Department of Human Services
Division of Medical Assistance and Health Services
Selected Programs and Activities

July 1, 1999 to March 31, 2001
The Honorable Donald T. DiFrancesco  
Acting Governor of New Jersey

The Honorable Donald T. DiFrancesco  
President of the Senate

The Honorable Jack Collins  
Speaker of the General Assembly

Mr. Albert Porroni  
Executive Director  
Office of Legislative Services

Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, Selected Programs and Activities for the period July 1, 1999 to March 31, 2001.

If you would like a personal briefing, please call me at (609) 292-3700.

August 2, 2001
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Department of Human Services
Division of Medical Assistance and Health Services
Selected Programs and Activities

Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services, Selected Programs and Activities for the period July 1, 1999 to March 31, 2001. Our audit included expenditure transactions accounted for in the state’s General Fund for the following programs and activities: Managed Care Program, Payment of Premium Program, Prescription Drug Discount Rate, Provider Enrollment/Upkeep Unit and Monthly Medicaid Cards. The annual expenditures for these selected programs and activities are approximately $1.3 billion.

The prime responsibility of the division is to provide immediate and quality diagnosis and treatment of acute illness or disability as well as health maintenance services.

Objectives

The objectives of our audit were to determine whether expenditure transactions were related to the above selected programs, were reasonable, and were recorded properly in the accounting systems. We also tested for resolution of significant conditions noted in our prior report.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section 1, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with Government Auditing Standards, issued by the Comptroller General of the United States.

In preparation for our testing, we studied legislation, administrative code, circular letters promulgated by the State Comptroller, and policies of the agency. Provisions that we considered significant were
documented and compliance with those requirements was verified by interview, observation, and through our samples of financial transactions. We also read the budget message, reviewed financial trends, and interviewed agency personnel to obtain an understanding of the programs and the internal controls.

A nonstatistical sampling approach was used. Our samples of expenditure transactions were designed to provide conclusions about the validity of transactions as well as internal control and compliance attributes. Sample transactions were judgmentally selected.

To ascertain the status of findings included in our prior report, we identified corrective action, if any, taken by the agency and walked through the system to determine if the corrective action was effective.

**Conclusions**

We found that the expenditure transactions included in our testing were related to the selected programs and activities, were reasonable, and were recorded properly in the accounting systems. In making this determination, we noted certain internal control weaknesses and matters of compliance with laws and regulations meriting management’s attention. We also found that the agency has resolved the significant issues noted in our prior report.
The division should seek a drug discount rate consistent with other state programs.

Drug Discount Rate

The division’s reimbursement to the pharmacies for the cost of prescription drugs for a medicaid recipient is the average wholesale price of a prescription drug less a ten percent volume discount rate. The State of New Jersey, State Health Benefits Program, Employee Prescription Drug Plan reimbursement to the pharmacies for the cost of prescription drugs for state employees are the same average wholesale price of a prescription drug less a 13 percent volume discount rate. If the division received the same discount rate as the State Health Benefits Program, Employee Prescription Drug Plan, they could save approximately $20 million annually.

Recommendation

We recommend the division seek the higher discount rate to be comparable to the other state program.

Auditee’s Response

For the past several years, Division of Medical Assistance and Health Services (DMAHS) has proposed cost saving measures as part of the State’s Open Budget Process to reduce prescription drug costs. Some proposals included across-the-board reductions in reimbursement intended to better align our reimbursement policy with those of the Health Benefits Program and private insurers.

We have also attempted to refine changes in reimbursement to recognize economies of scale that likely exist between chain and independent pharmacies. For State Fiscal Year (SFY) 2002, a proposal was prepared by DMAHS to reduce reimbursement to pharmacies dispensing more than 10,000 prescriptions annually to Average Wholesale Price less 15 percent.

Also, DMAHS has proposed changes in its Fee For Service (FFS) reimbursement policy to recognize differences in drug costs between generic and brand-name drugs. For example, for SFY 2002, DMAHS proposed new prior authorization requirements for dispensing brand-name drugs when generically-
equivalent products are available in the marketplace. This change in policy would have ensured that the State only provided reimbursement for more costly brand-name drugs (available generically) when these drugs were determined medically necessary.

Many attempts to change FFS reimbursement for drug costs have been unsuccessful. As the Office of Legislative Services is aware, the Open Budget Process provides opportunities for stakeholders to present opposing viewpoints to legislators. In cases involving drug cost reimbursement, these viewpoints have been effective in challenging changes in reimbursement.

DMAHS has been successful implementing other policy changes that are better at managing prescription drug costs. For example, in 1999, DMAHS implemented a Medical Exception Process (MEP) and Monthly Prescription Volume Threshold Process (MPTP) that are containing drug costs by ensuring that prescribed drug therapy is medically necessary.

The division should reduce the frequency of issuing medicaid identification cards.

**Monthly Medicaid Cards**

The division is spending over $1 million for the current medicaid card system including monthly postage and production costs which could be significantly reduced if they switched to a more permanent identification card system. The division is discussing this issue; however, nothing has been finalized. The objective is to promote a low cost, reliable approach to support electronic provider inquiry into recipient eligibility. The new medicaid identification card system could be beneficial in that it could redirect staff for other activities.

We recommend the division issue medicaid identification cards less frequently.

**Recommendation**
Auditee’s Response

We have reviewed the audit report and are in agreement with the recommendations of the audit team. The DMAHS has planned to implement the issuance of plastic identification cards for Medicaid and State’s Children Health Insurance Program (SCHIP) beneficiaries within the scope of its new fiscal agent contract with Unisys.

This contract, which was awarded in August of 2000, includes as a Phase 2 enhancement to the New Jersey Medicaid Management Information System the issuance of plastic identification cards. Phase 2 enhancements are scheduled to be completed by February 23, 2004. We have not, as of today’s date, finalized the Phase 2 enhancement schedule.

The division should improve the encounter data collection process.

Insufficient Encounter Data

Medicaid has traditionally been a fee-for-service program, meaning that doctors, hospitals, and other providers are paid based on the number and types of services they provide. To help control spiraling medicaid costs as depicted in the below chart, the division has elected to enroll eligible medicaid beneficiaries into a managed care program. The division has contracted with managed care organizations, paying them a monthly capitated fee for each medicaid recipient enrolled in their organization.

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>ENROLLMENTS</th>
<th>EXPENDITURES</th>
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<tbody>
<tr>
<td>1999</td>
<td>394,000</td>
<td>$639,000,000</td>
</tr>
<tr>
<td>2000</td>
<td>426,000</td>
<td>$647,000,000</td>
</tr>
<tr>
<td>2001</td>
<td>557,000*</td>
<td>$832,000,000*</td>
</tr>
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*Projected Amount

The managed care contract requires managed care organizations to maintain, collect, process, and
submit electronic encounter data for all the services delivered for which the managed care organization is responsible. Encounter data is defined as the record of the number and types of services rendered to patients during a specific time period. Under the fee-for-service program, data on service delivery is captured in individual claims which are submitted for payment as services are provided. In managed care, the division is paying a fixed monthly fee regardless of the amount of services provided.

We compared the six managed care organizations’ quarterly financial reports to the division’s encounter data for the quarter ending September 30, 1999 as shown below. There were discrepancies between claim types and the total claims reported for the six managed care organizations. The encounter data submitted was not complete and not usable for fraud and abuse analysis or rate setting. The division is responsible for receiving and validating the encounter data submitted quarterly by the managed care organizations. Assembling a useable encounter database is imperative for the division to properly monitor its managed care program. Encounter data could also be analyzed to reveal patterns of utilization.

**Managed Care Encounter Data Number of Claims Comparison to Quarterly Financial Reports For the Quarter July 1, 1999 to September 30, 1999**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Total Claims Encounter Data</th>
<th>Total Claims Financial Reports</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider A</td>
<td>561,737</td>
<td>522,757</td>
<td>38,980</td>
</tr>
<tr>
<td>Provider B</td>
<td>191,702</td>
<td>293,505</td>
<td>-101,803</td>
</tr>
<tr>
<td>Provider C</td>
<td>120,026</td>
<td>251,823</td>
<td>-131,797</td>
</tr>
<tr>
<td>Provider D</td>
<td>82,782</td>
<td>83,616</td>
<td>-834</td>
</tr>
<tr>
<td>Provider E</td>
<td>231,197</td>
<td>359,692</td>
<td>-128,495</td>
</tr>
<tr>
<td>Provider F</td>
<td>211,316</td>
<td>85,112</td>
<td>126,204</td>
</tr>
<tr>
<td>Total</td>
<td>1,398,760</td>
<td>1,596,505</td>
<td>-197,745</td>
</tr>
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</table>
We also reviewed encounter data sanctions totaling $29,000 since 1997 imposed by the division on the managed care organizations. The sanctions levied against the managed care organizations did not result in the managed care organization submitting reliable data.

**Recommendation**

We recommend that the division improve its encounter data collection process by:

- Comparing and reconciling quarterly encounter data to the quarterly financial reports submitted.
- Imposing greater monetary sanctions against providers submitting incomplete encounter data.
- Reviewing alternative options including withholding a percentage of the total monthly capitation fee from managed care organizations until the deficiencies are corrected.

**Auditee’s Response**

The division is aware that there are weaknesses in the submission of encounter data as submitted by the managed care organization. Having moved from a fee-for-service payment system to a managed care model has required the division to review its data needs. As part of this review, DMAHS has already implemented one change in the reimbursement methodology. Payment of a pregnancy outcome supplement to an HMO occurs only upon receipt of correct encounter data. This data is reviewed monthly.

At this time, the division has met with each managed care plan to provide technical assistance in correcting their data submissions as well as to alert them of the seriousness of reporting complete and accurate data. The DMAHS has utilized 1999 data for a number of quality studies which provide a comparison of services across plans and also has provided information for a member report card. We are also considering publishing comparison reports based on this data.
Through the DMAHS’ contract with the Peer Review Organization of New Jersey, the completeness and accuracy of the 1999 data was evaluated by the MEDSTAT Corporation. MEDSTAT has scored the data “fair” across all plans. Some plans have better data than others do and one plan brought the average down significantly (Aetna/US Health Care). Aetna/USHC is leaving the New Jersey Medicaid Program as of August 1, 2001; regardless, we are addressing their data deficiencies with them.

MEDSTAT staff will be presenting the encounter data findings to the managed care plans in the Fall of this year at a meeting hosted by DMAHS. At that time, we plan to establish “benchmarks” at which encounter data will be evaluated to determine completeness. This is a difficult task, as there are no proven and absolute benchmarks to utilize as a base. Additionally, it is difficult to prove that a service existed and therefore would have required an encounter report.

In the contract effective October 1, 2000, sanctions have been made more severe in regards to accuracy and completeness. These sanctions will be applied to data reporting during this contract period where applicable.

Recommendations contained in this report will be carefully reviewed and given due consideration in designing policies and procedures to improve encounter data reporting.

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**Managed Care Enrollees with Multiple Recipient Numbers**

Medicaid providers are paid by one of two methods: fee-for-service method, in which a provider is paid for each eligible service, and the capitation method, in which a managed care organization is paid a
for issuing recipient numbers.

monthly fee based on the number and type of recipients enrolled in their plan. The managed care plan must provide health services to enrolled recipients when services are needed.

County welfare agencies and state contracted vendors are responsible for determining and terminating medicaid eligibility. The county welfare agencies are not adequately screening individuals for existing medicaid numbers. Often an individual’s eligibility was established under a previous program and then the individual re-entered medicaid under another program and a new medicaid number was assigned without termination of the previous medicaid number. Our review of monthly prepared division reports noted more than 3,400 medicaid enrollees with two active recipient numbers, of which 1,200 have both managed care and fee-for-service coverage.

We found that the division potentially overpaid $838,000 for the period July 1, 2000 to December 31, 2000 in fee-for-service claims that should have been covered by managed care plans. Provider claims for pharmacy, physician, and hospital services were submitted and paid for these individuals who possess multiple medicaid numbers.

**Recommendation**

We recommend that the division resolve the multiple recipient numbers by requiring the counties to improve screening procedures and to issue monthly reports of duplicates to the counties to investigate.

**Auditee’s Response**

The division established an internal review process and has reached out to the County Welfare Agencies/Board of Social Services (CWAs/BSSs) and contracted vendor to involve them in exploring and resolving the occurrence of duplicate numbers. Duplicate reports are currently being evaluated to identify the source of the problem and to begin to develop solutions, including systemic modifications.

In the interim, a monthly report which identifies duplicate numbers involving managed care
enrollment is being distributed to the CWAs/BSSs and contracted under resolution. The responses to that dissemination are monitored continuously.

The division should periodically review the accuracy of their medicaid provider records.

Provider Records

The Provider Enrollment Unit within the division and Unisys, the fiscal agent of the New Jersey Medicaid Program, are responsible for enrolling, and maintaining files and a database of all providers. Depending on provider type and the New Jersey Administrative Code, specific documentation such as licenses, accreditations, medicare approval, or board certifications must be submitted by the provider to the Provider Enrollment Unit or Unisys for review and approval.

We reviewed 103 provider files for required documentation and noted 141 exceptions including expired licenses and the lack of: ownership disclosure, current inspection for independent mental health and partial care clinics, medicare approvals for radiology and end stage renal dialysis centers, and insurance certificates for transportation services.

During our review, we noted that a licensee who worked for two medical providers submitted a counterfeit license. These two medical providers collected $50,000 in medicaid claims. Accordingly, we expanded our testing by comparing a database of all active medicaid providers with a database from the Department of Law and Public Safety, Division of Consumer Affairs(DCA), the state regulator of professional licenses, in order to determine if all active medicaid providers are currently licensed. We found 900 active medicaid providers that were not listed on DCA records as possessing a valid license. Although the providers are active per medicaid, no claims were submitted.
**Recommendation**

We recommend the division periodically review the accuracy of their medicaid provider records.

**Auditee’s Response**

The OLS audit focused on several areas of updating credentialing and documentation of provider enrollment records after the initial provider enrollment occurs.

The current provider enrollment update process is driven primarily by self reporting activities of providers or exception reporting by allied agencies responsible for certification of licensing. Either a provider or another government agency reports changes to Medicaid (e.g. Board/Medical Examiners, NJDHSS, DMHS, etc.) of adverse action or change in status.

A third possibility occurs when a policing/monitoring governmental authority suspends, bars, or terminates a provider from participation.

The OLS audit pointed out that Medicaid presently manages changes in provider enrollment status by reactive methods instead of proactive.

The DMAHS recognized this concern and incorporated it into the recent Fiscal Agent contract as part of a program-wide re-enrollment effort. The provider re-enrollment project is scheduled to begin in development in phase II implementation of Fiscal Agent (Unisys) contract on and after 8/01. The Project is very extensive and will update all supportive documentation. Part of this documentation will be the requirement for submission of current licensing and certification material to substantiate a provider’s credentials in their field.

It is also expected that the Provider Re-enrollment Project will be repeated periodically in subsequent contract years to maintain accuracy of all provider data.
Insurance premiums should be independently verified.

Payment of Premiums Program

The Payment of Premiums (POP) program pays premiums for health insurance coverage for individuals on medicaid, so the division can avoid certain medical costs. Third party liability occurs when medicaid pays for charges of a recipient with other insurance that should have paid a portion of the medical bill. The recipient’s insurance company would be responsible for the medical costs rather than the medicaid program. Recipients must be medicaid eligible and must provide verification of insurance coverage and premiums. Qualified recipients must submit proof of their insurance premium payment by providing a pay stub indicating the amount deducted from their pay for insurance, or an invoice from the insurance provider. This information is to be updated and resubmitted each time a reimbursement is to be made. We reviewed a sample of 328 transaction totaling $860,000 and found that three recipients were improperly reimbursed for insurance premiums. These individuals were not eligible for reimbursement because there was no employee out-of-pocket expense associated with their insurance premiums. The division improperly reimbursed these individuals $90,000 since fiscal year 1997. We also noted 144 instances where the POP program did not seek current premium verification to document the actual amount to be reimbursed.

These weaknesses occurred because the program receives all documentation directly from the recipient and uses this information to determine how much money will be reimbursed. Independent verification of the information is not being sought by the division either through the employer or the insurance provider to determine the amount that should be reimbursed.

Recommendation

We recommend the division ensure the validity of the
documentation by contacting the employers and/or
the insurance provider and requesting
verification of who is responsible for the cost of
health insurance.

**Auditees Response**

The Payment of Premiums (POP) Program has been
and still is a very small program. The average
number of participants has remained stable at
approximately 170 active cases at any given time.

The division has considered over the past two years
to expand the program but has recognized that to do
so would require a revision of internal controls
procedures as well as electronic automation to
control and manage growth.

During this period, due to enactment of the
New Jersey Family Care program as well as favorable
Federal SCHIP regulations, the division has
concentrated on developing a Title XXI SCHIP
approved “Premium Support Program” (PSP) to
address the availability of employer sponsored
insurance for NJFC participants. The development of
the PSP Program is analogous to the Title XIX
Medicaid “Payment of Premiums” program. The
model under development and near to completion for
PSP will be used to automate and improve the
internal controls of the “POP” program.

There are extensive checks and balances both
systemic and manual for both staff and management
to control accurate processing and payment of
premiums in the PSP system. These same processes
will be incorporated into the expansion of POP
program.

As pertains to the specific audit findings, the new
POP automation project will also change the process
of relying solely on the beneficiaries for information.
Instead there will be contact established with the
employer and/or insurance carrier to verify and
validate the coverage and premium contribution
information both initial and on-going. These changes
in procedure are consistent with the OLS
recommendations to address the material weakness
of validating the information provided by the beneficiaries.