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

Department of Human Services
Division of Medical Assistance
and Health Services
Eligibility Determination

July 1, 2004 to December 31, 2006

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, Eligibility Determination for the period of July 1, 2004 to December 31, 2006. If you would like a personal briefing, please call me at (609) 292-3700.

Richard L. Fair  
State Auditor  
April 3, 2007
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Department of Human Services
Division of Medical Assistance and Health Services
Eligibility Determination

Scope

We have completed an audit of Eligibility Determinations at the Department of Human Services, Division of Medical Assistance and Health Services (the division) for the period July 1, 2004 to December 31, 2006. The scope of the audit was limited to the Medicaid eligibility process being performed by the county boards of social services on behalf of the division.

Objectives

Our audit objective was to evaluate whether the division provided effective assistance to the county boards of social services to improve program performance by reducing error rates in their Medicaid eligibility determinations and redeterminations. We also tested for resolution of significant issues pertaining to Medicaid eligibility noted in our prior Third Party Liability Process audit report dated August 13, 2003.

Methodology

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.

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 State Comptroller, and policies of the agency. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our samples of eligibility determinations. We also read the budget message, reviewed financial trends, and interviewed agency personnel to obtain an understanding of the programs and the internal controls.
A nonstatistical sampling approach was used. We tested recipient files at the following five counties: Atlantic, Bergen, Camden, Hudson, and Ocean. Our samples of recipients were designed to provide conclusions about the propriety of eligibility determinations as well as internal control and compliance attributes. Sample populations were sorted and recipients were judgmentally selected based on risk.

**Background**

The division administers the State’s Medicaid program, which provides medical assistance to individuals and families based on their income and/or asset levels. Annual expenditures for the program are $5 billion while servicing 800,000 recipients. To obtain Medicaid benefits, prospective recipients must apply for benefits with the various counties. A recipient, once deemed eligible, must recertify eligibility every twelve months or sooner if the recipient’s circumstances have changed. The division also administers a computerized Medicaid Management Information System (MMIS), which maintains information involving Medicaid, Medicare and third party liability (TPL) coverage. The division has the responsibility of balancing the need for timely medical access while also ensuring only eligible applicants receive benefits. Because of the complexity of the Medicaid eligibility process, the various Medicaid program types, and reliance on the 21 individual county boards of social services making these determinations; division oversight and monitoring is essential to ensure eligibility is correctly determined, and when necessary, corrections are made.
Conclusions

We found that the division did not provide effective assistance to the county boards of social services to improve program performance by reducing error rates in their Medicaid eligibility determinations and redeterminations. In making this determination, we noted certain internal control weaknesses and matters of compliance with regulations meriting management’s attention. We also found the agency has not completely resolved the significant issues noted in our prior report involving accurate social security numbers and third party liability. These issues have been restated in our current report.

Monitoring and Oversight of Eligibility Determination

County workers generally make correct eligibility determinations from available information at the time an application is received. However, employee errors, limited staffing and resources, and not obtaining critical information can significantly affect proper determination of an applicant’s eligibility and ultimately impact program costs. The division does not have a formal oversight mechanism in place to assist in accurate initial eligibility determinations and timely redeterminations.

Financial Eligibility Determinations

The New Jersey Administrative Code (N.J.A.C.) states that income and resource limitations must be met for an individual to be eligible for a Medicaid program. Our sample of 189 Medicaid recipients from five different counties found that 25 recipients had income above the limits for the programs in which they were enrolled. The income was verified by copies of pay stubs and/or information on the New Jersey Department of Labor Wage Reporting System (WRS). Five other recipients had resources above the limit for the aged program. Although the financial resources were disclosed in the case
files, their impact on eligibility was not properly investigated. As a result, the division wrongfully paid $525,000 for these 30 ineligible individuals.

**Redeterminations**

We also tested 149 recipients for timely redeterminations and found 45 recipients were not redetermined within the 12 month period as required by N.J.A.C. regulations.

<table>
<thead>
<tr>
<th>Months Late</th>
<th>Number of Recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 3</td>
<td>11</td>
</tr>
<tr>
<td>4 to 6</td>
<td>7</td>
</tr>
<tr>
<td>7-12</td>
<td>11</td>
</tr>
<tr>
<td>13 to 24</td>
<td>9</td>
</tr>
<tr>
<td>over 24</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>45</strong></td>
</tr>
</tbody>
</table>

The division does not have a functional mechanism to monitor compliance with performing timely redeterminations.

**Case Information**

Recipient files were tested for verification of personal information such as social security number, birth certificate, New Jersey residency, citizenship, and other medical insurance coverage. This information is needed to verify proper eligibility and possible cost avoidance for recipients with other insurance. We found the following exceptions.
<table>
<thead>
<tr>
<th>Documentation Tested</th>
<th>Number of Recipients</th>
<th>Missing from File</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security Number</td>
<td>210</td>
<td>20</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>211</td>
<td>22</td>
</tr>
<tr>
<td>New Jersey Resident</td>
<td>156</td>
<td>2</td>
</tr>
<tr>
<td>US Citizenship or approved VISA</td>
<td>209</td>
<td>10</td>
</tr>
<tr>
<td>Other Health Insurance</td>
<td>166</td>
<td>4</td>
</tr>
</tbody>
</table>

We noted that the recipient file organization at each of the five counties we visited differs. A uniform file organization would aid in assuring file completeness and ease in recipient file monitoring.

**Recommendation**

The division should develop procedures to assist counties in obtaining and analyzing financial information to identify ineligible recipients, and to assist the division in verifying that the counties are performing proper initial and subsequent financial eligibility determinations.

In an effort to monitor compliance and assist counties in doing redeterminations efficiently, the division's MMIS should be expanded to track and verify that redeterminations are performed timely and violations of the 12-month requirement be "flagged" and appropriate follow-up action be taken. The division should also research the possibility of performing redeterminations over the phone or another type of web based system. Lastly, the division should develop and encourage the counties to utilize a uniform file organization and a checklist of necessary recipient information.
The division should monitor that counties are investigating IEVS information.

Income and Eligibility Verification System (IEVS)

Because misreported income and/or resources leads to errors in eligibility and benefit determinations, Congress established the Income and Eligibility Verification System (IEVS). IEVS is an exchange of information between State and Federal agencies to verify income and other financial resources needed to determine eligibility. The U.S. Code of Federal Regulations Title 7, Section 272.8 requires that all IEVS information be investigated. The division does not monitor whether the counties are investigating all IEVS information. Although this information is received electronically by the state, the counties are given printed reports. The format of these reports does not allow for efficient review by the county; nor is there an efficient reporting mechanism to the division on any action taken. As a result, there is a backlog of unreviewed IEVS information at the counties and a 12-month delay in recording the results.

Also, when the counties determine a recipient ineligible, they request a report of claims for the period of ineligibility from a contracted vendor. The counties collect and remit reimbursed amounts to the division. The division then returns 25 percent of the collections back to the county that made the collections. During our review $57.5 million of ineligible claims was identified and $6.8 million was recovered. The division does not know the status of the unrecovered claims. The division has not established formal policies and procedures for monitoring the county collection efforts. The division is unaware whether all the funds collected by the counties are remitted to the division. We found one county instructed that reimbursement checks be made payable to the county instead of the "Treasurer, State of the New Jersey" as required.
Additionally, the division has expanded the role of the third party liability (TPL) contract vendor to supply the counties with a summary of ineligible recipient claims determined through the IEVS match. A recovery fee of approximately 10 percent is paid for this service. The division pays the TPL vendor its fee after receiving the reimbursements. The vendor was paid $660,000 for this expanded service from July 2004 to October 2006. Expanding the contract to include this additional service is questionable. This function could have easily been performed by a division employee at a fraction of the cost utilizing information currently available to the division.

### Various IEVS Information from 7/1/04 to 10/31/06

<table>
<thead>
<tr>
<th>County</th>
<th>Ineligible Claims</th>
<th>Recovered Amount</th>
<th>County Share</th>
<th>Vendor Fee</th>
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<tbody>
<tr>
<td>Atlantic</td>
<td>$7,031,908.01</td>
<td>$716,090.89</td>
<td>$179,022.72</td>
<td>$69,460.82</td>
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<tr>
<td>Bergen</td>
<td>$10,176,779.48</td>
<td>$1,511,981.15</td>
<td>$377,995.29</td>
<td>$146,662.17</td>
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<tr>
<td>Burlington</td>
<td>$5,336,355.59</td>
<td>$780,044.44</td>
<td>$195,011.11</td>
<td>$75,664.31</td>
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<tr>
<td>Camden</td>
<td>$4,117,931.17</td>
<td>$220,554.31</td>
<td>$55,138.58</td>
<td>$21,393.77</td>
</tr>
<tr>
<td>Cape May</td>
<td>$865,241.26</td>
<td>$29,140.74</td>
<td>$7,285.18</td>
<td>$2,826.65</td>
</tr>
<tr>
<td>Cumberland</td>
<td>$322,910.63</td>
<td>$13,083.32</td>
<td>$3,270.83</td>
<td>$1,269.08</td>
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<tr>
<td>Essex</td>
<td>$369,157.84</td>
<td>$82,430.72</td>
<td>$20,607.68</td>
<td>$7,985.78</td>
</tr>
<tr>
<td>Gloucester</td>
<td>$15,084.65</td>
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<td>$0.00</td>
<td>$0.00</td>
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<tr>
<td>Hudson</td>
<td>$446,897.73</td>
<td>$51,423.74</td>
<td>$12,855.93</td>
<td>$4,988.10</td>
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<tr>
<td>Hunterdon</td>
<td>$79,291.08</td>
<td>$904.68</td>
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<td>$87.75</td>
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<tr>
<td>Mercer</td>
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<td>$163,316.08</td>
<td>$40,829.02</td>
<td>$15,841.66</td>
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<tr>
<td>Middlesex</td>
<td>$1,342,424.43</td>
<td>$406,616.66</td>
<td>$101,054.16</td>
<td>$39,441.82</td>
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<tr>
<td>Monmouth</td>
<td>$5,326,040.34</td>
<td>$6,000</td>
<td>$1,500</td>
<td>$582.00</td>
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<tr>
<td>Morris</td>
<td>$336,624.57</td>
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<td>$350</td>
<td>$135.80</td>
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<tr>
<td>Ocean</td>
<td>$7,875,812.37</td>
<td>$1,059,998.46</td>
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<td>$102,818.78</td>
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<tr>
<td>Passaic</td>
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<td>$1,110,893.00</td>
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<tr>
<td>Salem</td>
<td>$78,050.17</td>
<td>$0.00</td>
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<tr>
<td>Somerset</td>
<td>$3,567,125.36</td>
<td>$447,346.28</td>
<td>$111,836.56</td>
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<tr>
<td>Sussex</td>
<td>$829,522.35</td>
<td>$219,607.19</td>
<td>$54,901.80</td>
<td>$21,301.90</td>
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<tr>
<td>Union</td>
<td>$1,243,512.99</td>
<td>$14,089.40</td>
<td>$3,522.35</td>
<td>$1,366.67</td>
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<tr>
<td>Warren</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**Total**: $57,521,121.76, $6,834,910.02, $1,708,727.51, $662,986.27
**Recommendations**

The division needs to pursue a computerized database of the IEVS information, which could be electronically submitted to the counties, so it can be efficiently analyzed, investigated, and actions reported by the counties and subsequently tracked by the division.

The division should also establish formal policies and procedures for monitoring the status of county collection efforts involving ineligible claims.

We also recommend that the division discontinue utilizing the service of a vendor to provide the counties with claim information on ineligible recipients. A division employee should supply this information from currently available data.

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**Invalid Social Security Numbers**

Social security number matches are used to research the financial eligibility of Medicaid recipients and their coverage by other health insurance. Invalid social security numbers recorded on MMIS negate the effectiveness of this process. The U.S. Code of Federal Regulations Title 42, Section 435.910 requires, as a condition of eligibility, that each individual requesting Medicaid services furnish his or her social security number to the state. The division does not require the recipient to produce a social security card, nor does it verify the accuracy of the social security number with the Social Security Administration. We analyzed the current Medicaid eligibility file and found more than 50,000 fictitious or duplicate social security numbers for recipients who were over three years of age. We found that of 133 recipients who had fictitious or duplicate social security numbers on MMIS 67 had valid social security cards in their case file.
**Recommendation**

The division should verify the accuracy of all social security numbers and require a hard copy of the social security card during the intake process to enhance the accuracy of posting to MMIS. The division should also supply the county intake units with the ability to verify the accuracy of social security numbers.

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**Third Party Liability**

Third party liability (TPL) exists when a Medicaid claim is paid for a Medicaid recipient who has health insurance coverage other than Medicaid. According to state regulations, if a Medicaid recipient has third party health insurance coverage, such as Medicare or private health insurance, the service provider must bill the recipient’s primary coverage before billing Medicaid. Service providers seeking Medicaid reimbursement for their services submit claims to the division. Claims are subjected to various Medicaid system (MMIS) edits including checks for Medicare and other third party health insurance coverage. Medicaid uses the amount paid by Medicare and other third party coverage to reduce the amount that Medicaid owes the provider. This methodology known as “cost avoidance” enables Medicaid to be the payer of last resort.

However, there are times when claims are paid by Medicaid without first being submitted to a primary health insurer. Because of this, the division contracts with a vendor to assist in identifying TPL and to seek reimbursement from Medicare and other primary health insurers. The contractor is paid a recovery fee for this service based on the amount reimbursed.

As noted in our prior report the division was not updating MMIS files when it was notified of
other insurance by the vendor. The division has made improvements, but still did not update 341 of the 918 cases (37 percent) we sampled from information identified in calendar year 2002. We also sampled recipient files identified by the vendor during the first quarter of calendar year 2006 and found that the division did not update 39 of the 100 cases tested. By not updating the MMIS files, future claims will continue to be paid first by Medicaid and when recoveries are discovered the vendor will be paid a recovery fee. During the first quarter of 2006, $30,000 in fees were paid on recoveries for recipients previously identified as having other insurance.

In a separate review, we identified 336 state employees on Medicaid and noted that 50 percent (169) did not have their state provided health insurance reflected on MMIS. Medicaid paid over $2 million for these 336 State employees, most of which was for managed care premiums. These managed care premiums, although redundant costs, are not for specific services and would not be recoverable from the TPL vendor.

**Recommendation**

As stated in our prior audit report, the division should update the MMIS files as soon as other health insurance coverage is known so claims can be avoided. The division should also develop procedures designed to ensure that recipients promptly and accurately report any changes in health insurance coverage. Furthermore, the division should consider switching recipients who have other health insurance coverage from a managed care to a fee-for-service type program. By doing so, redundant premium costs could be eliminated.
April 2, 2007

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

Dear Mr. Meseroll:

This is in response to your letter of March 6, 2007 to Acting Commissioner Velez concerning the Office of Legislative Services (OLS) draft audit report entitled “Department of Human Services, Division of Medical Assistance and Health Services, Eligibility Determination.” The letter provides an opportunity to comment on the audit report.

The draft audit report concludes that the division did not adequately provide an effective oversight of eligibility determinations made in accordance with Federal and State Medicaid eligibility requirements.

The Division of Medical Assistance and Health Services (DMAHS) is not able to concur with this conclusion. While the auditors have identified errors in some cases, it appears the review work may be insufficient and too narrowly focused to support the stated conclusion. The conclusion is based on a judgmental sample that appears inadequate in comparison to the overall population of Medicaid and related programs. It is not clear that program complexities and eligibility variations were appropriately considered. Likewise, the draft report does not reflect the numerous policies, procedures and activities currently employed to address this concern.

The DMAHS and related organizations expend substantial resources to perform accurate eligibility determinations. However, resource limitations can impact the effectiveness of these operations and should also be considered in the audit report. While enhanced oversight can be expected to improve outcomes, the additional costs may not be a prudent use of scarce resources. Please note that these eligibility determination functions have previously been approved by the federal government since errors identified through approved statistical sampling methods have been within acceptable tolerances.
DMAHS has corrected some of the errors identified and implemented corrective actions. Because of the number of items and issues referenced in the audit report and the limited time to respond, we have not completed our review. We will continue to address the contents of the audit report and the specific errors identified. These efforts are explained further in the following responses to the recommendations contained in the draft audit report.

The draft audit report recommends:

The division should develop procedures to assist counties in obtaining and analyzing financial information to identify ineligible recipients, and to assist the division in verifying that the counties are performing proper initial and subsequent financial eligibility determinations.

In an effort to monitor compliance and assist the counties in doing redeterminations efficiently, the division’s MMIS should be expanded to track and verify that the redeterminations are performed timely and violations of the 12-month requirement be “flagged” and appropriate follow-up action be taken. The division should also research the possibility of performing redeterminations over the phone or another type of web based system. Lastly, the division should develop and encourage the counties to utilize a uniform file organization and a checklist of necessary recipient information.

The Division understands and takes very seriously the importance of eligibility determinations of New Jersey’s most vulnerable citizens. The incorrect processing of a recipient could mean the difference between coverage and no coverage for a fragile child or senior citizen. The Medicaid program’s overall cost of over $9 billion this year represent New Jersey’s share along with the Federal government’s share for over 900,000 of our recipients. Every twelve months and sometimes more often, based upon the associated program our recipient is enrolled in, eligibility for benefits must be verified or redetermined. This process of eligibility redetermination is completed hundreds of thousands of times per year through the work performed at the 21 County Boards of Social Services (CBOSS) offices.

To this end, based upon the sheer number of times redetermination is completed, there are errors made in this process. It is a very delicate balancing act between ensuring the Federal and/or State governments do not spend any more than is correct and appropriate for a recipient but also ensuring someone is not taken off a program without just cause. And in fact, based upon this audit, 30 recipients were deemed eligible when they should have been ineligible. To date, 15 of these 30 recipients were terminated from the program while two remain in the program when they reimbursed the State a total of $31,399.11. The remaining 13 are currently being re-evaluated by the respective Boards of Social Services.
Timely redetermination of recipients within the required 12 month period is the ultimate goal. However, various factors influence the way the County Boards of Social Services have achieved these results. Personnel changeover, training for new employees and also employees that have been working cases for some time, along with receiving, analyzing and instituting proper guidance make up a portion of the mix of performance distracters. The Division has assisted one county as an example at least six days in the past six months with training, review of cases and assisting in clean up a backlog of cases.

The overall role of the Division is to have a functional mechanism in place to monitor compliance with the eligibility determination process. There are currently some oversight control methods in place with additional enhancements being completed to further aid this compliance issue. Additionally, there are new items in development as discussed herein.

One method to monitor compliance is The Medicaid Eligibility Quality Control System (MEQC). This process has been operational since the early 1980’s, per federal regulations at 42 CFR 431.800. During SFY 2006, the MEQC staff, with CMS approval, conducted a Medicaid pilot project in which 850 CBOSS case records were inspected and evaluated to determine the impact that reduced documentation or continuous eligibility policies adopted July 2005 had on the eligibility determination process. In addition to pursuing the primary project objective, secondary objectives, including identifying ineligible recipients, overdue redeterminations and bringing attention to missing cases were accomplished and the CBOSS notified to take corrective action on a case-by-case basis. For FFY 2007 the MEQC unit, with CMS approval has returned to conducting traditional quality control reviews with the sample size for the period being 1,200 cases. The traditional review is inherently comprehensive and includes case record analysis, recipient contact, verification of each eligibility element and an independent determination.

The Division must also participate in the Payment Error Rate Measurement (PERM) activities, beginning FFY 2007, in connection with the Improper Payments Information Act of 2002, and federal regulations at 42 CFR 431.950. A component of PERM requires eligibility audits to be conducted on several samples consisting of Medicaid records from all of the Medicaid/SCHIP certifying agencies/entities within the state. The total sample size for this FFY is about 1,400 cases. To expedite the redetermination processing by CBOSS staff, the following corrective actions are being taken this calendar year:

1. A number of Medicaid Eligibility System (MES) generated monthly reports are already sent to the CBOSS, including two that identify recipients who are due for redetermination or are overdue for redetermination. The redetermination reports are being modified to identify each case by supervisor and worker codes. The State will meet with all CBOSS Directors to address the use of the redetermination screens that are available in the Medicaid Eligibility System.
2. The Division is developing and will soon implement a new automated Medicaid eligibility determination software product called Universal Application Process (UAP) to replace the manual procedure used by the CBOSS. UAP features include the capability to capture, compile, extrapolate and report eligibility record information more efficiently than current practices. This will not capture the information for the ABD population and doesn’t need to since it is within the ability of the Medicaid Eligibility System.

Inadequate case information has been cited in this audit on select individuals. These recipient files were tested for verification of personal information such as valid social security file, birth certificate, New Jersey residency, citizenship, and other medical insurance. Although cases involving the Aged, Blind, and Disabled and other family related Medicaid programs require the documentation mentioned above, cases determined eligible under NJ FamilyCare are not bound by all the same rigorous eligibility requirements. Prior to the Deficit Reduction Act of 2005, NJ FamilyCare has employed self attestation for citizenship and did not require social security information for newborns. As of July 1, 2006, all new cases and redetermined cases, eligible for Plan A services, must prove citizenship and identity.

As far as recipient file organization, which differs from county to county, we have had supervisors share their file organizational systems and other procedures with other county supervisors. Field staff has also made suggestions to counties on file organization. We cannot enforce how a county organizes its files but we can make recommendations. A checklist was also created to assist applicants in securing needed information and documents for Medicaid eligibility. We are additionally working with a vendor for a Document Imaging Management System, where case records can be scanned and electronically viewed. Currently, this process is in the planning stages.

The division needs to pursue a computerized database of the IEVS information, which could be electronically submitted to the counties, so it can be efficiently analyzed, investigated, and actions reported by the counties and subsequently tracked by the division. The division should also establish formal policies and procedures for monitoring the status of county collection efforts involving ineligible claims.

We also recommend that the division discontinue utilizing the service of a vendor to provide the counties with claim information on ineligible recipients. A division employee should supply this information from currently available data.

The Division recently moved all IVES activity from the Third Party Liability Unit to the Office of Eligibility Policy. The Office of Eligibility Policy does not have the staffing to provide adequate oversight of IVES units in all 21 counties, therefore county support was enlisted. The Office of Eligibility Policy has conducted a training session to county IVES workers on March 26, 2007, which was well received. Policy and procedures regarding the management of the
IVES report was distributed to the workers. Future trainings will be scheduled, with follow-up trainings being provided as needed by the counties. The Office of Eligibility Policy will also assist the IVES workers as needed with policy matters as it pertains to eligibility determinations.

The Office of Eligibility Policy has encouraged mentoring among counties. On March 14, 2007 Bergen County provided a comprehensive overview of their IVES operation to Essex County workers in the development their IVES program. The Office of Eligibility Policy sent a Policy Analyst and county field representative to this meeting to observe this mentoring process. They also assisted Essex County with suggestions on the IVES specific to their county operation.

As referenced in N.J.A.C. 10:49 14-4 (a) 5, when a county board of social services recovers only for medical assistance improperly granted, the county board of social services shall remit the proceeds to DMAHS. The reimbursement shall be made payable to the Treasurer, State of New Jersey, who will then reimburse the county board of social services in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS. This policy is stated in Medicaid Communication 93-16. NOTE: Counties must work the IVES report; however, collection was never a mandate. We will be reissuing this communication to the counties as a policy review.

The Division has recognized the need to collect the amount of the identified resource which caused the period of ineligibility. The Division is currently working with the Department of Taxation, Office of Revenue, for cases where the county has been unsuccessful in collecting monies owed.

There was one instance that the auditors cited as “one county instructed that reimbursement checks be made to the county instead of the “Treasurer, State of New Jersey” as required. There are times when reimbursement checks come through Probation and these checks are made out to the county board rather than the Treasurer, State of New Jersey.

**The division should verify the accuracy of all social security numbers and require a hard copy of the social security card during the intake process to enhance the accuracy of posting to MMIS. The division should also supply the county intake units with the ability to verify the accuracy of social security numbers.**

The Division is working on a file clean up project addressing pseudo/inaccurate social security numbers. We are also developing a systemic algorithm for identification of pseudo/inaccurate social security numbers as an ongoing effort to identify these cases within 60 days of initial eligibility. Counties are able to verify some social security information through the use of the State Verification Exchange System (SVES). All Social Security numbers identified in this audit as being in the records but not on the system have been entered accordingly.
As stated in our prior audit report, the division should update the MMIS files as soon as other health insurance is known so claims can be avoided. The division should also develop procedures designed to ensure that recipients promptly and accurately report any changes in health insurance coverage. Furthermore, the division should consider switching recipients who have other health insurance coverage from a managed care to a fee-for-service type program. By doing so, redundant premium costs could be eliminated.

To put this finding into perspective, through the various means discussed below, in calendar year 2006 DMAHS identified, verified, and updated its eligibility files with health insurance records for over 130,000 clients whose claims are paid via the State MMIS, over 60,000 of which were for commercial health insurance coverage and 70,000 of which were for traditional Medicare coverage. In addition, almost 400,000 segments of Medicare Part D pharmacy coverage were identified and added to the MMIS. In aggregate, TPL cost-avoidance was well over $1 billion dollars in calendar year 2006.

Medicaid and NJ FamilyCare clients are questioned about changes in health insurance coverage at eligibility intake and redetermination interviews, and Medicaid Managed Care Organizations routinely send their clients questionnaires regarding other coverage; however, TPL is not always reported by these means, and the most effective way to identify TPL coverage remains the cross matching of the State’s eligibility files with health insurers’ enrollment files. This process has been enhanced by section 6035 of the Deficit Reduction Act of 2005, which gives States increased access to health insurer’s files.

There currently are three vendors actively identifying TPL coverage of clients enrolled in State benefits programs: Health Management Systems, Inc. (HMS), the DMAHS TPL Recovery Services contractor; Public Consulting Group, Inc. (PCG), the Department of Treasury Office of Management and Budget Federal Revenue Maximization contractor; and Policy Studies, Incorporated (PSI), the Division of Family Development National Medical Support Notice contractor. In addition to Identifying TPL for cost-avoidance purposes, vendor recovery activity resulted in revenue of over $100 million.

In addition to TPL coverage reported by providers and clients, DMAHS also reviews a report of claims where there is a TPL payment reported on the claim but none identified on the Medicaid Eligibility File to identify previously unknown health insurance.

DMAHS believes that its clients benefit greatly from being enrolled in a health care organization that manages their care, so it permits clients to remain enrolled in a Medicaid Managed Care Organization only if it is the same as their commercial coverage (i.e., Horizon or Physicians Health Service). Nevertheless, in calendar year 2006 over 40,000 clients were disenrolled from Medicaid Managed Care Organizations due to their TPL to avoid the redundant premium costs referenced in the OLS report.
The Division continues to follow-up on all of the specific items of concern provided by the auditors. DMAHS has and will take appropriate corrective action on these and any other issues identified. Likewise, DMAHS will further consider corrective action and other enhancements to improve the effectiveness and efficiency of these program activities.

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: DL

c: David Lowenthal