Department of Human Services
Division of Medical Assistance
and Health Services
Health Benefits Coordinator Contract for
Medicaid Managed Care Programs

July 1, 2000 to September 15, 2004

Richard L. Fair
State Auditor
The Honorable Richard J. Codey  
Acting Governor of New Jersey

The Honorable Richard J. Codey  
President of the Senate

The Honorable Albio Sires  
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, Health Benefits Coordinator Contract for Medicaid Managed Care Programs for the period July 1, 2000 to September 15, 2004. If you would like a personal briefing, please call me at (609) 292-3700.

December 17, 2004
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope</td>
<td>1</td>
</tr>
<tr>
<td>Objectives</td>
<td>1</td>
</tr>
<tr>
<td>Methodology</td>
<td>1</td>
</tr>
<tr>
<td>Background</td>
<td>2</td>
</tr>
<tr>
<td>Conclusions</td>
<td>2</td>
</tr>
<tr>
<td>Eligibility and Application Processing</td>
<td>4</td>
</tr>
<tr>
<td>Approvals for Plan A Cases</td>
<td>6</td>
</tr>
<tr>
<td>Vendor’s Data System</td>
<td>6</td>
</tr>
<tr>
<td>Premium Assessments/Refunds</td>
<td>7</td>
</tr>
<tr>
<td>Qualifications of Vendor Employees</td>
<td>8</td>
</tr>
<tr>
<td>Auditee Response</td>
<td>9</td>
</tr>
</tbody>
</table>
Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), Health Benefits Coordinator Contract for Medicaid Managed Care Programs for the period July 1, 2000 to September 15, 2004. Payments to the vendor totaled $75 million for the period January 2001 to August 2004 and are accounted for in the state’s General Fund. We did not test capitation (premium) payments made to managed care providers. These payments are estimated to be $310 million for fiscal year 2004.

Objectives

The objectives of our audit were to determine if payments to the vendor were reasonable, were related to the department’s programs, were in accordance with the contract, and were recorded properly in the accounting system; and to determine whether contract performance and compliance was achieved.

The audit was conducted pursuant to the State Auditors’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, and policies of the 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 researched industry and governmental publications and audit reports from other states. We also read the budget message, reviewed financial trends, and interviewed agency personnel to obtain an understanding of the programs and internal controls.

A statistical and nonstatistical sampling approach was used. Our samples of financial transactions were designed to provide conclusions about the validity of transactions as well as internal control and compliance attributes. Sample populations were sorted and transactions were randomly and judgmentally selected for testing.
Background

The Department of Human Services administers the Medicaid program which provides medical assistance to eligible low-income and disabled individuals. The department entered into a contract with a vendor for the period October 2000 to December 2004. The contract is part of the NJ Family Care Program which provides no cost or low-cost health insurance through managed care enrollment to uninsured parents and children with incomes up to 350 percent of the federal poverty level. Applicants become eligible for one of four NJ Family Care Plans identified as Plans A, B, C, and D dependent upon the family’s income relative to the federal poverty level. The contract was expanded in January 2001 to include eligibility determinations and to provide education and enrollment services for the NJ Family Care program which evolved from the NJ Kid Care program. The vendor also inherited a large backlog of applications from the previous vendor. Currently, eligibility determinations for Plan A cases may be performed by either the county welfare agencies or by the vendor, while eligibility for Plans B, C, and D are determined by the vendor. Expenditures for Plan A are paid by Medicaid under Title XIX, while Plans B, C, and D are paid under Title XXI of the Social Security Act.

The following chart presents the income guidelines for program eligibility for the NJ Family Care program as of March 2003 and the number of beneficiaries enrolled in the program by the vendor. The federal poverty level for a family of four was $5,367 in 2004:

<table>
<thead>
<tr>
<th>Maximum Annual/Monthly Income</th>
<th>Premiums</th>
<th>Copayments</th>
<th>Total Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan A 133% Poverty Level</td>
<td>No Premium</td>
<td>No Copay</td>
<td>51,609</td>
</tr>
<tr>
<td>Plan B 134 - 150% Poverty Level</td>
<td>No Premium</td>
<td>No Copay</td>
<td>11,186</td>
</tr>
<tr>
<td>Plan C 151 - 200% Poverty Level</td>
<td>$16.50 monthly per family</td>
<td>$5 - $35</td>
<td>33,834</td>
</tr>
<tr>
<td>Plan D 201 - 350% Poverty Level</td>
<td>$33 - $110 monthly per family</td>
<td>$5 - $35</td>
<td>55,320</td>
</tr>
</tbody>
</table>

Conclusions

We found the payments to the vendor were reasonable, were related to the department’s programs, were in accordance with the contract, and were recorded properly in the accounting system. However, we identified several noncompliance issues with contractual performance terms because the division was prevented from administering and monitoring the contract properly. In making these determinations, we noted certain internal control weaknesses, matters of compliance with laws and regulations, and opportunities for cost savings meriting management’s attention.
It was the vendor’s contractual obligation to administer and manage the programs under its control. Processing applications, processing missing information on pending applications, and reviewing renewals for benefits in a timely and accurate manner were essential requirements of the contract. The vendor’s noncompliance with contractual obligations for processing applications timely jeopardized the state’s efforts to provide medical benefits for a needy population. Moreover, the vendor’s failure to process renewals or terminate benefits timely resulted in additional costs to the state because ineligible beneficiaries continued to receive benefits long after their eligibility should have been suspended. We also found numerous instances where program eligibility was not properly determined, the enrolled plan was incorrect, files were incomplete, premiums were not billed, and refunds were not processed timely. We found in general that vendor employees did not have the knowledge and experience required by the contract. This factor plus vendor work flow requirements may have had a negative impact on vendor performance.

An important aspect of eligibility and managed care plan designation is income determination and verification. Our tests and a division review disclosed error rates over 30 percent which impacts the propriety of the monthly capitation costs paid to managed care providers. A portion of these high error rates are due to the vendor’s limited access to databases which would enable one to perform a thorough verification of income disclosed on the application. The state’s county welfare agencies (CWAs), who in fact process a portion of the Plan A enrollments, have access to several additional databases. Whether the vendor or CWAs process enrollments, the division must establish procedures and monitor performance to ensure the integrity of the program.

In 2002, the department filed six complaints with the Department of Treasury, Bureau of Contract Compliance against the vendor for unsatisfactory performance and not meeting contractual commitments. We found that the conditions that initiated the complaints are still in existence, there hasn’t been any follow up on corrective action plans, and no subsequent complaints were filed until after our audit.

The department lacks enforcement ability because, although the department withheld payments from the vendor for disputable billings that had been submitted, in October 2003 a settlement agreement was negotiated which ultimately resulted in limiting the vendor’s liability for damages that the state could recover. By limiting the vendor’s liability and accountability, there was little incentive for the vendor to take corrective actions or be held responsible for their noncompliance.

The department should immediately address the issues and weaknesses identified in this report. A new vendor will be in place beginning in January 2005 and to ensure the continuity of the program, will be transitioning with the current vendor until July 2005. If the existing problems are not corrected, the state and the new vendor will be starting out with the same problems that have plagued the current contract since its inception. More timely monitoring of contractual compliance and performance may help to minimize or eliminate the negative results experienced during the current contract.
An additional consideration for the division is to remove eligibility determinations of Plan A cases from the vendor’s contract and place the responsibility with the CWAs. The NJ Family Care Program eligibility criteria is extremely complex and requires an in-depth knowledge of Medicaid regulations for determining individuals into the appropriate benefits plans. There are 22 eligibility levels within the four plans. The CWAs are recognized as having an expertise in processing Medicaid eligibility. They have access to child support information and other databases which can be used to verify applicants’ income. Additional potential benefits could include the following.

- Annual cost savings could be realized if the department removed the eligibility processing segment of Plan A cases from the vendor and place responsibility back with CWAs. The current 52,000 Plan A cases could be absorbed by the 21 counties, resulting in savings of up to $1.6 million annually. This savings may be offset by some additional costs to the counties.

- The CWA case workers follow a case through the entire eligibility and redetermination process from receiving the application to its final determination. This process ensures accountability for each case and provides beneficiaries with direct access to the county worker for any inquiries regarding the case status. The current vendor’s process did not include this level of accountability. Various employees could work on an individual case.

In addition, to improve the accuracy of eligibility determinations, we recommend the division increase its monitoring efforts over Plans B, C and D. We also recommend the division require submission of federal tax returns for all applicants. Currently, this requirement applies only to self-employed applicants. Furthermore, we recommend the division match child support information with vendor files. These procedures would ensure the vendor’s eligibility determinations are within acceptable levels as prescribed by federal requirements.

Additional details of performance deficiencies and other control weaknesses are presented in the following sections.

**Eligibility and Application Processing**

We found significant error rates in the determination of eligibility and accuracy of plan designations. We also found deficiencies in the timely processing of applications and follow up of missing or new information.

- We identified 8900 beneficiaries with invalid SSNs processed by the vendor. Federal social security regulations require, as a condition of eligibility for benefits under any program, that the beneficiary furnish their SSN. The department has stated that this practice of filling in improper social security numbers on the Medicaid eligibility file applies to newborns. Our review noted that approximately 7600 of the 8900 beneficiaries were over the age of one. The department should implement and enforce regulations to ensure that time limits are placed on securing proper SSNs. Additionally, income verification can not be effectively performed without proper SSNs.
We randomly selected 193 cases processed by the vendor to test the propriety of eligibility determinations. Of the beneficiary files inspected, 43 percent did not contain the necessary supporting documentation to process the case. Supporting documentation includes proof of social security number, birth certificates or other documentation to verify date of birth, and proof of United States citizenship. The lack of proper documentation can have a negative or detrimental impact on program integrity.

Of the 193 beneficiaries tested, 31 percent were placed in the wrong plan and seven percent should have been determined ineligible. If these errors are projected over the entire population, 49,800 individuals could have been enrolled in the wrong health plan and 11,600 individuals in the program may be ineligible. Based on this projection, the division could be paying $1.9 million monthly in capitation for ineligible beneficiaries. Our results were supported by the 66 percent accuracy rate found by the DMAHS, Bureau of Quality Control in an April 2003 review of eligibility determinations for Plans B, C, and D. The review encompassed the period July 2002 through December 2002. In that report, the vendor was cited for a variety of mistakes and processing problems. Federal standards require a 95 percent accuracy rate.

The Bureau of Quality Control’s review also indicated that the complaint process needs to be monitored more closely. The vendor errors and processing delays resulted in high volume of complaints. “There was evidence in the case records and computer system that the applicants complained repeatedly about the mistakes, without resolution. In some cases, the parents stopped paying the disputed amounts and were justly terminated for non-payment of premium. Other parents appeared to have withdrawn their applications because the mistakes they contested went uncorrected.” A referral unit was established by the department to address the numerous complaints that were received because they were not addressed by the vendor. Our review of complaint logs from October 2003 through June 2004 found that the division received, on average, 105 of these complaints a month from various sources including the governor’s office and legislators.

The contract requires initial applications be reviewed and processed within five business days of receipt. Renewal applications are required to be redetermined within 30 days. Our review of 45 applications during the contract period found that 51 percent were not processed within the specified times.

As of July 15, 2004 there were 22,000 renewal cases in missing information status, of which 10,700 cases were more than 60 days old. If the application is incomplete, the contractor is required to notify the applicant. After 60 days, if the request is not satisfied, the applicant should be disenrolled. The vendor’s failure to terminate enrollments which were no longer valid caused the state to overpay capitation costs $1.6 million per month.
Approvals for Plan A Cases

The DMAHS maintains a staff of 11 employees at the vendor’s facility. They are required to provide final approval on the completion of all Plan A applications pursuant to federal regulations under Title XIX. Although all Plan A cases are forwarded to this state unit for final approval, the cases were initialed and returned to the vendor’s employees for uploading to the state eligibility file. This process allows vendor employees to bypass the state’s approvals. This weakness was exploited and resulted in a fraud in 2001 when several vendor employees inappropriately enrolled themselves into the NJ Family Care Program by creating fictitious applications. The division’s investigation resulted in six employees being indicted and one convicted. This control weakness has not been corrected by the division.

Vendor’s Data System

Weaknesses in the vendor’s system have had a significant effect on the vendor’s overall performance in meeting contractual obligations and are underlying reasons for other audit issues found in our review. The vendor’s computer software system was developed in the 1970s as the means of processing beneficiaries’ eligibility and managed care information. Our review noted the following.

- The vendor’s system interfaces daily with the state’s Medicaid eligibility file and uploads any changes to beneficiaries’ eligibility segments. The vendor’s system and the state’s Medicaid eligibility file are not in agreement. Although the vendor performs weekly reconciliations to reconcile the two systems, there were 700 cases with differences. Most of the discrepancies involved plan codes which are essential in ensuring that beneficiaries are charged proper premiums and co-payments.

- Navigating the vendor’s system for case information is cumbersome and often has conflicting information regarding beneficiaries’ current eligibility status. Our review noted that calls were made by beneficiaries indicating changes in their current eligibility. These changes were logged on the system “action/call history” screen; however, the changes were never made to the eligibility screens. Two examples follow.

  A beneficiary was determined eligible for the program in April 2001, two years after the date of death (February 1999). Several phone calls were made to the vendor regarding the beneficiary’s death. The call history screens documented the telephone calls; however, no action was taken to terminate the individual’s eligibility. Eligibility for the deceased continued until it was finally terminated on June 30, 2004. The state paid $9,000 to the HMOs for health coverage for this deceased individual.

  The vendor continued program eligibility for beneficiaries after mail was returned showing an out of state address or documentation of telephone calls indicating a new residence outside the state. The vendor did not terminate eligibility, causing the state to pay excess capitations of up to $7900.
Historically, the division has not been able to verify the information on the vendor’s computer system. The division had to rely on the vendor to supply accurate and timely managerial reports, limiting the division’s ability to monitor program information. The division requested a diagnostic report in April 2004, identifying cases where parents might still be in the program after their children were no longer enrolled. These beneficiaries would no longer be eligible. There were 334 participants who were not terminated until three months later, resulting in the overpayments of capitation totaling $162,000. The division assumed that the vendor terminated these individuals when they were first reported.

**Premium Assessments / Refunds**

Our review disclosed that the vendor is not in compliance with the contractual requirements for premium collections, and they did not refund premiums on a timely basis.

- There were 1900 beneficiaries enrolled in the program who did not pay the required premium. We examined 125 of these cases and found that 49 percent of the beneficiaries did not remit premiums because the vendor never sent a letter indicating that payment was required. Additionally, 46 percent of the beneficiaries were notified of the required premium, but never remitted a payment. These beneficiaries were not disenrolled as required by procedure. The appropriate plan designation could not be ascertained for the remaining cases tested.

In one example, a family’s eligibility became effective November 1, 2001. According to the vendor’s computer system, the eligibility for this household should have never been made effective because the family never made a premium payment and they also never renewed their eligibility. The state paid capitation of $6,700 for this family of four in error from November 2001 to September 2003.

- NJ Family Care beneficiaries, who by nature of their program participation often possess limited incomes, are entitled to have refunds processed within a reasonable period of time as intended by state regulations. Our test of 90 refunds processed during calendar year 2003 found that 90 percent of refund checks were not processed within 15 business days as specified by the contract. The average time between the termination date and the refund processing date was 286 days. The delays in processing could be attributed to the vendor’s computer system lacking the capability to refund beneficiary premiums causing the vendor to manually input the refund information onto a retail accounting software. This increases the possibility of human error and duplicate work.

- The vendor’s finance department initiated, processed, and mailed all of the refunds. This lack of segregation of duties increases the possibility of fraud, although our testing did not identify such fraud.
Qualifications of Vendor Employees

It is recognized that NJ Family Care is a complex program. The contract required a minimum level of experience and education for certain positions, in particular Eligibility Specialists and Health Benefit Coordinators. We reviewed personnel files for 30 employees in those titles as of June 2004 and found 80 percent lacked the required educational experience or the required experience in health care, social services, health maintenance organizations, and customer service.
James Patterson
Assistant State Auditor
Office of Legislative Services
Office of the State Auditor
125 South Warren Street
PO Box 067
Trenton, NJ 08625-0067

Dear Mr. Patterson:

I am writing in response to your November 22nd letter concerning the audit report of the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), Health Benefits Coordinator (HBC) Contract for Medicaid Managed Care Programs.

The DMAHS supports the findings of the audit report prepared by the Office of Legislative Services for Contractual Performance. The findings will be used as we prepare for the implementation of the new HBC contract.

In August 2004, the Division released an RFP to procure a vendor to perform the HBC process. On October 8, 2004, the Department of Treasury’s Division of Purchase and Property awarded the contract to ACS for its experience and technical abilities; and on January 1, 2005, ACS will replace the current vendor, Maximus.

The administration of the HBC contract is complex. State-of-the-art technology and workflow, as well as knowledgeable staff, are critical components to its success. ACS utilizes a state-of-the-art web-based, eligibility, enrollment, contract management and premium processing application.

The Division recognized that the monitoring and administration of the current contract lacked the tools and staff necessary to ensure compliance and proper contract performance. To resolve this issue, the Division has created the Office of Contract Compliance (OCC) which is responsible for the oversight of the...
outgoing contract with Maximus and the implementation of the new contract with ACS. In contrast to the staff of four who had the responsibility of monitoring the current contract, this Office consists of staff who are knowledgeable in the areas of Medicaid eligibility as well as monitoring and contract compliance. This Office consists of a group of six managers with staff that oversee the following areas: Operations Management, Contract Compliance, Eligibility Management, Managed Care Operations, Systems Management, Training and Quality Control.

To specifically address some of the issues raised in the audit of the current contract, the OCC will establish procedures for the vendor that will provide for a more accurate and efficient process for our applicants to become enrolled in the NJ FamilyCare and Medicaid Managed Care programs. An example of how the OCC will seek to accomplish this goal is the development of a process for the vendor to follow when identifying income so that eligibility may be determined accurately.

DMAHS believes that by establishing these oversight units in the OCC, it will ensure the proper administration and monitoring of the contract. We will have the ability to establish internal controls, to identify weaknesses, and to ensure the timely processing of applications and renewals.

If you have any questions, please contact me at 609-588-2600 or Michele Romeo, Administrator of the Office of Contract Compliance, at 609-588-2815.

Sincerely,

Ann Clemency Kohler
Director

ACK:R