New Jersey State Legislature
Office of Legislative Services
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Department of Health and Senior Services
Office of Hospital Finance and
Charity Care
Charity Care Program

July 1, 2006 to May 2, 2008

Richard L. Fair
State Auditor
The Honorable Jon S. Corzine  
Governor of New Jersey  

The Honorable Richard J. Codey  
President of the Senate  

The Honorable Joseph J. Roberts, Jr.  
Speaker of the General Assembly  

Mr. Albert Porroni  
Executive Director  
Office of Legislative Services  

This letter is to provide you with details of our review of the Charity Care program administered by Department of Health and Senior Services, Office of Hospital Finance and Charity Care. In response to the Charity Care Fraud Prevention and Detection Act, the State Auditor conducted a review of the management and operations of the hospital charity care subsidy program, with particular attention to those aspects of the program analyzed in the State of New Jersey Commission of Investigation report dated April 2007. This letter addresses those concerns and identifies areas in need of improvement.  

Enclosed is our report which highlights those areas of concern. If you would like a personal briefing, please call me at (609) 292-3700.  

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Assistant State Auditor  
June 19, 2008
DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF HOSPITAL FINANCE AND CHARITY CARE
CHARITY CARE PROGRAM

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**Background**

New Jersey’s acute-care hospitals are mandated to provide needed medical care to state residents regardless of their ability to pay. These hospitals are provided with a subsidy for a portion of the charity care costs incurred. The level of funding is designated each year for this state subsidy and is matched dollar-for-dollar by the federal Department of Health and Human Services, Disproportionate Share Hospital Program.

We have completed our review of the Charity Care program administered by the Department of Health and Senior Services (DHSS), Office of Hospital Finance and Charity Care for the period July 1, 2006 to May 2, 2008. The prime responsibility of the DHSS is to foster accessible health and senior services of the highest quality for all New Jersey citizens to ensure optimal health, dignity, and independence. Charity Care funding, excluding the hospital assistance grants, for fiscal year 2007 was $583.4 million of which 50 percent was reimbursed by the federal government. The fiscal year 2008 subsidy totaled $715 million.

Our objective, resulting from the Charity Care Fraud Prevention and Detection Act (ACT), was to conduct a review of the management and operations of the hospital charity care subsidy program, with particular attention to those aspects of the program analyzed in the State of New Jersey Commission of Investigation report.

**Conclusions**

Charity Care is a subsidy program which does not reimburse hospitals on a per claim basis. The statutory language that establishes the funding mechanism was an attempt to have the subsidy proportional to the level of care. However, the Legislature has continued the practice of adding language to the annual appropriations act that modifies the distribution of the Charity Care
subsidy. If subsidies are to be made on a proportional basis, future distributions should be calculated in accordance with the current statute and should be based on the most up-to-date documented charity care information for the hospitals.

Charity Care claims are audited quarterly by a contract vendor. These audits test the accuracy of hospital eligibility determinations and verify that required documentation is on file. However, an independent verification of information provided to the hospital by the recipient is not performed. Based on our review, nothing would be gained by increasing the frequency of these audits.

Our analysis disclosed that some hospitals do not include social security numbers as part of the claims data submitted. Although social security numbers are not required for eligibility determination, it is part of the information requested during the intake process. When a social security number is provided by a recipient the information should be included with the claims data submitted. The lack of social security numbers hinders DHSS’ ability to monitor eligibility determinations and whether recipients have health insurance.

Hospital personnel are charged with the responsibility to determine a recipient’s eligibility based on regulatory criteria and information provided by the recipient. Income is the primary criterion used to determine eligibility and someone can be determined eligible by any one of three methods: gross annual income for the 12 months immediately preceding the services; gross income for the three months prior to services multiplied by four to determine gross annual income; or income for the month prior to services multiplied by 12 to arrive at gross annual income. Currently, there is no independent verification of income. The ACT requires random checks of personal state income tax returns and other state records to confirm eligibility. Review of tax records may not be
useful under the current income eligibility criteria. If someone is determined eligible based on the one month prior to services method, looking at their tax return will not prove eligibility since financial circumstances may change during the year.

There are no procedures performed by DHSS to search for private insurance that may cover the cost of a recipient’s care. We submitted a list of claims to a contract vendor who performs searches of private insurance for the Department of Human Services’ Bureau of Third Party Liability. The vendor indentified claims that may be covered by private insurers. Charity Care claims should be submitted to a contract vendor on a regular basis. A determination needs to be made as to how any recoveries are to be distributed.

The DHSS forwards Charity Care claims suspected to be fraudulent to the Department of Human Services, Bureau of Program Integrity (BPI) for investigation. Our review disclosed that BPI has given Medicaid provider fraud a higher priority over Charity Care recipient fraud due to staffing restraints. The ACT requires an inter-agency agreement between the DHSS and the Medicaid Inspector General (MIG). Once the MIG office is operational there should be additional resources to investigate suspected fraudulent claims.

The primary computer system utilized by Charity Care is the Electronic Claims Payment System (ECPS). The ECPS is designed to price claims at the Medicaid rate. The system is not designed to allow for thorough cross-checking of recipient demographics against Medicaid eligibility files to ensure that recipient services are being charged to the proper program. In addition, system upgrades are required to allow the system to record family size, income, and other information that is useful in determining compliance with program eligibility.