Department of Human Services
Division of Medical Assistance
and Health Services
Health Benefits Coordinator Contract
for the NJ FamilyCare Program

January 1, 2005 to December 31, 2007

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

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 the New Jersey FamilyCare Program for the period of January 1, 2005 to December 31, 2007. If you would like a personal briefing, please call me at (609) 292-3700.

Richard L. Fair  
State Auditor  
March 28, 2008
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Department of Human Services  
Division of Medical Assistance and Health Services  
Health Benefits Coordinator Contract for the NJ FamilyCare Program

Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services, Health Benefits Coordinator Contract for the NJ FamilyCare Program for the period January 1, 2005 through December 31, 2007. Payments to the vendor totaled $62.7 million for the audit period and are accounted for in the state’s General Fund. We did not test capitation payments made to managed care organizations for vendor enrolled participants. These payments were approximately $240 million for fiscal year 2007.

Objectives

The objectives of our audit were to determine whether payments to the vendor were reasonable, were related to the contracted services, and were in accordance with the contract, and to determine whether contract performance and compliance was achieved.

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 Department of the Treasury, and policies of the division. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our samples of case files. We also read the budget message, reviewed financial trends, and interviewed division personnel to obtain an understanding of the programs and the internal
controls.

A statistical and nonstatistical sampling approach was used. Our samples of case files were designed to provide conclusions about the vendor’s eligibility determinations as well as internal control and compliance attributes. Sample populations were sorted and case files were randomly and judgmentally selected for testing.

**Conclusions**

We found that the payments to the vendor were reasonable, were related to the contracted services, and were in accordance with the contract. However, we identified an issue of vendor noncompliance with contractual performance terms which was not effectively addressed by the division. In making these determinations, we noted a matter of noncompliance with a Department of the Treasury circular letter and an opportunity for program enhancement meriting management’s attention.
Background

NJ FamilyCare Program

NJ FamilyCare (NJFC) is a federal and state funded health insurance program created to help New Jersey’s uninsured children and certain low-income parents and guardians have affordable health coverage. NJFC 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 NJFC plans identified as Plans A, B, C, and D dependent upon the family’s income relative to the federal poverty level.

Health Benefits Coordinator Contract

The department contracts with a vendor to screen and process NJFC applications, make determinations of program eligibility, assess and collect premiums, provide outreach, provide marketing and education, and conduct and maintain enrollment with contracting managed care organizations in accordance with the program requirements of the Division of Medical Assistance and Health Services (division). The contract is for the period January 1, 2005 to June 30, 2008 which included a six month transition period from January 1, 2005 to June 30, 2005.

In October 2004, the division awarded the contract to the current vendor. Recognizing that the monitoring and administration of the previous contract lacked the tools and staff necessary to ensure compliance and proper contract performance, the division created the Office of Contract Compliance which was responsible for the oversight of the transition from the previous vendor as well as the administration and monitoring of the contract with the current vendor.
NJ FamilyCare Vendor Enrollment

During the course of our audit, the number of vendor enrolled beneficiaries decreased from approximately 170,000 in April 2007 to 140,000 in September 2007. The decrease was due mostly to the termination of approximately 30,000 beneficiaries in May, June, and August 2007 for their persistent noncompliance with program guidelines. These beneficiaries failed to pay their premiums for an extended period of time, failed to respond to repeated requests for missing information, or failed to submit a renewal application.

The following chart presents the NJFC 2007 Income Guidelines and the estimated number of participants enrolled in the program by the vendor as of September 2007. The federal poverty level for a family of four was $20,650 in 2007.

<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>62,000</td>
</tr>
<tr>
<td>Plan B 134 - 150% Poverty Level</td>
<td>No Premium</td>
<td>No Copay</td>
<td>15,500</td>
</tr>
<tr>
<td>Plan C 151 - 200% Poverty Level</td>
<td>$18 monthly per family</td>
<td>$5 - $10</td>
<td>35,000</td>
</tr>
<tr>
<td>Plan D 201 - 350% Poverty Level</td>
<td>$36 - $120.50 monthly per family</td>
<td>$5 - $35</td>
<td>28,200</td>
</tr>
</tbody>
</table>
Redetermination of Eligibility

NJ FamilyCare (NJFC) regulations state that eligibility must be redetermined every twelve months and the vendor’s contract requires that it perform renewals annually for all NJFC plans. As of September 2007, approximately 7,000 cases with 13,000 beneficiaries enrolled prior to 2005 were never sent a renewal application by the vendor. Transition meeting minutes and emails showed that both the division and the current vendor were aware of these 7,000 cases. Approximately 80 percent of the cases had a renewal date of July, August, or September 2005. The previous vendor should have sent a renewal application for these cases in April, May, and June 2005, respectively. To facilitate the transition, the division instructed the previous vendor not to send out these renewal applications with the expectation that the new vendor would move their renewal dates forward. We found no evidence that the renewal dates were moved forward. The division should have taken steps to ensure that these cases were renewed in a timely manner. Although some recipients would remain eligible, managed care premiums totaling $43.1 million were paid to provide coverage for these beneficiaries from July 2005 through September 2007 with $1.6 million being paid in September 2007.

A test of 66 of the 7,000 cases disclosed that 25 appeared to have enrollment issues. Based on recent wage data, 19 cases appeared to be ineligible and six appeared to be enrolled in the wrong plan. We were unable to assess the eligibility of the remaining 41 cases since complete wage data was unavailable.

In addition, we analyzed the encounter data and found that 5.6 percent of the 13,000 beneficiaries did not use any services from July 1, 2005 through September 30, 2007. Although it is
anticipated that not all beneficiaries will utilize services, without an annual redetermination this non-use of services could be an indicator that some of these beneficiaries were no longer eligible for the program for reasons such as excess income, obtaining other health coverage, or having moved out of state.

The division implemented a renewal plan in November 2007 to address these 7,000 cases by having the vendor adjust the renewal dates of the cases and distribute them equally over the period February 2008 through July 2008 to minimize the effect on the vendor’s workload.

We identified an additional 3,000 cases with 5,800 beneficiaries that had their eligibility renewed by the current vendor in either 2005 or 2006, but had potential issues with their subsequent year’s renewal due to defects within the vendor’s system. Our testing of 24 of the 3,000 cases disclosed that seven had 2006 or 2007 renewal dates that had passed without the vendor renewing eligibility and four of the seven appeared to be enrolled in the wrong plan based on current wage data. We were unable to assess the eligibility of the remaining three cases since complete wage data was unavailable.

**Recommendation**

We recommend the division monitor the vendor to ensure that all cases have their eligibility redetermined in accordance with NJFC regulations. Specifically, the division should monitor the renewal plan for the 7,000 cases to make certain the cases are properly redetermined. The division should also instruct the vendor to investigate the additional 3,000 cases with potential renewal issues identified in our report. Finally, the division should consider imposing sanctions on the vendor for failing to redetermine eligibility annually for all cases as required by the contract.
Unreported Income

A computer match of NJFC beneficiaries with state tax returns would detect unreported income.

Some beneficiaries are underreporting income on their NJ FamilyCare (NJFC) application such as income from self-employment and rentals, interest, and dividends. NJFC applicants are required to list all jobs and employers for each working person in their household as well as other non-work income on their application and are asked to send in proof of all income. The vendor reviews the documentation submitted and screens applicants against the state’s wage, disability, and unemployment databases to verify the income reported. These databases do not include income from self-employment and rentals, interest, or dividends. Although beneficiaries authorize the Division of Taxation to release their tax returns to the NJFC program when signing their application, the division does not currently perform a computer match of all beneficiaries with state tax files.

A computer match of all 86,600 cases with eligible participants as of April 2007 with state tax files resulted in 60,800 cases with at least one household member that filed a 2006 state tax return. We identified 6,781 unique cases with $10,000 or more in self-employment income on their 2006 state tax return. A test of 70 of these cases disclosed that 21 failed to indicate that they were self-employed on their NJFC application. Based on the income reported on their tax returns, 18 of these 21 cases appeared ineligible and two appeared to be enrolled in the wrong plan. In three of these cases, participants were determined eligible in 2006 because they failed to report self-employment incomes of $295,000, $186,000, and $177,700 per their 2006 state tax returns.

The same computer match identified 873 cases with $85,000 or more in gross income reported on their 2006 state tax return. A test of 24 of these cases disclosed that five had either self-employment income, rental income, interest
income, or dividend income that they failed to report on their application. Based on their tax returns, four of the five cases appeared ineligible and one appeared to be enrolled in the wrong plan. One case had eligible participants throughout 2006 despite unreported dividends of $137,000 and interest of $42,000 per their 2006 state tax return. Eligibility for the case continued despite the beneficiary failing to respond to the vendor's request for tax returns.

The above test of 24 cases also disclosed that 15 had net gains of more than $100,000 on their 2006 state tax return with three having more than $700,000. Additional analysis identified 441 cases with eligible participants as of April 2007 with net gains of $10,000 or more on their 2006 state tax return. Sixty-five of those cases had a net gain of more than $100,000 while the median net gain was $34,000. Without access to a computer match against state tax returns, an unreported net gain would most likely go undetected. In addition, program regulations are unclear and do not provide sufficient guidance on how a net gain should be considered when determining eligibility. Program regulations should be changed to provide the vendor with better guidance on how to consider net gains when determining eligibility.

Although the vendor followed program regulations when verifying income, it appears that regulations that were intended to simplify the application process have made it easier for a beneficiary to underreport income. The addition of a post-enrollment and a periodic computer match of beneficiaries with state tax returns would assist the division in identifying unreported income.

**Recommendation**

We recommend the division work with the Division of Taxation to perform both a post-enrollment and a periodic program-wide computer match of NJFC beneficiaries including all household members with state tax files to
identify unreported income that may have an effect on past and future eligibility determinations. In addition, the division should consider whether beneficiaries who failed to accurately report their income can be prosecuted under federal and state laws for providing false information or billed for health benefits costs incurred during the period they were determined ineligible. Finally, program regulations should be changed to provide the vendor with better guidance on how to consider net gains when determining eligibility.

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**Premiums Owed by Disenrolled Beneficiaries**

As of August 2007, a total of $4 million in premiums involving 16,300 disenrolled cases was owed to the division. These cases involved terminations for failing to pay their premiums for an extended period of time, failing to respond to repeated requests for missing information, or failing to submit a renewal application. The average amount owed per case was $247 with approximately 11,200 cases owing less than $250 and 487 cases owing $1,000 or more. Subsequent analysis disclosed that premiums owed by disenrolled cases increased to $4.6 million as of January 2008 with the number of cases increasing to 19,100. Once a case is disenrolled, the division makes no further collection efforts.

Treasury Circular Letter 06-03-OMB requires that non-tax debt be transferred to the Department of Treasury, Division of Revenue (DOR) for further collection efforts. The Division of Medical Assistance and Health Services has not yet turned over records to DOR.

**Recommendation**

The division should take steps to maximize collection of the $4.6 million and any future
premiums owed by disenrolled beneficiaries by transferring it to the Department of the Treasury, Division of Revenue for further collection efforts as required by Treasury Circular Letter 06-03-OMB.
March 20, 2008

Stephen M. Eells
Office of Legislative Services
Office of the State Auditor
125 South Warren Street
P.O. Box 067
Trenton, NJ 08625-0067

Dear Mr. Eells:

This is in response to your letter of March 6, 2008 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 (DMAHS), Health Benefits Coordinator (HBC) Contract for the NJ FamilyCare Program". Your letter provides an opportunity to comment on the audit report.

The conclusion of the audit is that the payments to the vendor were reasonable, were related to the contracted services, and were in accordance with the contract. However, the auditor identified an issue of vendor non-compliance with contractual performance terms which was not effectively addressed by the division. In making these determinations, the auditor noted a matter of noncompliance with a Department of the Treasury circular letter and an opportunity for program enhancement meriting management’s attention.

DMAHS does not concur with this conclusion. While the auditors did identify cases that were not sent a renewal application by the vendor, the Division and its Office of Contract Compliance (OCC) were aware, as mentioned in the audit report, of this vendor operational error and worked with the vendor to correct this situation in as timely a manner as the Division deemed possible.

The auditor’s findings and the Division’s responses are provided below:
FINDING 1:

NJ FamilyCare (NJFC) regulations state that eligibility must be redetermined every twelve months and the vendor's contract requires that it perform renewals annually for all NJFC plans. As of September 2007, approximately 7,000 cases with 13,000 beneficiaries enrolled prior to 2005 were never sent a renewal application by the vendor.

Transition meeting minutes and emails showed that both the division and the current vendor were aware of these 7,000 cases. Approximately 80 percent of the cases had a renewal date of July, August, or September 2005. The previous vendor should have sent a renewal application for these cases in April, May, and June 2005, respectively. To facilitate the transition, the division instructed the previous vendor not to send out these renewal applications with the expectation that the new vendor would move their renewal dates forward. We found no evidence that the renewal dates were moved forward. The division should have taken steps to ensure that these cases were renewed in a timely manner. Although some recipients would remain eligible, managed care premiums totaling $43.1 million were paid to provide coverage for these beneficiaries from July 2005 through September 2007 with $1.6 million being paid in September 2007.

A test of 66 of the 7,000 cases disclosed that 25 appeared to have enrollment issues. Based on recent wage data, 19 cases appeared to be ineligible and six appeared to be enrolled in the wrong plan. We were unable to assess the eligibility of the remaining 41 cases since complete wage data was unavailable.

In addition, we analyzed the encounter data and found that 5.6 percent of the 13,000 beneficiaries did not use any services from July 1, 2005 through September 30, 2007. Although it is anticipated that not all beneficiaries will utilize services, without an annual redetermination this non-use of services could be an indicator that some of these beneficiaries were no longer eligible for the program for reasons such as excess income, obtaining other health coverage, or having moved out of state.

The division implemented a renewal plan in November 2007 to address these 7,000 cases by having the vendor adjust the renewal dates of the cases and distribute them equally over the period February 2008 through July 2008 to minimize the effect on the vendor's workload.

We identified an additional 3,000 cases with 5,800 beneficiaries that had their eligibility renewed by the current vendor in either 2005 or 2006, but had potential issues with their subsequent year's renewal due to defects within the vendor's system. Our testing of 24 of the 3,000 cases disclosed that seven had 2006 or
2007 renewal dates that had passed without the vendor renewing eligibility and four of the seven appeared to be enrolled in the wrong plan based on current wage data. We were unable to assess the eligibility of the remaining three cases since complete wage data was unavailable.

RECOMMENDATION:

We recommend the division monitor the vendor to ensure that all cases have their eligibility redetermined in accordance with NJFC regulations. Specifically, the division should monitor the renewal plan for the 7,000 cases to make certain the cases are properly redetermined. The division should also instruct the vendor to investigate the additional 3,000 cases with potential renewal issues identified in our report. Finally, the division should consider imposing sanctions on the vendor for failing to redetermine eligibility annually for all cases as required by the contract.

DMAHS RESPONSE:

The Division created the OCC in 2004 with responsibility for the oversight of the transition from the previous HBC vendor to the new HBC vendor and the new vendor's continuing operations. The Office consists of staff who are experienced in the areas of Medicaid/NJ FamilyCare eligibility, monitoring and contract compliance. The OCC monitors the HBC vendor very closely and continually tests all of the vendor's operations to make sure they are in compliance with the contract terms and are providing a satisfactory level of service to our clients.

The transition from the previous HBC vendor to the present vendor was very difficult and required the transfer of large amounts of data from one electronic system to a completely different electronic system. This created processing backlogs which had to be addressed and questions about the integrity of the data received from the previous vendor. The Division's over-riding concern was to not negatively affect any of our clients by inappropriately disenrolling them due to either data integrity problems or processing delays. The Division through its OCC was aware of the approximately 7,000 cases that had not received renewal applications and decided to leave them on the NJ FamilyCare program until such time as pressing system problems were corrected. The Division believed that it would not be seriously impacted by leaving these clients enrolled in the Program because the majority of these cases would remain eligible.

The OCC also identified an anomaly in the vendor's system that caused it to occasionally miss a client's renewal date. We believe all of these 3,000 cases have been identified so that their renewal applications will be appropriately sent. We understand the problem in their system that caused this issue has been
corrected; however, the OCC has directed the vendor to periodically search its system in order to identify any other cases where a renewal date is inadvertently overlooked.

FINDING 2:

Some beneficiaries are underreporting income on their NJ FamilyCare (NJFC) application such as income from self-employment and rentals, interest, and dividends. NJFC applicants are required to list all jobs and employers for each working person in their household as well as other non-work income on their application and are asked to send in proof of all income. The vendor reviews the documentation submitted and screens applicants against the state's wage, disability, and unemployment databases to verify the income reported. These databases do not include income from self-employment and rentals, interest, or dividends. Although beneficiaries authorize the Division of Taxation to release their tax returns to the NJFC program when signing their application, the division does not currently perform a computer match of all beneficiaries with state tax files.

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Although the vendor followed program regulations when verifying income, it appears that regulations that were intended to simplify the application process have made it easier for a beneficiary to underreport income. The addition of a post-enrollment and a periodic computer match of beneficiaries with state tax returns would assist the division in identifying unreported income.

RECOMMENDATION:

We recommend the division work with the Division of Taxation to perform both a post-enrollment and a periodic program-wide computer match of NJFC beneficiaries including all household members with state tax files to identify unreported income that may have an effect on past and future eligibility determinations. In addition, the division should consider whether beneficiaries who failed to accurately report their income can be prosecuted under federal and state laws for providing false information or billed for health benefits costs incurred during the period they were determined ineligible. Finally, program regulations should be changed to provide the vendor with better guidance on how to consider net gains when determining eligibility.

DMAHS RESPONSE:

The Division concurs with this recommendation and is presently working with the Division of Taxation in order to implement this recommendation. The Division previously explored this with the Division of Taxation but at the time Medicaid/NJ FamilyCare applications did not provide applicant authorization to do this match, which is required by the Division of Taxation. The application has since been modified and we expect to implement this recommendation.

The OCC is presently reviewing the specific cases identified by the auditors to determine if the applicant failed to accurately report their income or did not report that they received self employment income. The applicant is asked to state on the application if they receive self-employment income and if so, they must submit appropriate tax returns with their application in order to be determined eligible. All cases that are deemed to have failed to accurately report their income or
misrepresented their status on an application will be sent to the DMAHS Bureau of Program Integrity for investigation.

The Division believes that the vendor has been properly following all program procedures in verifying income as noted in the audit report. The Division disagrees with the statement in the audit report that procedures relating to how to consider net gains in determining eligibility are unclear. The Division has reviewed the income determination procedures and does not intend to change them.

FINDING 3:

As of August 2007, a total of $4 million in premiums involving 16,300 disenrolled cases was owed to the division. These cases involved terminations for failing to pay their premiums for an extended period of time, failing to respond to repeated requests for missing information, or failing to submit a renewal application. The average amount owed per case was $247 with approximately 11,200 cases owing less than $250 and 487 cases owing $1,000 or more. Subsequent analysis disclosed that premiums owed by disenrolled cases increased to $4.6 million as of January 2008 with the number of cases increasing to 19,100. Once a case is disenrolled, the division makes no further collection efforts.

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RECOMMENDATION:

The division should take steps to maximize collection of the $4.6 million and any future premiums owed by disenrolled beneficiaries by transferring it to the Department of the Treasury, Division of Revenue for further collection efforts as required by Treasury Circular Letter 06-03-OMB.

DMAHS RESPONSE:

The Division concurs with this recommendation and intends to implement this procedure when DMAHS resources are available to process the information. The HBC vendor presently tracks all uncollected premiums owed by disenrolled clients and the client is required to pay these premiums before they can be reenrolled into a premium paying program. No other attempts are made at this time to collect these unpaid premiums.
The Division will continue to have the OCC closely monitor the HBC vendor's operations to ensure that all operations are performed according to the terms of the contract and provide our clients with a very high level of service. The Division intends to strengthen our income verification procedures through matches with the NJ Division of Taxation and other methods so only clients who truly meet the required income levels are allowed to participate in our Programs.

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

Sincerely,

[Signature]
John R. Guhl
Director

JRG:L

cc: Jennifer Velez
    David Lowenthal