts to determine if they have explicitly agreed to be subject to any audits or recoupments sought by the State. Absent express provisions in the contract authorizing these audits, providers have a valid basis to challenge the State's attmpts to recover on claims that were preauthorized and paid by an MCO. This is a threshold issue which should be addressed before turning to the merits of any particular claim.

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