



**New Jersey State Legislature  
Office of Legislative Services  
Office of the State Auditor**

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**Department of Human Services  
Division of Medical Assistance and Health Services  
and  
Office of the State Comptroller  
Medicaid Fraud Division**

**Medicaid Third Party Liability (TPL)  
Recovery Services**

July 1, 2010 to August 31, 2013

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**Stephen M. Eells  
State Auditor**

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New Jersey State Legislature

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Enclosed is our report on the audit of the Department of Human Services-Division of Medical Assistance and Health Services and Office of the State Comptroller - Medicaid Fraud Division, Medicaid Third Party Liability (TPL) Recovery Services for the period of July 1, 2010 to August 31, 2013. If you would like a personal briefing, please call me at (609) 847-3470.

A handwritten signature in black ink, appearing to read "Stephen M. Eells".

Stephen M. Eells  
State Auditor  
October 17, 2013

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### *Scope*

We have completed an audit of Medicaid Third Party Liability (TPL) Recovery Services for the period July 1, 2010 through August 31, 2013. The Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), has contracted with a vendor to obtain and update TPL information for Medicaid beneficiaries and to seek recovery of state medical costs from liable carriers on a post-payment basis. The contract term is January 1, 2008 through October 31, 2013, and includes five extensions. In June 2011, the Office of the State Comptroller, Medicaid Fraud Division (MFD) was assigned responsibility for managing the contract. Our audit included a review of the contract as well as vendor payments which totaled \$23.2 million for fiscal year 2012. The vendor is also responsible for audits of Medicaid providers under a section of the contract referred to as Recovery Audit Contract. This was excluded from our scope.

### *Objectives*

The objectives of our audit were to determine whether financial transactions were related to the TPL recovery process, were reasonable, and were properly recorded in the accounting systems. We also tested to determine that payments to the vendor were in compliance with the contract terms and whether the contract was properly monitored.

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 testing, we studied legislation, the administrative code, policies of the agency, and the TPL contract. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our review of contract payments. We interviewed MFD and DMAHS personnel as well as individuals employed by the vendor to obtain an understanding of the TPL recovery process.

A nonstatistical sampling approach was used. Our samples were designed to provide conclusions on the audit objectives, as well as compliance with contract provisions. Contract payments and tort cases were sorted and judgmentally selected for testing.

### ***Conclusions***

We found the financial transactions included in our testing were related to the TPL process and were recorded properly in the accounting systems. We did note however, financial transactions were not always reasonable, payments to the vendor were not always in compliance with the contract terms, and the contract was not always properly monitored. We noted the vendor billed for services that were not in compliance with the contract while the DMAHS and the MFD continually approved those invoices resulting in payments to the vendor totaling \$7.5 million for unbillable outcomes. A provision in the contract was waived, diminishing the state's ability to effectively monitor the vendor's recovery efforts. Furthermore, the vendor's performance in the legal settlement recovery process has been inadequate resulting in attorneys' complaints, inaccurate calculations of the Medicaid lien amount, and the DMAHS closing cases that were the responsibility of the vendor. Lastly, we determined that changes should be made to the future contract to include a flat fee for compensating the vendor for updates to the beneficiaries' TPL files which could result in significant cost savings.

### ***Background***

Third Party Liability (TPL) occurs when Medicaid beneficiaries have access to other health care coverage in addition to qualifying for Medicaid. According to state regulations, if a beneficiary has third party health insurance coverage, such as Medicare and private health insurance, the Medicaid service provider generally must bill the recipient's primary coverage before billing Medicaid. Federal and state regulations require the state to maintain a system to identify third parties that may be legally obligated to pay for medical services provided to Medicaid recipients. Since 1986, the DMAHS has contracted with the current vendor to identify and verify other health coverage of Medicaid beneficiaries and to recover Medicaid payments when third party coverage exists. In addition, the vendor updates beneficiaries' files to identify third party coverage. Recoveries of \$102 million and cost avoidance of \$402 million were reported in the Office of the State Comptroller's 2012 Annual Report. Based on information provided by the MFD, below is a chart which identifies the vendor's significant effort to the Medicaid program's third party recoveries and cost avoidance (in millions).

### **Medicaid Recoveries and Cost Avoidance for 2012**

#### **Vendor Services**

TPL Recoveries	\$ 71.8
Cost Avoidance	402.0
RAC and other Audit Recoveries	8.2
<b>Sub Total</b>	<b><u>\$482.0</u></b>

#### **Medicaid Fraud Division**

Recoveries and other Settlements	\$ 13.6
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#### **Other**

National Settlements	\$ 8.8
<b>Total</b>	<b><u>\$504.4</u></b>

## Third Party Liability Re-verification

**There is no provision that re-verification was intended to be a billable outcome under the contract.**

During the period July 1, 2010 through January 31, 2013, the vendor billed the state \$34.3 million for updating 565,428 Medicaid records identifying third party liability health coverage. These identifications enable the Medicaid program to cost avoid payments when other insurance resources are available to the beneficiaries.

According to the contract, Request for Proposal (RFP) Section 3.5, Identification and Verification of TPL Information, the contractor is to “identify and verify the existence of health insurance which has not been disclosed, identified, or utilized by clients...” Based on our review of the vendor’s monthly billing data, we determined the vendor billed for identifying TPL health coverage that had previously been identified. Our review noted that the vendor billed the division \$7.5 million for updating approximately 112,000 beneficiary records during their re-verification process, where no *new* health insurance coverage was identified. We found the vendor has billed for re-verification since 2008. The vendor invoiced these services using commodity codes associated with the identification of *new* TPL information. According to the contract, re-verification is a “normal follow-up to the update procedure, for the purpose of keeping the TPL data current and accurate; the vendor would re-verify beneficiaries’ updates that are older than 12 months.” There is no provision that these services were intended to be billable outcomes under the contract.

Updating existing TPL information would have been a billable service, if it led to the identification of *new* or *undisclosed* health insurance coverage. At that time, it becomes a *new* “identification”, which is billable and complies with the intent of the contract. The intent of the contract is further supported by the manner in which the contract fees are structured. The vendor is compensated based on an annualized cost savings/avoidance for identifying *new* TPL. However, when no *new* coverage is identified, there is no added benefit or cost savings. The Medicaid system would continue to deny all claims relating to the existing TPL coverage whether it was re-verified or not.

Furthermore, our review of the contract, RFP Section 4.4.6, Price Schedule, found descriptions and price listings for 51 types of TPL identifications and recovery fees permissible under the contract. The contract’s Price Schedule does not describe or list a unit price for the re-verification of TPL coverage that had previously been disclosed. If the re-verification of TPL information results in *new* or *undisclosed* health insurance, that *new* identification would be a billable service under the contract. All services covered under the contract must be listed under the “vendor’s services” section with the corresponding unit price. Proper monitoring of the contractor’s invoices could have disclosed these invalid charges.

### **Recommendation**

We recommend that the contract monitoring be improved to ensure billings are in agreement with contract terms. We further recommend that the practice of paying for updates when no new coverage is identified be discontinued.



### **Non-residents**

**The division needs to amend the contract through the Department of the Treasury, Division of Purchase and Property for all new services.**

In November 2011 the vendor began a new service of providing the DMAHS with data identifying New Jersey Medicaid beneficiaries who appear to be living in another state. It is then the responsibility of DMAHS staff to validate the information provided and confirm the non-resident status. If determined to be non-residents, the DMAHS will update the Medicaid eligibility files. During a 13-month period, the vendor billed \$563,000 for 5,600 Medicaid beneficiaries whose non-resident status was confirmed and validated by the DMAHS. It was noted that the vendor billed for the terminated beneficiaries at a fee similar to that of identifying/verifying new insurance coverage and updating beneficiaries' TPL files.

Although this service is beneficial, as it impacts a beneficiary's ability to continue to receive New Jersey Medicaid benefits, it is not defined under the TPL contract. The contract should have been amended to provide for this new service through the Department of the Treasury, Division of Purchase and Property and an appropriate fee determined that considered the work performed by the division's staff.

### **Recommendation**

We recommend the contract be properly amended when changes or modifications to the terms occur.



### **Reporting of Incomplete Recoveries by the Vendor**

**The reporting of incomplete recoveries is essential to the monitoring of recovery efforts by the vendor.**

According to the contract, RFP Section 3.6.7, Incomplete Recoveries, 180 days after a claim has been submitted to the state by the provider of service, the vendor shall submit an electronic report to the state contract manager identifying the status and follow-up activities for all cases for which recovery action has been initiated but not resolved. The contract also states the fees for recoveries made after the 180 days shall not be paid to the vendor unless the contract

manager authorized such payment based on the effort expended by the vendor. Our review found the vendor did not submit electronic reports to the division as required. DMAHS management stated this reporting requirement was waived when the contract went into effect on January 1, 2008. The division could not provide any documentation supporting the waiver. Furthermore, any changes in the scope of work to be performed by the vendor should have been approved by the Department of the Treasury, Division of Purchase and Property.

We obtained data from the vendor identifying the billing and collection efforts for the period July 1, 2009 through April 1, 2013. Based on this unaudited data, the vendor billed third parties for 12 million claims in the amount of \$1.3 billion and collected \$157.8 million. The schedule below summarizes the total claims that were billed by the vendor to third parties as open, paid, void, and denied, and the related collected amounts.

Claim Status	Number of Claims	Billed Amount	Collected Amount
Open	2,558,095	\$ 290,451,412	\$ 0
Paid	1,772,499	\$ 214,969,135	\$157,787,545
Void	119	\$ 41,666	\$ 0
Denied	7,679,251	\$ 750,609,381	\$ 13,134
<b>Total</b>	<b>12,009,964</b>	<b>\$1,256,071,594</b>	<b>\$157,800,679</b>

Of the 12 million claims billed to third parties, 7.7 million claims, totaling \$750.6 million were denied. The open claims represent those claims that have not been denied by the third parties and are unresolved. Claims are denied for multiple reasons and the vendor may rebill certain claims depending upon the explanation for the denial provided by the third party. A federal audit report issued in January 2013 by the Department of Health and Human Services, Office of Inspector General, cited challenges that states continue to face when recovering payments from third parties.

*“The most frequently cited longstanding challenge to recovering payments is denial from third parties for procedural reasons or with no explanation... Although third parties may legitimately deny claims (e.g., if the insurer did not cover the Medicaid beneficiary), denials for procedural reasons or with no explanation are not considered legitimate.”*

A separate vendor report which detailed denial codes, disclosed approximately 2 million claims totaling \$200 million were denied for what appeared to be procedural reasons. It is unclear what portion of these denied claims that were inappropriately denied by third parties were subsequently collected, or are eligible for collection. We also noted \$7.6 million of denials where the third party insurance stated that the claim was paid to the service provider, indicating the provider may have improperly billed and received reimbursements from both Medicaid and the insurance carrier.

As of May 2013, we noted 4.5 million open claims, totaling \$475.8 million, dating as far back as 2003 as summarized in the following schedule.

Calendar Year Billed	Number of Open Claims	Billed Amount (In millions)
2003	1,662	\$ 1.2
2004	33,305	\$ 4.6
2005	108,362	\$ 20.9
2006	796,592	\$ 47.5
2007	948,058	\$ 90.3
2008	144,039	\$ 24.9
2009	337,106	\$ 28.1
2010	204,080	\$ 37.3
2011	203,858	\$ 18.0
2012	991,935	\$120.9
2013	759,861	\$ 82.1
Total:	<u>4,528,858</u>	<u>\$475.8</u>

Furthermore, with 2.4 million open claims, totaling \$217.5 million, billed prior to 2010, the collectability of these claims and the effectiveness of the vendor's recovery efforts is not evident.

Proper monitoring of the contract would have required the vendor periodically submit reports detailing recovery efforts and the status of unresolved claims. Waiving the reporting provision in the contract restricted the state contract manager's ability to effectively monitor the vendor's collection efforts and investigate questionable claims.

**Recommendation**

The vendor should be required to provide periodic reports detailing recovery efforts. The contract manager should review these reports to determine whether adequate collection efforts are occurring. Any changes to the contract, specifically to the scope of work, should be approved by the Department of the Treasury, Division of Purchase and Property.



**Legal Settlements**

**The vendor needs to accurately determine Medicaid recovery amounts and respond in a timely manner to attorney inquiries.**

The vendor is responsible for pursuing TPL recoveries when Medicaid beneficiaries enter into legal settlements for tort cases. The vendor determines the recovery amount requested based on the paid Medicaid claims related to the incident. During the period July 1, 2009 through

December 31, 2012 the vendor was responsible for pursuing recoveries on 2,719 cases. We sampled 13 cases to determine the accuracy of the vendor's requested recovery amounts with the assistance of the DMAHS, Office of Legal and Regulatory Affairs (OLRA) and found all of the amounts were inaccurate. The vendor included claims that were not related to the incidents, resulting in recovery requests for six cases that were \$51,800 more than the actual Medicaid claims paid. Conversely, seven cases did not include all the Medicaid related claims, resulting in recovery requests that were \$325,800 lower than the actual Medicaid claims paid. Inaccuracies in the vendor's recovery amounts have been brought to the attention of the vendor, however, these inaccuracies still consistently occur. The vendor needs to accurately identify claims when determining the Medicaid recovery amounts so that the Medicaid program has the ability to recover the proper amount while allowing beneficiaries to receive an accurate settlement amount.

Pursuant to N.J.S.A. 30:4D-7.1b, prior to determining the Medicaid recovery amount, the vendor must deduct generally one-third from the total Medicaid recovery amount to reflect the pro-rata share of attorney fees for cases unrelated to certain motor vehicle or Workers' Compensation incidents. We reviewed four applicable cases and found two did not deduct the attorneys' share totaling \$38,600.

Although the vendor is responsible for the recoveries related to tort cases, many of these cases are referred to the OLRA for closing. This transfer of cases usually occurs because the OLRA was informed by outside sources, usually attorneys, that the vendor was non-responsive or acted untimely to attorney inquiries regarding the settlement of the cases. Complaints are received on a regular basis and several cases are closed by the OLRA. However, documentation as to the number closed by the unit was not maintained because the staff simply closed each case as the referrals were received. Once an inquiry is received from an attorney, it takes the OLRA approximately one to two days to provide the necessary information. Correspondence from attorneys document that the vendor took a period of three months to three years to respond to attorney inquiries. In one instance an attorney responded that they had been trying to resolve a case with the vendor for three years and when it was referred to the OLRA, it was immediately settled and \$84,000 was returned to the Medicaid program. In another instance, the vendor stated there was no money due back to the Medicaid program when \$13,000 was due back. These examples are indicative of the recurring issues that the OLRA is experiencing regarding the vendor. Although monthly meetings are held with the vendor to discuss these and other issues, the problems still persist.

### **Recommendation**

We recommend that the DMAHS monitor the vendor's legal settlement recovery process to determine if the vendor is responding timely to inquiries and accurately determining Medicaid lien amounts. The DMAHS should consider if the assessment of liquidated damages should be pursued in cases where the vendor did not respond timely and recoveries were lost. In addition, the DMAHS should consider placing a formal complaint with the Department of the Treasury, Division of Purchase and Property regarding the vendor's efforts.

## **Fees For Updating Beneficiaries' TPL Files**

**The new TPL Recovery Services Contract should utilize a flat fee for paying the vendor to update Medicaid beneficiaries' TPL files.**

During the period July 1, 2010, through January 31, 2013, the state paid the vendor \$32 million to update beneficiaries' files for TPL coverage. According to the contract terms, the vendor's fee for updating Medicaid beneficiaries' TPL files is determined by charging a percentage of an amount equal to the beneficiary's annualized monthly capitation rate. These rates are paid monthly by the Medicaid program to a Managed Care Organization for each beneficiary enrolled in the plan. The rates vary among beneficiaries based upon health risk factors. Currently, there are over 68 capitation rates used in determining the vendor's fees. These fees range from \$3.00 to \$581 per update of which 61.4% of the updates were charged a fee of \$28 or less. We estimate that had the vendor been paid a flat fee of \$28 per update, the state may have saved \$16 million for the period July 1, 2010 through January 31, 2013. Our review noted the state of New York has a contract with the same vendor and pays a flat fee to perform these updates. The methodology of using beneficiaries' health risk factors to determine the vendor's update fees is unreasonable. With the current contract set to expire on October 31, 2013 and a "Request for Proposal" (RFP) for a new contract to be issued, it would be in the state's best interest to include a flat fee for updating beneficiaries' TPL files and exclude the use of health risk factors as they are not related to the vendor's level of effort when performing these updates.

### **Recommendation**

We recommend that the new RFP include a reasonable flat fee for updating Medicaid beneficiaries TPL coverage.



## **Timeliness of Updating Beneficiaries' Files**

**TPL information provided by a Managed Care Organization was not updated timely.**

A Managed Care Organization (MCO) provided information to the Medicaid Fraud Division (MFD) to update Medicaid beneficiaries' files which they found had third party health insurance coverage. The MCO provided 11,973 records from December 5, 2011 through December 28, 2012 to the MFD for updating, of which 4,941 records had not been updated as of January 14, 2013. On average, this TPL information had been open for 186 days while 1063 records had been open more than 300 days. TPL information needs to be updated timely to ensure Medicaid claims are properly cost avoided when possible.

We sampled 38 of the 4,941 records and determined that 27 records still had not been updated as of July 23, 2013. The MFD will only update beneficiaries' TPL files when they are able to validate the information provided by the MCO. On August 12, 2013, we provided these 27 records to the MFD to determine whether updates were justified. Upon further review by the

MFD, they determined 5 records had changes related to Medicare coverage which are not updated by the MFD, 13 records had not been updated because of discrepancies in the MCO's data, and 9 beneficiary TPL files did need updating.

Discrepancies in MCO data included records that had previously been updated and records that lacked sufficient information for the MFD's validation process. This information was not communicated to the MCO.

**Recommendation**

We recommend that TPL information provided by the MCO be validated and updated timely. In addition, we recommend the MFD communicate with the MCO when TPL information cannot be validated.





*State of New Jersey*

**CHRIS CHRISTIE**  
*Governor*  
**KIM GUADAGNO**  
*Lt. Governor*

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**MARK ANDERSON**  
*Director*

September 30, 2013

Gregory Pica  
Assistant State Auditor  
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125 South Warren Street  
P.O. Box 067  
Trenton NJ 08625-0067

Dear Mr. Pica:

We are in receipt of the September 11, 2013, draft audit report of the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), and Office of the State Comptroller, Medicaid Fraud Division (MFD), Medicaid Third Party Liability (TPL) Recovery Services.

Thank you for the opportunity to comment on the draft report. For ease of reference, we have provided comments corresponding to each finding that is set forth in the report.

**Third Party Liability Re-Verification**

*Finding:* There is no provision that re-verification was intended to be a billable outcome under the contract.

*Response:* Re-verification was intended to be a billable outcome. This contract commenced in January 2008 and billings for the re-verification service provided by this vendor have been made since that time. While MFD was not involved in the drafting or procurement of this contract (MFD was not yet in existence at that time), DMAHS, which is the state agency that procured the service, has consistently stated that this service was intended by the parties to be a billable outcome under the contract. DMAHS has similarly informed us that re-verification was a billable outcome under the state's previous TPL contract as well, when this service was provided

by a different vendor. All of these factors are significant in terms of the proper interpretation of this contract under the law.

The process of re-verification is a beneficial one for the state because it enables the state to determine whether third-party insurance coverage is still in place for an individual or has been terminated. Resolving this issue on a periodic basis enhances the accuracy of the state's Medicaid records and avoids confusion that could affect the timely provision of medical services and payment for those services. Re-verifying third-party coverage specifically enables the state to avoid payment for medical expenses that instead are borne by the third-party insurer. For example, in the instances referred to in the audit report, re-verification allowed the state to avoid Medicaid costs that exceed the amounts paid to the vendor, rendering this service cost-effective to DMAHS as the agency making these vendor payments and other Medicaid expenditures.

In terms of the language of the TPL contract itself, we agree with the draft audit report insofar as the language of the contract is lacking in clarity. The audit team correctly notes that the term "re-verification" does not appear on the contract's price schedule. We would add that the term "verification" does not appear there either, and verification is a central component of this vendor's services. Instead, both of these services are to be billed under the schedule for "Identification." Although there could have been greater clarity in the contract language, the process being used is the one contemplated by DMAHS and the vendor as the contract parties, as confirmed by the vendor's bid documents that discuss the annual re-verification process. As a matter of law, those bid documents are part of the final contract between those parties. In short, the payments at issue were cost-effective and appropriate under the contract.

Having now been assigned the responsibility of contract manager for this contract, MFD will take steps to ensure that the contract terms are more clearly defined and specifically appear on the price schedule in the state's next TPL contract. As the audit report notes, the current contract expires on October 31, 2013.

### **Non-Residents**

*Finding:* The division needs to amend the contract through the Department of the Treasury, Division of Purchase and Property for all new services.

*Response:* This finding pertains to the service provided by the vendor to identify individuals who are participating in the New Jersey Medicaid program but are not eligible to do so because they reside in another state. This service already is encompassed by the TPL contract. For example, the third item in the price schedule itself references "Identifications – Blue Cross Blue Shield plans of other states." Similar language appears elsewhere in the contract. While, as noted above, the language of this lengthy contract could have been clearer, this service is encompassed by the contract and has provided the state with substantial cost savings. MFD will take steps to

ensure that this service and others are defined with greater precision in the new TPL contract to be completed later this year.

### **Reporting of Incomplete Recoveries by the Vendor**

*Finding:* The reporting of incomplete recoveries is essential to the monitoring of recovery efforts by the vendor.

*Response:* As the audit report notes, the contract provision at issue was waived by the state in January 2008, prior to any MFD involvement with this contract. MFD will take steps to ensure that the provision will be reinstated in the new TPL contract.

### **Legal Settlements**

*Finding:* The vendor needs to accurately determine Medicaid recovery amounts and timely respond to attorney inquiries.

*Response:* MFD has no response to this finding as this service is provided exclusively to DMAHS and MFD does not have oversight responsibilities concerning this aspect of the contract.

### **Fees for Updating Beneficiaries' TPL Files**

*Finding:* The new TPL Recovery Services Contract should utilize a flat fee for paying the vendor to update Medicaid beneficiaries' TPL files.

*Response:* MFD shares the goal of the audit team in seeking to achieve savings when this 2008 contract is re-bid later this year. We are in the process of determining the pricing system that will provide maximum cost savings to the state.


### **Timeliness of Updating Beneficiaries' Files**

*Finding:* TPL information provided by a Managed Care Organization was not updated timely.

*Response:* MFD acknowledges delays in our updating of TPL information, resulting in part from discrepancies in the data MFD received. As of the date of this letter, MFD has now updated all TPL information provided by the Managed Care Organization as referenced in the audit report. In addition, MFD has put procedures in place to ensure that going forward such TPL information

will continue to be updated in a more timely manner.

Very truly yours,



Mark Anderson  
Director, Medicaid Fraud Division

MA/dmd



CHRIS CHRISTIE  
*Governor*

KIM GUADAGNO  
*Lt. Governor*

**State of New Jersey**  
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September 30, 2013

JENNIFER VELEZ  
*Commissioner*

VALERIE HARR  
*Director*

Gregory Pica, Assistant State Auditor  
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Office of the State Auditor  
125 South Warren Street  
P O Box 067  
Trenton, NJ 08625-0067

Dear Mr. Pica:

This is in response to your letter of September 11, 2013 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, Medicaid Fraud Division, Medicaid Third Party Liability (TPL) Recovery Services**". Thank you for the opportunity to comment on the draft audit report.

In June 2011, the Office of the State Comptroller, Medicaid Fraud Division (MFD) assumed responsibility for managing the TPL contract as the State Contract Manager. The Division of Medical Assistance and Health Services (DMAHS) has only addressed the section in your draft audit report relating to "Legal Settlements" because oversight responsibilities for this work has remained with DMAHS. DMAHS has reviewed the September 30, 2013 letter to you from Mark Anderson, Director of the Medicaid Fraud Division, in which he addresses the other findings in your draft audit report. DMAHS concurs with his response.

**Legal Settlements:**

**Finding:**

*The vendor needs to accurately determine Medicaid recovery amounts and timely respond to attorney inquiries.*

**Response:**

DMAHS agrees that, in some cases, the vendor's claim amounts have been inaccurate. We have advised the vendor of our belief that one cause of this problem is the vendor's reliance on diagnosis codes. DMAHS has advised the vendor that it should be reviewing all claims for services rendered after the incident, and looking at all information on those claims, including but not limited to procedure codes and diagnosis codes. DMAHS has also recommended to the vendor that a nurse be utilized in determining which claims are tort or casualty-related. DMAHS will continue to pursue these recommendations with the vendor.

DMAHS agrees that, in many cases, the vendor has not deducted a pro rata share of counsel fees and costs as required by state statute. The reason for this is that the vendor was under the belief that it must receive a settlement sheet from the plaintiff's attorney in order to properly calculate the pro rata deduction. While the vendor is correct as far as calculating a pro rata deduction for costs is concerned, the settlement sheet is not necessary in order for the vendor to calculate the deduction for counsel fees. This is because the formula for calculating counsel fees in tort cases is contained in a Rule of Court. DMAHS has advised the vendor that, in the future, it must calculate a pro rata share of counsel fees based on the Rule of Court even when the plaintiff's attorney does not submit a settlement sheet to the vendor. If and when a settlement sheet is provided, the pro rata deduction for costs can be calculated and refunded to the plaintiff through the plaintiff's attorney.

DMAHS agrees that there have been delays by the vendor in responding to attorneys and that this continues to be a problem. DMAHS has had numerous discussions with the vendor about this, and the vendor has pledged to improve its performance in this regard. Although we continue to receive complaints from attorneys about vendor delays and non-responsiveness to inquiries, the vendor's representative in Texas does follow up on a timely basis when we bring these problems to her attention.

As indicated above, DMAHS has taken various corrective actions on the problems identified by the auditor. DMAHS will continue to monitor the situation and take further corrective action as needed. DMAHS also appreciates the recommendation for sanctions, and will consider using them if they are needed to remedy any continuing problems.

While DMAHS agrees that there have been some problems with the vendor relating to legal settlements, it should be noted that the vendor's tort and casualty recoveries have increased from \$3.3M in SFY 2010 to \$6.3M in SFY 2013, an increase of over 88%.

If you have any questions or require additional information, please contact me or Richard Hurd at 609-588-2550.

Sincerely,



Valerie Harr  
Director

VH:H  
c. Jennifer Velez  
Richard Hurd

## Auditor's Follow-up Response

The Medicaid Fraud Division response to our audit includes several comments that we believe require clarification.

### Third Party Liability Re-verifications

Per the contract, the vendor's re-verification process, as well as other services they are contractually required to perform, is a billable service as long as it results in the identification of **new, previously unknown, unutilized, or not disclosed** insurance coverage. The contract's basis for compensation is outcomes, not the vendor's performance of the required services and tasks.

The contract's Price Schedule refers to RFP Section 3.0 (Scope of Work) for task requirements and deliverables. According to this section, the contractor is to "identify and verify the existence of health insurance which has **not been disclosed, identified or utilized** by clients..." As noted, the vendor provides other services including the maintenance of a TPL call center. Compensation for these other services is included in the rates paid per the Price Schedule for the identification of *new* TPL coverage.

### Non-Residents

The service the finding is referring to is an eligibility issue and does not pertain to, nor should it be compensated as, a TPL service. None of the non-residents identified in the finding involved the identification of TPL, contrary to the agency's response. As an eligibility issue, the vendor does not verify the non-resident status. DMAHS verifies the information as well as terminates the eligibility file for non-residents. The vendor is not permitted to update Medicaid eligibility files.

As stated in our finding, the service of providing the DMAHS with data identifying non-resident Medicaid beneficiaries is beneficial. The contract should have been amended to provide for this service and an appropriate fee determined that considered the work performed by the vendor and DMAHS to update these files.