State of New Jersey
Commission of Investigation

CHARITY CARE

An Ailing System

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April 2007

Governor Jon S. Corzine
The President and Members of the Senate
The Speaker and Members of the General Assembly

The State Commission of Investigation, pursuant to N.J.S.A. 52:9M, herewith formally submits the final report of its investigation into the funding and oversight of New Jersey's Hospital Care Payment Assistance Program, also known as Charity Care.

Respectfully,

W. Cary Edwards
Chair

Joseph R. Mariniello, Jr.
Commissioner

Kathy Flicker
Commissioner

Patrick E. Hobbs
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Executive Summary

New Jersey maintains one of the nation's most generous hospital safety nets for the poor. Under the Hospital Care Payment Assistance Program, commonly called Charity Care, the state devotes more than half a billion dollars annually to inpatient and outpatient services for the uninsured and indigent. Despite the magnitude of this taxpayer-financed subsidy, borne evenly by the state and federal budgets, many of New Jersey's 80 acute-care hospitals remain in dire fiscal straits because Charity Care covers only a portion of the actual cost incurred in caring for thousands who turn up at their doors every year for treatment claiming no other means of support.[1] Amid this festering cost crisis, Charity Care's funding has been re-visited many times by legislators and policymakers. The most recent change came three years ago when the Legislature altered the fund-distribution formula, ostensibly to ensure that hospitals with the heaviest share of the Charity Care burden would receive the largest subsidies.

In 2006, the Commission launched an investigation into the fiscal and operational integrity of Charity Care and found that the program is losing tens of millions of dollars every year through waste, fraud and lack of oversight.

The Commission also found that while revisions to the formula may have been designed to bring equity to the distribution of funds, achievement of that goal has been frustrated by two major factors: one, the total pot of money available to hospitals under Charity Care – $583.4 million – has been frozen at that level since July 2004; and two, the intent of the formula has been circumvented, undermined and distorted by state

[1] Every hospital in New Jersey that fits the criteria of an acute-care institution is required by law to treat any resident of the state regardless of ability to pay. In such cases, the Charity Care program provides subsidies, at a reduced rate, solely for direct hospital costs related to treatment. N.J.S.A. 26:2H-18.59 et. seq.

budgetary language and by other budget-related provisions, including the award of millions of dollars worth of special discretionary grants each year to select hospitals.

The Commission's key findings include:

- The state has failed to recover tens of millions of dollars due to the failure to pursue claims that should have been paid by private insurance carriers, by proceeds from settlements of civil litigation, or by other supplemental health-care programs, such as Medicare and Medicaid. These losses will continue to mount absent aggressive corrective action.

- Charity Care is highly vulnerable to recipient fraud because the two state agencies that administer the program – the Department of Health and Senior Services (DHSS) and the Department of Human Services (DHS) – have no effective mechanism to detect such fraud and do not actively pursue credible complaints or suggestions of fraudulent activity in the program.

- The Commission itself investigated allegations of fraud, including tips that had been brought to the state's attention but lay dormant for months and even years, and identified approximately $1 million in medical services received by individuals who did not legally qualify for coverage under Charity Care.

- Language inserted in the state budget has skewed the Charity Care distribution formula since 2004, delivering financial assistance to hospitals without regard to the real costs incurred. The language enables certain hospitals that experience a drop in the dollar value of Charity Care services provided to reap beneficial subsidies while those with increased Charity Care costs face reductions– exactly the reverse of how the program is supposed to function.

- DHSS spends more than $2 million in taxpayer funds on personnel, computer equipment and other costs to calculate Charity Care distributions on an annual basis, but this costly exercise has been rendered all but irrelevant because the

formula is so regularly prone to outside interference and tinkering during the process of finalizing the state budget.

The Commission's findings come at a critical juncture for the Charity Care program, as well as for the hospitals and the genuinely needy patients it was designed to support. Acute-care hospitals across the state now provide more than $1 billion worth of care in this realm, and the cost continues to spiral even as the state, buffeted by its own serious fiscal problems, is struggling merely to maintain the status quo on subsidy payments. Under terms of the proposed state budget for Fiscal Year 2008 beginning July 1, overall Charity Care funding would, for the fourth consecutive year, remain frozen at $583.4 million. It has also been proposed that unrestricted hospital assistance grants, which totaled approximately $70 million in combined state and federal funds in FY2007, be eliminated.

Against this backdrop, the Commission, through this report, respectfully submits a number of recommendations for systemic reform designed to enable the Charity Care program to function effectively and as its framers intended.

At a minimum, the state should move immediately to identify and recover money from claims improperly or inappropriately billed to Charity Care and to equip the program with adequate safeguards against further fraud and abuse.

The Commission also recommends that Charity Care claims be subject to a broader regimen of routine audits, that all participating hospitals be required to utilize a uniform in-take application for prospective patients under the program and that DHSS strengthen the monitoring of Charity Care by establishing a centralized patient registry.

Finally, even under conditions of static funding at the state level, the Commission's findings plainly demonstrate that practical and effective steps need to be taken to "level the playing field" among eligible hospitals in the actual distribution of this limited revenue source. Indeed, the program was founded upon a statutory formula crafted to provide hospital-to-hospital equity. Because that formula has since been subjected to repeated administrative and budgetary adjustments, equity under the program has been thrown out of kilter, and efforts should be undertaken by the Legislature and Governor to restore proper equilibrium to it.

CHARITY CARE OVERVIEW

Since 1971, it has been statutorily mandated that New Jersey's acute-care hospitals provide medical care to patients in need regardless of ability to pay. In 2005**,** nearly 300,000 New Jersey residents received health-care services paid in whole or in part through Charity Care.[2] Over the years, myriad changes have been made to the Charity Care program, but the mission remains the same: to lessen the financial burden placed on hospitals because of the legal mandate to provide care to the state's most vulnerable.

In 1991, the New Jersey Legislature enacted the "Health Care Cost Reduction Act" (HCRA). The Legislature summarized the program in the following statement:

> *Access to quality health care shall not be denied to residents of this State because of their inability to pay for care; there are many residents of this State who cannot afford to pay for needed hospital care and in order to ensure that these persons have equal access to hospital care, it is necessary to provide disproportionate share hospitals with a charity care subsidy supported by a broad-based funding mechanism.*[3]

Under the program established by this statute, acute-care hospitals are compensated by the state for a portion of the Charity Care costs incurred. To determine the rate of compensation for hospitals, each must submit claims to the state annually showing all Charity Care cases that were treated that year. Funding for Charity Care is provided by the state budget as approved by the Legislature and the Governor. A level of

[2] This is the most recent data available from the State Department of Health and Senior Services.
[3] Disproportionate share hospitals are designated by the State as having a disproportionate share of low-income or uninsured patients.

funding is designated each year for the state's share of the subsidy, which is matched dollar-for-dollar by the federal government.

The way hospitals are reimbursed for Charity Care changed in July 2004 when legislation was signed altering the funding formula. The goal of this modification was to provide greater equity in the distribution of the funding so that hospitals with the heaviest load of Charity Care patients would receive the largest reimbursements. The new law also provided a substantial increase in the total pool of available Charity Care funding, boosting it from $381 million in FY2004 to $583.4 million in FY2005 to the present. The new formula ranks hospitals based on each hospital's share of the total number of Charity Care cases submitted to the State. That ranking determines the level of reimbursement each hospital receives. The reimbursements are based on the prevailing fee-for-service rate used under the federal/state Medicaid program. Hospitals that treat the greatest number of Charity Care patients qualify for a higher reimbursement rate equal to 96 cents on the dollar of the Medicaid-priced claim. The percentage then decreases on a sliding scale with the bottom-ranked hospitals receiving 43 cents on the dollar.

To qualify for Charity Care, a New Jersey resident must have no health insurance coverage or only partial coverage, be ineligible for private or government-sponsored plans such as Medicaid, and meet a set of income and asset eligibility criteria.[4] Under the 2006 income eligibility requirements, a person earning less than $19,600 a year would be eligible for 100 percent coverage of medical treatment he/she received through Charity

[4] Only bona fide American citizens, with certain exceptions, qualify for Medicaid. No such requirement exists for Charity Care.

Care. The threshold for individual assets cannot exceed $7,500, and total family assets cannot exceed $15,000 a year.[5]

Unlike Medicaid, for which a recipient receives a coverage identification card in advance of a hospital visit, Charity Care is applied for at the point of service and may be utilized for a period of up to one year after treatment at a given hospital.[6] Eligibility screening is initially conducted by hospital staff. In order to receive Charity Care, prospective patients must fill out a form providing detailed personal financial and health insurance information and submit proof of income and assets.[7] In addition, each form includes a certification the patient must sign attesting to the accuracy of the information provided and accepting responsibility and possible civil penalties if it is not accurate. Once the paperwork is submitted, it is up to hospitals to perform the basic due diligence. The Commission found that such follow-up work by hospitals is spotty and weak. In one specific incident, it consisted merely of a drive-by by hospital personnel to confirm the existence of an address provided by a prospective Charity Care patient.

The individual hospitals maintain Charity Care patient files and are responsible for transmitting claim information to the state Department of Human Services, which oversees claims processing for several New Jersey health-care programs. Critical operations for Charity Care are divided between Human Services and the Department of Health and Senior Services (DHSS), which has overall responsibility for administering the program. Once the claims are processed, the information is given to DHSS staff for use in calculating the annual Charity Care reimbursement to each hospital. While Human Services handles some administrative issues related to the claims, DHSS deals directly

[5] Asset eligibility rules exclude an applicant's or family's primary residence.
[6] A prospective Charity Care patient may complete the application process up to two years after treatment.
[7] In cases in which a patient is unable to fill out the form hospital personnel will do it.

with hospitals on most issues involving the program, and oversees the subsidy distribution, audits and reports.

Just as the Commission found weaknesses in the hospitals' performance of due diligence, investigators also discovered inadequacies in the process used to audit hospital Charity Care files. The Charity Care regulations allow for up to six auditor visits per year, but under the State's current oversight protocols, hospitals are only subjected to quarterly audits. Further, hospitals are given advance notice of the planned audits, and only a portion of the actual files are randomly selected. The scope of these audits, outlined in a contract between the state and an outside vendor that performs them, are limited to making sure the papers have been filled out and that required documentation has been attached. The scope of the audit does not include verification of the information or confirmation that the documents provided are authentic.

FAILURE TO RECOVER CLAIMS

The Commission found that the Charity Care program lacks any mechanism to identify and pursue claims that should have been paid by other health-care providers and, as a result, the State of New Jersey has missed the opportunity to recover tens of millions of dollars in the course of the past decade. The amount of money forfeited by the State in this regard continues to mount.[8]

In 1997, third-party recovery efforts were initiated for the Charity Care program when the Department of Human Services expanded an existing contract with a vendor already conducting recoveries for other state programs. While the initial work for Charity Care was done on a small scale, it demonstrated at the time that the State could net more than $2 million in claims inappropriately paid via Charity Care. These monies were pursued along the same lines as third-party recoveries performed for other government health-care programs, such as Medicaid.

At the time, the vendor estimated there was another $23.4 million of claims that remained unidentified and potentially available for recovery by the State. The vendor based this estimate on the assumption of a recovery rate of 7.8 percent of New Jersey's then-$300 million Charity Care budget. That projected recovery rate was based upon work conducted during a similar third-party claims recovery project for the Massachusetts Charity Care program and included both Medicare and commercial claims.

[8] Charity Care funding is equally divided between the Federal and State governments but any recovery of third-party claims would remain exclusively for use by the State.

These additional claims, however, were never pursued because in 2002 the State stopped further recovery efforts for Charity Care after DHSS officials concluded there was no regulatory or statutory basis for the recovery process that was being utilized. Confusion over the legality of the process persists to this day within the agencies that administer Charity Care. While the Charity Care statute does not specifically address the matter, similar third-party recovery actions are permitted by statute and regulation for other government health-care programs – such as Medicaid and the health insurance plan FamilyCare – that are administered by the Division of Medical Assistance and Health Services (DMAHS) in Human Services. These third-party recovery efforts are supervised by DMAHS' Bureau of Third-Party Liability, which was responsible for overseeing the Charity Care pilot projects done in the 1990s.

The Commission examined the full scope of the statutory underpinnings of the Charity Care program and could find no prohibition against third-party recovery in this realm and no formal legal opinion referencing any such prohibition.

A number of other factors were identified by the Commission that collectively contributed to the end of recovery of third-party claims for Charity Care. One disincentive for pursuing these claims was the burdensome task of recalculating each hospital's share of the subsidy after third-party monies were recovered. This effort would require reallocating Charity Care funds and distributing the money to the other hospitals. In addition, there were also concerns within the agencies that administer Charity Care about the State's obligation to pay the vendor a 15 percent contingency fee based on the number of claims that were ultimately recovered.[9] Ultimately, it was determined that the

[9] The vendor estimated the contingency would now be 9 percent because technology has brought efficiencies to the process of identifying the claims.

vendor costs were too steep compared to the amount of claims that were identified to be recovered and did not justify the expense of continuing the program.

Since the time of the vendor's 1997 estimate of $23.4 million of recoverable third-party claims, the amount of unclaimed monies has grown exponentially. The estimate, which included both Medicare and commercial claims, assumed a recovery rate of 7.8 percent of the then-$300 million Charity Care budget. By taking into account how the Charity Care budget has grown until reaching the current amount of $583.4 million in FY2005, the estimate of third-party claims not being recovered by the state each year has resulted in the forfeiture of tens of millions of dollars.

VULNERABILITY TO FRAUD

The Commission found that Charity Care is highly vulnerable to fraud by ineligible recipients because the State has no effective mechanism to detect fraud and does not actively pursue complaints regarding fraudulent activity in the program.

The Commission examined the disposition of 11 confidential tips regarding suspicious Charity Care claims between 2001-2006 that were received by the State and forwarded to DMAHS' Bureau of Program Integrity and found that no substantive action had been taken to investigate any of the allegations. Based upon its own investigation, the Commission found that nine involved fraudulent claims. Recipients in these nine instances collectively received more than $1 million in free medical services under Charity Care by failing to disclose their true financial condition at the time they applied for benefits. Besides constituting a rip-off of the Charity Care program, this activity had the added consequence of penalizing the hospitals because the services were reimbursed at a reduced Charity Care rate instead of the full price that should have been paid.

The Commission's investigation demonstrated how easily Charity Care benefits can be obtained with impunity by misrepresenting personal income and assets. When confronted by Commission investigators about having engaged in what clearly appears to have been fraudulent Charity Care activity, one recipient stated: "The hospitals make it too easy."

In the most egregious case in terms of dollars obtained under false pretenses, Commission investigators determined an Ocean County man received more than $340,000 in Charity Care medical services after failing to disclose an ownership interest

in real estate other than his home.

Similarly, a Monmouth County woman received more than $110,000 worth of medical services paid for by the Charity Care program by hiding the fact that she and her husband owned a valuable piece of commercial real estate. A few months after receiving the medical services in question, the property sold for $850,000. She has since moved out of the state.

In another case, a Bergen County man received $267,215 in free medical services by failing to disclose $2,100 in monthly rental income from the three-family home he inherited.

In some instances, applicants told hospitals outright lies when asked about income eligibility. The owner of a limousine company, for example, received more than $88,000 in medical treatment from a Morris County hospital paid by Charity Care by claiming that he was indigent. Confronted by Commission investigators, the man broke down emotionally, admitted he had lied on his application, and voluntarily produced documentation indicating he was earning $119,000 in annual income from his business at the time he applied for Charity Care.

Other ineligible recipients devised false identities to procure free medical services. A Hudson County man who operated a fabric importing business in New York City obtained free medical services through the Charity Care system for himself, his wife, and three of his children. Commission investigators determined that not only was he ineligible for the program on personal income grounds but that during the time he and his family were receiving Charity Care he purchased a home in Jersey City for $226,000 in cash. The Commission was able to confirm the family received $20,000 in free medical

services but the actual figure may have been higher because the complete array of pseudonyms they used when applying for Charity Care could not be determined by Commission investigators.

In each case where Commission investigators had an opportunity to question the Charity Care recipients concerning the false representations made on their Charity Care application, the recipients readily admitted doing so and offered to pay restitution.

The Commission found that these cases were not pursued because an effective mechanism for investigating fraud was never established for Charity Care. DHSS is not equipped with a fraud unit and simply refers tips about potentially fraudulent activity in the Charity Care program to DMAHS' Bureau of Program Integrity. Once the information arrives at the bureau, the Commission found that, at best, only cursory efforts, such as basic phone calls, are made to pursue credible suggestions of fraud. DMAHS managers told Commission investigators that this perfunctory follow-up was the best that could be done because they did not have the authority or funding to conduct more comprehensive investigations involving Charity Care. Despite the fact that the bureau was already conducting extensive investigatory activities for other programs housed in DMAHS, such as Medicaid, governmental inertia has persisted regarding fraud investigations for Charity Care. In order to aggressively pursue fraud, Medicaid investigators are authorized to use powerful investigatory tools, such as the ability to issue subpoenas and to impose liens. No such apparatus was ever set up for Charity Care and as a result, little has been done to detect fraud or pursue reports of fraudulent activity.

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CHARITY CARE FORMULA MANIPULATION

Charity Care funds are allocated to individual acute-care hospitals through a formula that is designed to be weighted based upon the number of indigent patients treated in a given year. The program was crafted so that hospitals are reimbursed at a rate consistent with the Charity Care costs they incur. The Commission, however, found that the formula has been subjected over the years to arbitrary manipulation even to the point, at times, of being completely bypassed despite statutory provisions intended to provide more equitable distribution of limited funds.

The first major change to the distribution formula beyond the confines of the statute or regulation occurred in the mid-1990s when a new component was added that gave teaching hospitals a disproportionate share of funding. The change coincided with the federal government's decision in late 1996 to eliminate additional funding for teaching hospitals. Previously, the federal government had provided New Jersey's 41 teaching hospitals with an additional financial boost via "Graduate Medical Education" (GME) and "Indirect Medical Education" (IME) subsidies that were designed to compensate them for the extra cost of operating an educational facility. Concurrent with the elimination of this federal benefit, the State added its own GME and IME components to the Charity Care funding formula in a manner similar to the federal government's components and codified that change in state regulations. However**,** an extra step in calculating the GME component was added to the mix outside the formal regulatory structure, the net effect of which was to increase the amount of money delivered to the teaching hospitals. DHSS documents indicate that since FY2004, this non-statutory

change has inflated by approximately $120 million each year the amount teaching hospitals could use as a basis for calculating Charity Care reimbursements.

In 2004, recognizing that inequities had cropped up in the Charity Care distributions, the Legislature amended the statute governing the formula to make payment distribution among urban and suburban hospitals more equitable and to guarantee that all acute-care hospitals received at least some level of reimbursement. However, the intent was quickly undermined by budget language. Facing a fiscal crunch and a limited pool of available funding, language was inserted into the FY2005 budget that required the distribution to be calculated using Charity Care data dating back three years to 2002. In each subsequent year, the budget language has imposed that same requirement.

The FY2005 State of New Jersey Appropriations handbook at page B-78 contains the following language regarding the Charity Care program:

> *Notwithstanding any provision of law to the contrary, in fiscal year 2005 reimbursed documented Charity Care shall be priced at the Medicaid rate for calendar year 2002 as published by the Department of Health and Senior Services in September 2003; except that the total amount distributed in fiscal year 2005 shall not exceed $583,400,000 . . .*

The FY2006 and FY2007 budgets each contained the following language:

> *Notwithstanding any provision of law to the contrary . . . in fiscal year 2006 [2007] Charity Care payments to hospitals shall be made in the same amounts as fiscal year 2005 [2006].*

A consequence of this language is that the Charity Care distribution no longer provides equitable reimbursements to hospitals. By using data that is several years old to

calculate the current subsidies, the payments do not necessarily reflect the growth of Charity Care services provided at each hospital.

A Commission analysis of DHSS data compared the reimbursement that hospitals should have received based on the statutorily-mandated formula using documented Charity Care from the immediate prior year to what the hospitals actually received based on the 2002 data. The analysis showed that the use of that data resulted in the award of boosted Charity Care reimbursements to certain hospitals where the actual costs warranted lower subsidies. On the other hand, certain hospitals that did experience growth in documented Charity Care saw reductions in their reimbursements.

For example, between FY2005 and FY2007 University Hospital-UMDNJ received $50.5 million less than it was entitled to receive based on actual Charity Care costs; St. Joseph's Hospital and Medical Center received $50.4 million less; Cooper Hospital/University MC received $33.5 million less; Kennedy Hospitals/UMC received $13.5 million less; and Bergen Regional Medical Center received $12.1 less.[10]

One by-product of this formula manipulation has been to render largely irrelevant a portion of the work done by a DHSS unit whose bureaucratic mission includes determining each hospital's share of Charity Care funding on an annual basis. Each year, this unit utilizes computers and special software programs to calculate Charity Care distributions based on the statutory formula. The cost of personnel and technology to fund this effort is roughly half of the unit's $5 million budget. In the past three years, however, this unit has learned after each State budget took effect on July 1 that its calculations were superseded by budget language.

[10] See Appendix at page A-1 for a chart showing the effect of budgetary language on reimbursements for all of New Jersey acute-care hospitals from FY 2005 to FY 2007.

Concurrent with budget decisions made annually on the magnitude of the total pool of Charity Care funding, and the language governing its distribution, the Legislature also makes the determination on whether to appropriate separate financial assistance grants to some hospitals. These grants, which are grouped in a single line item in the state budget, involved approximately $35 million in state money combined with an equal amount of matching federal funds in FY2007. In some cases, the grants were used to make up for losses in Charity Care funding**.** For example, between FY2005 and FY2007, the State budget provided University Hospital-UMDNJ with $15.2 million in hospital assistance grants; St. Joseph's Hospital and Medical Center received $35.1 million; Cooper Hospital/University MC received $17 million and Bergen Regional Medical Center received $7.6 million.[11] Separately, select hospitals also received approximately $77 million in direct state services and community development grants during FY2007.

[11] These hospital assistance grants, funded at approximately $70 million in state and matching federal funds in FY2007, have been targeted for elimination in the budget proposal for FY2008.

Referrals and Recommendations

The Commission refers the findings of this investigation to the following government agencies for whatever action they deem appropriate:

- The Governor and Legislature of New Jersey
- The Office of the New Jersey Attorney General
- The New Jersey Department of Health and Senior Services
- The New Jersey Department of Human Services
- The United States Attorney for the District of New Jersey

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Given the full scope of structural weaknesses, administrative deficiencies and policy problems that routinely subject New Jersey's Charity Care program to real and potential waste, fraud and abuse, the Commission makes the following recommendations for systemic reform:

1. PURSUE THIRD-PARTY RECOVERY OF CHARITY CARE CLAIMS

The State's ongoing failure to hold third-party health insurers and other responsible parties accountable for claims that should never have been paid through Charity Care has produced huge and unacceptable budgetary losses of tens of millions of dollars each year at taxpayer expense. Bureaucratic confusion aside, there should be no doubt as to Charity Care's standing under Title 19 of the federal Social Security Act as a program authorized to recover claims that should

have been paid by other programs or private insurance companies based on federal documents reviewed by the Commission. Also, there should be no impediment to the State's ability to recalculate and redistribute any recovered monies to hospitals. To remove any real or perceived obstacles to the recovery of third-party claims, the Commission recommends promulgation of statutory language amending the existing Charity Care statute and relevant regulations as follows:

- Eliminate any ambiguity or question regarding Charity Care's status as a Title 19 program.
- Require the Division of Medical Assistance and Health Services in Human Services' Bureau of Third Party Liability to conduct the recovery of third-party Charity Care claims, just as it does with such claims under Medicaid.
- Allocate recovered-claim money to the Charity Care fund for distribution as an additional subsidy to hospitals in accordance with the 2004 statutory amendments to the Charity Care formula.

2. ESTABLISH AN EFFECTIVE MECHANISM TO INVESTIGATE CHARITY CARE FRAUD

The findings of this investigation demonstrate that Charity Care in New Jersey is highly vulnerable to fraud and other forms of programmatic abuse. Despite that fact, the statute governing Charity Care statute lacks proper and appropriate language to enable effective investigation of suspicious claims. As a result, Charity Care cases referred to the DMAHS' Bureau of Program Integrity

for investigation either lay dormant or are closed without substantive follow-up. Thus, the Commission recommends promulgation of language to amend the existing Charity Care statute and relevant regulations as follows:

- Require the DMAHS' Bureau of Program Integrity (BPI) to investigate Charity Care claims.[12]
- Provide the BPI with the same powers to investigate Charity Care claims that it has to investigate claims for other health-care programs administered by the State, including, but not be limited to, authority to issue subpoenas and certificates of debt (liens). Charity Care investigators should also be granted access to the same databases used to verify income, assets and eligibility under Medicaid.[13]
- Amend the Charity Care statute to adopt penalties under the state Medicaid statute for defrauding a health-care benefit program, with $2,000/per false claim civil fraud penalty applicable to recipient fraud as a minimum penalty.[14]
- Establish a confidential telephone or e-mail hotline for use by informants to provide information regarding suspicious Charity Care claims. Currently, there is no organized mechanism for presenting or evaluating such tips.

[12] An alternative to this recommendation would be to create a stand alone unit to investigate Charity Care claims instead of using the BPI. However, the Commission questions whether the creation of a separate investigatory unit would be cost effective.

[13] Administrators of New Jersey's Medicaid program, under contract with a private vendor, can electronically verify the financial eligibility of applicants by examining wage and benefit data maintained by the state Department of Labor.

[14] Consideration should be given to implementing this recommendation so it does not conflict with the existing treble damage civil penalty for false statements made by persons seeking to obtain Charity Care. See *N.J.A.C. 10:52-11.12 and N.J.S.A. 26:2H-18.63*

3. EXPAND THE SCOPE OF CHARITY CARE CLAIM AUDITS

Charity Care is susceptible to fraud and abuse, despite the State's existing mechanism for auditing claims. Under current rules, these are pre-scheduled "desk audits" that simply require auditors to determine whether Charity Care eligibility files contain proper paperwork with no inquiry into the authenticity of the information regardless of how suspect it may be. As a result, the Commission recommends that:

- Future contracts between DMAHS and outside health-care auditing firms should require referral of claims deemed suspicious by auditors to the agency's Bureau of Public Integrity for further investigation.
- The frequency of the audits should be increased to six times a year and audits should be unannounced instead of giving hospitals five-day advance notice per current practice.
- A cost analysis should be performed and consideration given to having auditors conduct random income verification of eligibility files as a regular part of the claim audits to confirm the accuracy of representations made by prospective recipients concerning income and assets.

4. ISSUE DISTINCTIVE NUMBERS TO CHARITY CARE RECIPIENTS FOR USE IN A CENTRALIZED ELECTRONIC REGISTRY

The decentralized manner in which Charity Care eligibility applications are taken and kept at the hospital level renders the program vulnerable to abuse in several respects. DHSS officials agreed that many people who rely on Charity

Care may not have, or are not able to produce, proof that they possess a valid social security number that could be used to verify eligibility and track the care they receive. Issuance of distinctive numbers to Charity Care recipients for use in a centralized electronic registry similar to the registries currently used in other state-administered health-care programs would benefit patients and provide program administrators with improved capabilities in all facets of the program's operation, including bolstering the State's ability to detect fraud and abuse by tracking claims more accurately. Under the current system, recipients can deter tracking of claims via minor changes to names, addresses and dates of birth. The ability to recover third-party claims would also be enhanced through the maintenance of a central registry. Patient identifiers could be developed in the same manner that is used in other programs administered by the State. This data would assist DMAHS' Bureau of Third Party Liability in identifying other health-care coverage for prospective Charity Care recipients, as well as the recovery of those claims. Specifically, the Commission recommends:

- A feasibility study on the issuance of distinctive numbers to Charity Care recipients for use in a centralized registry to determine whether it would be practical and cost-effective.
- Creation of a uniform Charity Care application form, as necessary, to insure that all hospitals collect the same information from applicants for the registry.

5. CONSIDER THE IMPACT OF BUDGETARY LANGUAGE ON CHARITY CARE SUBSIDY DISTRIBUTIONS

The Commission's findings illustrate how the insertion of certain budgetary language has affected the Charity Care subsidy distribution since Fiscal Year 2005 and the unintended consequences of this intrusion into the statutory and regulatory scheme in terms of real dollars gained or lost for various hospitals. As a result, the Commission recommends that consideration be given to returning to the statutory blueprint for future distributions, and, in the event this may not be fiscally feasible, that the development of an entirely new system of subsidizing hospitals for the Charity Care burden be considered.

APPENDIX

WINNERS AND LOSERS

SCHEDULE OF THE EFFECT OF STATE BUDGET LANGUAGE ON HOSPITAL CHARITY CARE SUBSIDIES
FOR FY2005 to FY2007
(Bracketed Amounts Indicate Loss)

HOSPITAL NAME	SFY2005 Effect of Budgetary Language On Subsidy	SFY2006 Effect of Budgetary Language On Subsidy	SFY2007 Effect of Budgetary Language On Subsidy	Net Effect of 3 Years Budgetary Language On Subsidy
Newark Beth Israel Medical Center	$ 18,196,482	$ 14,940,327	$ 6,101,890	$ 39,238,700
St. Michaels Medical Center (1)	3,081,118	684,991	15,879,432	19,645,542
Raritan Bay Medical Center (2)	5,294,888	3,691,909	5,029,200	14,015,997
St. Mary Hospital - Hoboken	2,138,876	4,757,000	2,783,383	9,679,259
Hackensack University Medical Center	1,906,037	5,130,451	2,630,463	9,666,952
Atlanticare Regional MC - City	2,910,236	2,616,289	3,078,270	8,604,795
East Orange General Hospital	(2,339,657)	3,987,213	5,223,713	6,871,269
Trinitas Hospital	2,741,013	3,664,800	313,037	6,718,849
PBI Regional Medical Center (3)	1,071,275	1,847,994	3,066,983	5,986,252
Monmouth Medical Center	2,149,909	3,153,644	1,037,294	6,340,847
Barnert Hospital	852,321	2,020,110	2,812,424	5,684,854
Our Lady of Lourdes Medical Center	873,871	2,346,932	2,426,543	5,647,347
St. Barnabas Medical Center	2,572,171	2,240,721	828,450	5,641,342
Deborah Heart and Lung Center	1,154,605	1,470,726	2,996,601	5,621,933
Hospital Center @ Orange (Closed 1/04)	920,522	1,880,212	2,192,972	4,993,707
Irvington General Hospital (Closed 1/06)	954,927	1,695,888	2,094,885	4,745,701
Kimball Medical Center	1,791,376	1,986,504	617,352	4,395,232
Bayonne Medical Center	776,921	1,048,095	1,662,171	3,487,187
Atlanticare Regional MC - Mainland	2,691,019	(207,764)	524,341	3,007,595
Clara Maass Medical Center	1,286,235	940,029	670,144	2,896,408
CentraState Medical Center	1,035,386	807,451	900,289	2,743,126
Morristown Memorial Hospital	192,466	985,167	1,332,484	2,510,118
Columbus Hospital	(332,103)	791,440	1,993,249	2,452,587
Englewood Hospital and Medical Center	(248,918)	981,287	1,262,040	1,994,409
Newton Memorial Hospital	1,243,545	(129,437)	735,523	1,849,632
Robert Wood Johnson University Hospital	1,647,475	1,155,679	(957,565)	1,845,588
St. Joseph's Wayne Hospital	561,521	661,264	601,469	1,824,253
Greenville Hospital	450,280	407,216	899,000	1,756,497
St. Francis Medical Center	(709,586)	969,135	888,270	1,147,819
St. Clare's Hospital - Denville	(4,276,056)	1,485,345	3,936,972	1,146,261
West Hudson Hospital (Closed 1/04)	25,351	510,221	552,678	1,088,249
Mountainside Hospital	336,392	353,589	315,885	1,005,866
Union Hospital	353,522	309,932	197,492	860,946

WINNERS AND LOSERS

SCHEDULE OF THE EFFECT OF STATE BUDGET LANGUAGE ON HOSPITAL CHARITY CARE SUBSIDIES
FOR FY2005 to FY2007
(Bracketed Amounts Indicate Loss)

HOSPITAL NAME	SFY2005 Effect of Budgetary Language On Subsidy	SFY2006 Effect of Budgetary Language On Subsidy	SFY2007 Effect of Budgetary Language On Subsidy	Net Effect of 3 Years Budgetary Language On Subsidy
Riverview Medical Center	184,725	122,533	438,124	745,383
Ocean Medical Center	123,564	248,185	242,600	614,349
Burdette Tomlin Memorial Hospital	235,681	218,225	90,556	544,462
Holy Name Hospital	179,278	133,481	229,754	542,513
Pascack Valley Hospital	230,189	65,916	234,541	530,646
Warren Hospital	35,057	441,955	29,062	506,074
Valley Hospital	285,732	30,643	137,664	454,039
Bayshore Community Hospital	265,450	116,505	54,692	436,648
Underwood Memorial Hospital	176,579	111,558	97,569	385,706
RWJ University Hospital at Rahway	262,781	44,272	27,752	334,806
Capital Health System at Fuld	241,054	(112,761)	188,263	316,557
Hackettstown Regional Medical Center	108,902	80,646	125,593	315,141
RWJ University Hospital at Hamilton	179,839	11,182	95,188	286,209
St. Clare's Hospital - Sussex	48,783	81,786	106,887	237,455
Overlook Hospital	(103,477)	35,407	268,244	200,174
Shore Memorial Hospital	108,586	154,466	(65,261)	197,791
Southern Ocean County Hospital	201,187	(92,422)	30,205	138,970
Hunterdon Medical Center	240,041	(7,204)	(141,181)	91,657
Community Medical Center	247,934	(85,627)	(131,516)	30,791
William B. Kessler Memorial Hospital	(11,030)	50,389	(19,632)	19,727
South Jersey Hospital - Elmer	(38,165)	(6,853)	(17,835)	(62,854)
Meadowlands Hospital Medical Center	163,889	(145,900)	(122,605)	(104,617)
Christ Hospital	(1,436,373)	(93,593)	1,385,191	(144,775)
St. Peter's University Hospital	(181,582)	(224,041)	109,605	(296,018)
St. Mary's Hospital - Passaic	(274,598)	(382,901)	344,433	(313,066)
Chilton Memorial Hospital	(188,131)	(139,297)	(170,976)	(498,404)
Muhlenberg Regional Medical Center	(225,009)	471,368	(1,020,722)	(774,363)
Palisades Medical Center	43,219	(638,988)	(503,908)	(1,099,677)
Jersey Shore University Medical Center	(628,837)	(545,372)	(29,519)	(1,203,727)
University Medical Center at Princeton	(287,058)	(596,611)	(589,974)	(1,473,644)

WINNERS AND LOSERS

SCHEDULE OF THE EFFECT OF STATE BUDGET LANGUAGE ON HOSPITAL CHARITY CARE SUBSIDIES
FOR FY2005 to FY2007
(Bracketed Amounts Indicate Loss)

HOSPITAL NAME	SFY2005 Effect of Budgetary Language On Subsidy	SFY2006 Effect of Budgetary Language On Subsidy	SFY2007 Effect of Budgetary Language On Subsidy	Net Effect of 3 Years Budgetary Language On Subsidy
JFK Medical Center/Anthony M Yelensics	197,487	(540,446)	(1,192,724)	(1,535,683)
Virtua-Mem. Hospital of Burlington County	203,231	(881,753)	(925,649)	(1,604,171)
Memorial Hospital of Salem County	(336,542)	(776,213)	(1,176,729)	(2,289,484)
Virtua-West Jersey Health System (4)	22,471	(1,334,085)	(1,298,672)	(2,610,285)
Capital Health System at Mercer	(1,493,592)	(764,372)	(606,573)	(2,864,538)
Somerset Medical Center	(1,095,534)	(861,324)	(1,410,292)	(3,367,151)
St. Clare's Hospital - Dover	(817,587)	(465,076)	(2,643,984)	(3,926,646)
Lourdes Medical Center of Burlington Cty	(1,405,746)	(1,161,960)	(1,576,994)	(4,144,700)
South Jersey Healthcare Regional M C	(1,507,796)	(1,385,187)	(3,140,978)	(6,033,962)
Jersey City Medical Center	(671,051)	(1,814,044)	(5,092,914)	(7,578,010)
Bergen Regional Medical Center	(1,735,902)	(6,286,659)	(4,124,211)	(12,146,773)
Kennedy Hospitals/UMC (5)	(2,953,758)	(5,009,205)	(5,557,539)	(13,520,502)
Cooper Hospital/University MC	(1,703,934)	(12,969,519)	(18,803,084)	(33,476,537)
St. Joseph's Hospital and Medical Center	(21,908,414)	(16,063,415)	(12,435,175)	(50,407,004)
University Hospital - UMDNJ	(16,284,961)	(18,218,053)	(16,064,610)	(50,567,625)

Information provided by Department of Health and Senior Services.
Positive numbers in the schedule reflect additions created by budgetary language to the subsidies hospitals would have received pursuant to the formula.
(Negative numbers) in the schedule reflect reductions created by budgetary language to the subsidies hospitals would have received pursuant to the formula.
Only 78 entities are identified in this schedule due to the consolidated reporting referenced below.
(1) Saint Michael's Medical Center & Saint James Hospital combined.
(2) Raritan Bay Medical Center - Old Bridge and Perth Amboy Facilities combined.
(3) PBI Regional MC was the result of a hybrid merger, closure and relocation with Passaic General & Passaic Beth Israel. Passaic Beth Israel was considered the closed hospital which resulted in its subsidy being reallocated.
(4) Virtua West Jersey Health System combined with Berlin; Marlton & Voorhees facilities.
(5) Kennedy Hospitals combined with Cherry Hill; Stratford and Washington Township facilities.
Note: Closed hospital reallocations have not been included or simulated.