Department of Human Services
Division of Medical Assistance and Health Services
Managed Care Program
Third Party Liability Medical Coverage

July 1, 2007 to June 30, 2008
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

Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, Managed Care Program, Third Party Liability Medical Coverage for the period of July 1, 2007 to June 30, 2008. If you would like a personal briefing, please call me at (609) 292-3700.

Stephen M. Eells  
Assistant State Auditor  
April 23, 2009
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Department of Human Services  
Division of Medical Assistance and Health Services  
Managed Care Program  
Third Party Liability Medical Coverage

Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services, Managed Care program as it relates to third party liability medical coverage for the period July 1, 2007 to June 30, 2008. This audit was performed in conjunction with our overall review of the Managed Care program. Several audit reports will be issued on selected topics relating to the Managed Care program.

Objectives

The objective of our audit was to determine the propriety of enrolling beneficiaries with comprehensive third party liability coverage in the Managed Care program.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, 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 audit, we studied legislation, the State Medicaid Plan, administrative code, 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 analysis of financial transactions. We also interviewed agency personnel to obtain an understanding of the program and the internal controls. Populations of beneficiaries enrolled in managed care with comprehensive third party liability coverage were sorted and analyzed.
Managed Care

The Division of Medical Assistance and Health Services administers the state’s Medicaid and NJ FamilyCare programs, which provide medical assistance to needy or uninsured individuals. Medicaid pays providers by one of two methods: the fee-for-service method, in which a provider is paid for every Medicaid eligible service rendered to the beneficiary; or the capitation method, in which a managed care organization (MCO) receives a monthly payment for each beneficiary enrolled in the plan. The NJ FamilyCare program uses only the capitation method. The MCO is responsible for ensuring enrollees have access to a comprehensive range of preventative, primary, and specialty services. Five MCOs participate in the state’s Managed Care program which is intended to provide quality health care in a cost-effective manner. In return for the monthly capitation, the MCOs ensure that each enrollee has a primary care provider and adequate access to quality health care and needed medical services. MCOs enter into contracts with health care providers for delivering these services to beneficiaries and are responsible for paying the actual service providers.

The division contracts with a consultant to develop actuarially sound capitation rates annually. In determining capitation rates, the division will review encounter data, eligibility data, programmatic changes, demographic changes, and MCO financial reports. The primary data source for the capitation rates are the medical expenses reported through the financial data submitted by the MCOs. To arrive at the final managed care capitation rates, the consultant analyzes each of the five MCOs’ administrative expenses and includes a pre-tax underwriting profit as a flat percentage. For fiscal year 2009 the administrative expense and pre-tax underwriting profit rate components were 13.5 percent of the monthly capitation rate.
For the year ended June 30, 2008 the state spent $2 billion on managed care for approximately 770,000 beneficiaries. MCOs are contractually obligated to submit information on beneficiary medical services, known as encounters, to the division quarterly. An encounter is a professional face-to-face contact or transaction between a beneficiary and provider who delivers services. Encounter data is comprised of the services rendered during the contact. Encounters for the state’s Managed Care program include: visits to a physician or other medical provider, inpatient hospital stays, and purchases of durable medical equipment or hearing aids.

Third Party Liability

Some adult beneficiaries may have access to private health coverage because they may be working and covered by an employer’s health plan in addition to qualifying for Medicaid. In addition, children may qualify for Medicaid and also be included on a parent’s health plan provided by the parent’s employer or purchased directly by the parent from a private insurer. Third Party Liability (TPL) exists when a Medicaid recipient has health insurance coverage other than Medicaid. Third party coverage may be provided by a recipient’s own private insurer, an employer-sponsored insurer, or other federal insurance program such as Medicare. According to state regulations, if a Medicaid recipient has third party health insurance coverage, the Medicaid service provider must bill the recipient’s primary coverage before billing Medicaid. Service providers seeking Medicaid reimbursement for their services submit claims to the division. Claims are subjected to various system edits including checks for Medicare and other third party health insurance coverage. Medicaid uses the amount paid by Medicare and other third party coverage to reduce the amount that Medicaid owes the provider. This methodology known as “cost avoidance,” enables Medicaid to be the payer of last resort.
There are times when claims are paid by Medicaid without first being submitted to the primary health insurer. Because of this, the division contracts with a vendor to assist in identifying TPL and to seek reimbursement from Medicare or the other primary health insurers. The contractor is paid a fee for this service based on the amount recovered.

Conclusions

The division has controls to identify beneficiaries with comprehensive third party liability. However, the division needs to improve its process over reporting changes impacting beneficiaries that should disqualify them coverage in a Managed Care program. This would better ensure MCO compliance with cost avoidance procedures, ensure division compliance with managed care enrollment regulations, and minimize program costs.
Third Party Liability

Medicare and other private health insurers may pay for a substantial portion of the cost of health care services provided to beneficiaries with third party liability (TPL). Because of this comprehensive primary coverage, the division’s regulations prohibit most of these beneficiaries from enrollment in NJ FamilyCare or Medicaid managed care. Allowing their enrollment would make the division reliant on the managed care organization (MCO) to enforce cost avoidance requirements, and capitation premiums could result in overpaying for services.

Over 120,000 beneficiaries with comprehensive TPL coverage were properly denied managed care enrollment and were covered by the fee-for-service method. However, our review of the division’s June 2008 eligibility data files found:

- 2,800 Medicaid beneficiaries enrolled in managed care that also have comprehensive TPL coverage. They should have been disenrolled and placed in the Medicaid fee-for-service program. The Medicaid program paid $513,000 in capitation premiums for these beneficiaries for June 2008. If this result was consistent throughout the year, capitation premiums for these beneficiaries would have totaled $6.2 million (50 percent federal). The coverage change of these beneficiaries may result in cost savings, depending on the impact on capitation rate calculations and resulting fee-for-service costs.

- 1,150 beneficiaries with comprehensive TPL coverage that should have precluded them from enrollment in the NJ FamilyCare program. The capitation payments for these beneficiaries totaled $150,000 (50 percent federal) for June 2008. The removal of these beneficiaries may result in cost savings,
depending on the impact on capitation rate calculations.

Most third party liability information is obtained at the time of application or redetermination for Medicaid services. Various sources have the ability to update the TPL resource file. The division employs a vendor that actively looks for beneficiaries that have TPL and provides update information for entry into the Medicaid Management Information System (MMIS). However, there are no coordinated procedures that would process changes in eligibility resulting from TPL coverage so that the proper actions could be taken to disenroll these beneficiaries from the program.

**Recommendation**

The division should investigate the recipients enrolled in managed care that were identified in our review and change their coverage to Medicaid fee-for-service, or remove the beneficiary from NJ FamilyCare, where appropriate. In addition, the division needs to strengthen procedures to act upon changes in comprehensive third party liability coverage. These changes will ensure compliance with the TPL cost avoidance requirements, preclude unnecessary capitation payments, and streamline division oversight activities.

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**Duplicated Health Coverage**

The health and medical care provided under the Medicaid program is considered to be last resort benefits. Last resort benefits means that these programs only pay benefits after all other resources of funding are exhausted. The division, pursuant to N.J.A.C. 10:74-8.3 allows individuals already enrolled in, or covered by, either a Medicare or commercial MCO to also be covered by New Jersey Medicaid managed care as long as the two plans are with the same MCO. This
policy results in duplicate coverage and results in a managed care organization receiving two capitation payments for the same individual. Furthermore, this practice weakens the division’s monitoring controls by making them overly reliant on the MCO to ensure the proper allocation of medical costs to these two managed care plans and the MCO’s compliance with cost avoidance requirements. Our review of June 2008 files identified 3,700 beneficiaries that had been covered by the Medicaid Managed Care program and had other insurance with the same MCO. The Medicaid program paid monthly capitation premiums totaling $701,000 for these individuals. Disenrolling these individuals would minimize the efforts required by the division to ensure that MCO plans were properly following cost avoidance procedures. In addition to a more efficient process, the removal of these enrollees may result in some cost savings, depending on the impact on capitation rate calculations.

**Recommendation**

We recommend the division review and revise the contract with MCOs and the applicable regulations which would then enable the division to disallow individuals with duplicate coverage from being enrolled in or maintaining their managed care coverage with the Medicaid program.
April 22, 2009

Thomas R. Meseroll, Assistant State Auditor  
Office of Legislative Services  
Office of the State Auditor  
125 South Warren Street  
P O Box 067  
Trenton, NJ 08625-0067

Dear Mr. Meseroll:

This is in response to your letter of February 27, 2009 to Commissioner Velez concerning the Office of Legislative Services (OLS) draft audit report entitled “Department of Human Services Division of Medical Assistance and Health Services Managed Care Program Third Party Liability Medical Coverage.” The letter provides an opportunity to comment on the draft audit report.

The objective of the audit was to determine the propriety of enrolling beneficiaries with comprehensive third party liability coverage in the Managed Care program during the period July 1, 2007 through June 30, 2008. The auditor’s conclusion and recommendations and the Division of Medical Assistance and Health Services’ (DMAHS) responses are provided below:

Conclusion

The division has controls to identify beneficiaries with comprehensive third party liability. However, the division needs to improve its process over reporting changes impacting beneficiaries that should disqualify them coverage in a Managed Care program. This would better ensure MCO compliance with cost avoidance procedures, ensure division compliance with managed care enrollment regulations, and minimize program costs.

DMAHS continually strives to improve processes to provide timely, high quality medical care to eligible beneficiaries at the most economical cost. The processes related to eligibility determinations, managed care enrollment and third party liability are expansive and complex. A review of the available information

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indicates that improvements could be made to these processes as recommended in the audit report. Therefore, the auditor's conclusion appears reasonable. It should be noted that DMAHS does not believe these improvements are likely to provide current, material financial savings. However, these improvements will reduce the prospective risk of unnecessary expenditures and provide compliance with existing regulations.

Recommendations

1. The division should investigate the recipients enrolled in managed care that were identified in our review and change their coverage to Medicaid fee-for-service, or remove the beneficiary from NJ FamilyCare, where appropriate. In addition, the division needs to strengthen procedures to act upon changes in comprehensive third party liability coverage. These changes will ensure compliance with the third party liability (TPL) cost avoidance requirements, preclude unnecessary capitation payments, and streamline division oversight activities.

The beneficiaries identified by the auditors have either been placed in Medicaid fee-for-service coverage or disenrolled from NJ FamilyCare. DMAHS and the TPL vendor have implemented improvements in the applicable processes. The improvements include a monthly comparison of Managed Care enrollment with the TPL Resource File in order to identify beneficiaries who switched from fee-for-service coverage to managed care coverage subsequent to being identified with other comprehensive coverage. This comparison which coordinates and reviews all TPL updates regardless of source and includes updates made by the State and/or County generates a monthly disenrollment and termination report which is being processed on a monthly basis.

2. We recommend the division review and revise the contract with MCOs and the applicable regulations which would then enable the division to disallow individuals with duplicate coverage from being enrolled in or maintaining their managed care coverage with the Medicaid program.

DMAHS currently allows Medicaid MCO enrollment for beneficiaries with TPL coverage provided by the same organization because of the benefits of care management and coordination provided by a single medical home. The Division believes this allows the MCO to review and manage all services provided to the beneficiary regardless of the varied plan coverages or the payer. This MCO oversight is expected to reduce program expenditures through avoidance of unnecessary or duplicative procedures and through the delivery of coordinated preventative strategies and care.
As indicated by the auditor, the practice of providing Medicaid MCO enrollment to beneficiaries with other coverage results in the risk of potential unnecessary program costs and added oversight responsibilities for the Division. DMAHS will review the impact of this recommendation and determine if a change is appropriate considering the impact on beneficiaries, Division operations and the MCOs.

The professionalism and consideration of the audit staff is noteworthy and greatly appreciated. If you have any questions or require additional information, please contact me or David Lowenthal at 609-588-7933.

Sincerely,

John R. Guhl
Director

JRG:L
C: Jennifer Velez
   David Lowenthal