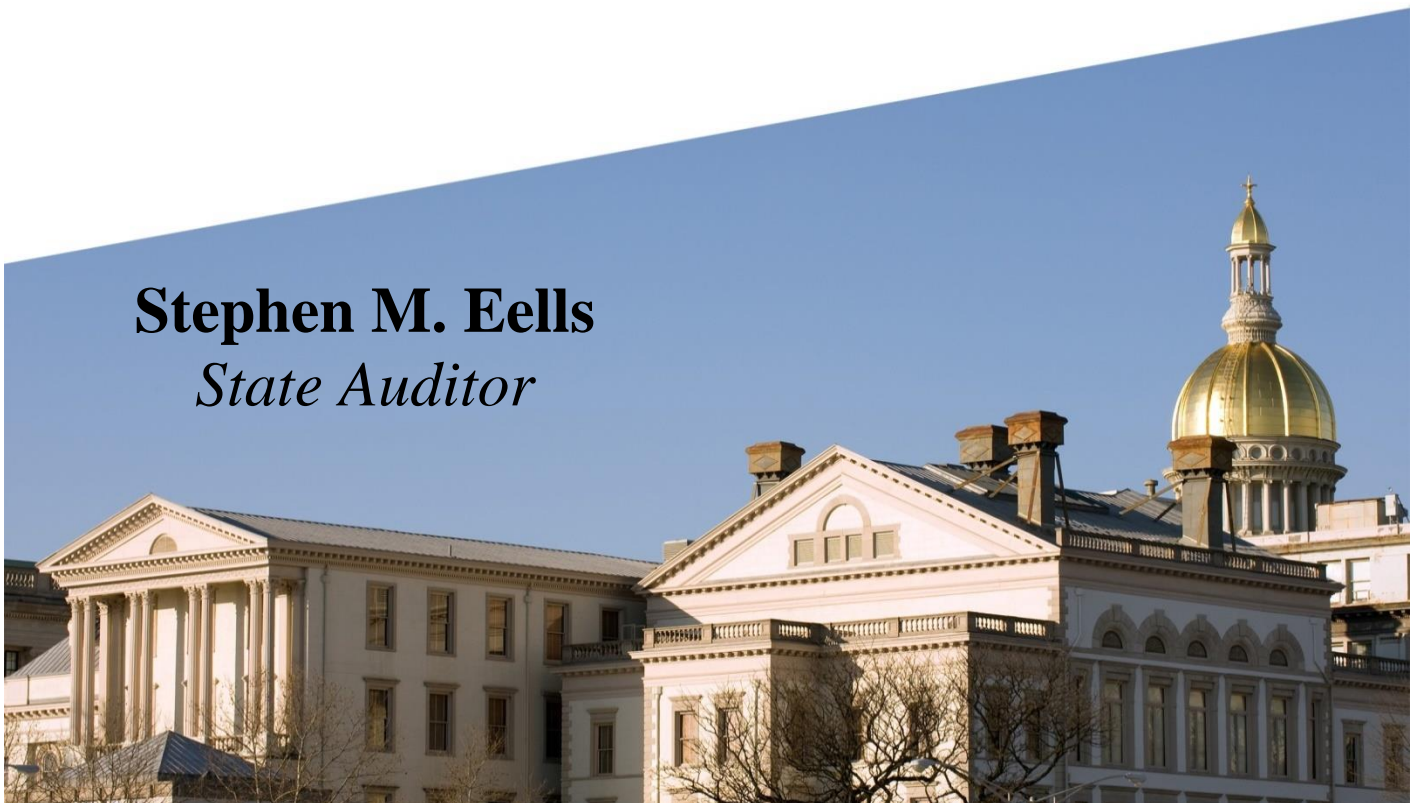


*New Jersey Legislature*  
★ *Office of* LEGISLATIVE SERVICES ★  
**OFFICE OF THE STATE AUDITOR**

Department of Human Services  
Division of Medical Assistance and Health Services  
NJ FamilyCare Eligibility Determinations

July 1, 2014 to July 30, 2017

**Stephen M. Eells**  
*State Auditor*



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Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, NJ FamilyCare Eligibility Determinations for the period of July 1, 2014 to July 30, 2017. If you would like a personal briefing, please call me at (609) 847-3470.

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

Stephen M. Eells  
State Auditor  
September 25, 2018

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## *Scope*

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services (division), NJ FamilyCare Eligibility Determinations for the period July 1, 2014 to July 30, 2017.

The scope of the audit was limited to NJ FamilyCare (NJFC) eligibility determinations, including Medicaid, performed by the county boards of social services (counties) and the contracted health benefits coordinator (vendor) on behalf of the division.

Our audit included activities accounted for in the state's General Fund. Annual expenditures for NJFC for fiscal years 2015, 2016, and 2017 averaged \$15.4 billion, a portion of which is federally reimbursed. The average number of NJFC recipients during fiscal years 2015, 2016, and 2017 was 1,681,317. As of May 23, 2016, approximately 97 percent are Medicaid recipients.

## *Objectives*

The objective of our audit was to determine if initial NJFC eligibility determinations and subsequent redeterminations were proper and as a result of adequate procedures by the counties and the vendor.

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. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In preparation for our testing, we studied legislation, the administrative code, and policies of the division. Provisions we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our testing of NJFC eligibility. We also interviewed program personnel to obtain an understanding of the programs and the internal controls.

A nonstatistical sampling approach was used. Our samples of recipient data were designed to provide conclusions on our audit objectives as well as internal controls and compliance. Sample populations were sorted and transactions were judgmentally and randomly selected for testing from recipients actively enrolled in NJFC as of May 23, 2016 for the majority of testing.

## ***Conclusions***

We found that NJFC initial eligibility determinations and subsequent redeterminations were not always proper, and procedures by the county or the vendor could be enhanced/improved. We noted issues relating to redetermination dates and end-dates in the Medicaid Eligibility System. We also noted active recipients who had unreported income, were ineligible based on their income, were using inaccurate Social Security numbers, or were deceased. In addition, we noted some employees of the vendor were receiving NJFC benefits, but were ineligible.

## ***Background***

The division administers the NJFC program which provides health insurance to eligible individuals and families based on specific criteria, including their income levels and household size. NJFC benefits are offered to adults whose monthly income is 138 percent or less than the federal poverty level (FPL), and to pregnant women whose income is 205 percent or less than the FPL. Children qualify as long as the household income is 355 percent or less than the FPL. For each category, household size is also taken into consideration to determine eligibility as well as to determine if premiums will be assessed. In order to obtain NJFC benefits, prospective recipients must apply with either their county or the vendor. Once enrolled in the program, recipients must have their eligibility redetermined every twelve months, or sooner, if their circumstances have changed. The division is responsible for balancing the need for timely medical access while also ensuring only eligible applicants receive benefits. Because of the complexity of the NJFC eligibility process, the various program types, and reliance on the 21 individual counties and the vendor making these determinations, division oversight and monitoring is essential to ensure eligibility is correctly determined and, when necessary, corrections are made. One of the ways the division ensures proper eligibility is by issuing internal regulations known as Medicaid Communications.

The division contracts with Managed Care Organizations (MCOs) to provide quality healthcare and needed medical services to NJFC recipients. Each MCO receives a monthly premium, or capitation payment, for each NJFC recipient enrolled in its plan. There are also recipients who have claims paid on a fee-for-service basis prior to enrolling in an MCO or for certain services which are carved out of the plans.

## Redetermination and End-Date Issues

**Eligibility is not being redetermined timely, nor are end-dates being utilized for the termination of benefits.**

The Medicaid Eligibility System (MES) maintains the annual redetermination (redet) date of recipients as well as the date their benefits should be terminated (end-date). We found that the counties and the vendor are not redetermining eligibility timely, nor are they utilizing end-dates for the termination of benefits, thus increasing the risk of recipients improperly receiving benefits in perpetuity. When benefits continue for ineligible recipients, the MCOs continue to receive capitation payments for these ineligible recipients.

Redets are required to be performed annually, in accordance with N.J.A.C. 10:78-2.6, to verify continued eligibility. The redet date is used to determine when letters are generated and sent to recipients notifying them of the need to redetermine their eligibility. One of the reasons redet dates may not be entered into the system is that MES cannot enter a redet date for those who are batched and electronically transferred from the Federal Marketplace and those who age-out of children's programs. However, for all other recipients a redet date should already be in the system.

We found that as of August 9, 2016, a total of 361,072 recipients enrolled through the counties had no redet date, had a past-due redet date, or a future redet date beyond one year as per the system. In addition, as of October 1, 2016, a total of 23,388 recipients enrolled through the vendor had a past-due redet date or a future redet date beyond one year as per the system. The chart below summarizes the redet data.

	Total Enrolled	Past-due Redet Date	Missing Redet Date	Future Redet Date
Counties as of August 9, 2016	1,041,509	263,836	87,302	9,934
Vendor as of October 1, 2016	423,789	12,944	0	10,444

In a separate analysis, we found that as of May 23, 2016, 1.4 million of the 1.6 million active recipients did not have an end-date in the system. Without an end-date, a recipient could potentially receive NJFC benefits in perpetuity. The division does not use the end-date function in the system because they are aware redets are not performed timely by the counties and the vendor. Utilizing an end-date when redets are not timely could cause recipients to be wrongfully terminated from NJFC. Conversely, when a redet letter is sent to the recipient timely, but no response is received, the end-date would ensure the timely termination of benefits. The omission of the end-date in the system increases the risk of recipients continuing to receive benefits in perpetuity. Once a redet date goes past-due, unless a new future redet date is manually entered, another eligibility redet will not be done – ever.

## **Recommendation**

We recommend the division ensure all redeterminations are performed timely and benefits are terminated when appropriate. In addition, a process for entering redetermination dates when recipients are batched and electronically transferred to MES should be established. Furthermore, the division should ensure that end-dates are entered in the system for all recipients.



## **Unreported Income**

### **Our match with New Jersey Gross Income Tax (GIT) returns disclosed unreported income.**

We found some NJFC recipients did not report all income on their applications, and with the counties' and vendor's limited ability or use of data to verify an applicant's non-wage income, these omissions may result in incorrect income eligibility determinations. We matched all recipients receiving NJFC benefits as of May 23, 2016 with filed 2015 GIT returns to verify if all income was being reported on the NJFC applications. We identified 1,337 NJFC recipients who applied for benefits after January 1, 2016 and filed a 2015 tax return, or were listed as a spouse or a dependent on a tax return, and who reported between \$100,000 and \$4.2 million in taxable income. Once arriving at this segment of the population, we focused on those whose total income was more than 150 percent of their wages. We identified 1,002 of these recipients having \$3.9 million in potentially improper capitation payments and paid fee-for-service claims during calendar year 2015. We further noted that 949 of these recipients used their NJFC benefits at least once during this period. In order to determine ongoing eligibility, we matched the same 1,337 recipients to their 2016 GIT return and found 410 recipients who would not have been eligible in 2016.

We noted that the guardians of two recipients listed as dependents on the tax return of the guardian reported \$1.47 million in taxable income, of which \$1.3 million was reported as S corporation income on their 2015 tax return. In addition, \$129,895 in wages was reported. They also reported interest income, dividends, net gains, and rental income. Other examples include a tax return showing taxable income of \$404,055, of which \$386,864 was net gains; and another tax return showing \$345,702 in taxable income, of which \$343,929 was attributed to net gambling.

In accordance with the division's Medicaid Communication No. 14-12, income is calculated based on Modified Adjusted Gross Income (MAGI), which is the taxable amount after certain exceptions are deducted. In addition, MAGI is calculated by adding back tax-exempt interest, foreign-earned income, and non-taxable Social Security benefits to the adjusted gross income. By signing the application for benefits, applicants authorize the New Jersey Division of Taxation (Taxation) to release their tax return information to the counties or the vendor for eligibility determinations. Per the division's agreement with Taxation, the counties and the vendor are only permitted to use taxable interest income, dividends, net profits from business, net gains or income from property, distributive shares, S corporation income, and net gains or income from rent

In addition, the division is not in compliance with Medicaid Communication No. 14-12 which states the Federal Data Services Hub (FDSH) is to be used to electronically verify information on an application. The FDSH gathers information from the Internal Revenue Service (IRS), as well as other federal data sources to verify information regarding income, citizenship, immigration status, Social Security number, and Medicare status for New Jersey. The division has decided not to utilize the IRS information because of the stringent background requirements regarding access to this data.

We recommend that the counties and the vendor review New Jersey and federal tax returns to aid in their verification of an applicants' total income and the determination and re-determination of NJFC eligibility. We further recommend the division update its agreement with Taxation to include other categories of income reported on the tax returns.



## Wage Reporting

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1, 2017. The general information necessary to determine which NJFC program an individual qualifies for is their income, household size, and relationship to other household members. An adult with an annual income of \$100,000 would need to have a household size of 17 to qualify for NJFC. The largest household size for these recipients was six. We further noted that during 2016, coverage for 123 of these ineligible recipients enrolled through the counties and all recipients enrolled through the vendor resulted in improper capitation payments or fee-for-service claims totaling \$596,012. In addition, 97 of these recipients enrolled through the county and 7 enrolled through the vendor actually used their benefit during calendar year 2016.

Some examples of ineligible individuals identified during testing include the following.

- One recipient with wages totaling \$212,417 had a household size of five. To qualify for the assigned program, the annual income limit based on household size was \$37,826. This individual would need to have a household size of 37 to be enrolled in the same program.
- One recipient had wages of \$241,923 and was the only member of the household. The maximum salary for a single adult was \$16,395.
- One recipient had wages of \$139,957 and became employed with the State of New Jersey at the end of 2016. This recipient had a salary of \$128,000 for calendar year 2017.

We found that all but eight of the recipients we tested had overdue or missing redetermination dates in Medicaid Eligibility System. Furthermore, we found that neither the counties nor the vendor performed periodic matches to New Jersey's wage reporting system until the annual redetermination was performed. These matches would identify recipients who potentially do not qualify based on income and should be further reviewed.

### *State Employees*

In accordance with federal regulations, individuals are permitted to be enrolled in both NJFC and the state health benefits program as long as their income is at or below 133 percent of the federal poverty level based on their household size. We tested 96 state employees with biweekly wages of \$1,500 during pay period 11 (May 14<sup>th</sup>-27<sup>th</sup>) of calendar year 2016, who were receiving NJFC benefits as of May 23, 2016 while also receiving state health benefits during their NJFC enrollment. Of these state employees, we noted 89 were still actively receiving NJFC benefits as of June 1, 2017 but were ineligible for these programs based on their income and household size. Improper capitation payments and fee-for-service claims incurred by the 89 recipients totaled \$444,406 during calendar year 2016. Eighty of these recipients used their NJFC benefit during this same period.

Periodic matches to the New Jersey wage reporting system would identify recipients that potentially do not qualify based on income.

### *List of Excluded Individuals and Entities*

The U.S. Department of Health & Human Services Office of Inspector General's List of Excluded Individuals/Entities (LEIE) provides information to the healthcare industry, patients, and the public regarding individuals and entities currently excluded from providing and billing federally funded healthcare programs due to convictions for program-related crimes. We matched NJFC recipients active on May 23, 2016 to the LEIE database on December 16, 2016 and identified 103 recipients who were on the list. Although these individuals are not excluded from receiving NJFC benefits due to the nature of their program-related offenses, we considered them to be a high risk population and tested their eligibility solely based on New Jersey wages reported.

We found that 18 of the 103 recipients (17 percent) should either not have received benefits, or should have had their benefits terminated, based on New Jersey wages reported. Of the 18 recipients, we determined 7 should not have been eligible at the time of their application, and the remaining 11 had exceeded the income thresholds during their eligibility period. Capitation payments and fee-for-service claim amounts between January 1, 2015 and June 30, 2017 for the 7 recipients who were not eligible at the time of application totaled \$33,908; the capitation payments and fee-for-service claims for the 11 recipients who became ineligible during their benefit period totaled \$57,753. In addition, 16 of the 18 used their benefit during the same time period. These improper payments could have been avoided had these individuals been identified by periodically checking the New Jersey wage reporting system and either denied coverage or terminated from NJFC.

### **Recommendation**

In addition to the annual eligibility redeterminations, we recommend the division require periodic matching of NJFC recipients to New Jersey's wage reporting system. We further recommend that the division require periodic matching of recipients with the LEIE database to identify potentially ineligible recipients.



### **Inaccurate Social Security Numbers**

**\$177.5 million of potential improper payments were associated with recipients who are identified in the system with invalid and/or duplicate Social Security numbers.**

We identified 18,020 recipients enrolled in NJFC on May 23, 2016, as per the Medicaid Eligibility System, having invalid and/or duplicate Social Security numbers (SSNs). All recipients we found were over the age of two, and their SSN was not associated with deceased individuals, (noted later in this report) or eligible aliens who do not need a SSN. In accordance with Title 42 of the Code of Federal Regulations, SSNs are a required condition of eligibility. They are used to research eligibility criteria such as wages, unemployment, and disability. Inaccurate information provides incorrect research results and leads to improper eligibility

determinations. As of January 20, 2017, as per federal regulation, SSNs must be validated with the Social Security Administration (SSA) to ensure a recipient's SSN is accurate.

Potential improper capitation and fee-for-service claim payments totaling \$177.5 million were made between July 1, 2014 and July 30, 2017 on behalf of 17,952 recipients who we identified as having inaccurate SSNs. We further noted that 85 percent of those with an inaccurate SSN used their benefit during our audit period.

### ***Initial Verification of SSN***

The vendor uses the State Verification and Exchange System (SVES) to validate a recipient's identity, SSN, and citizenship status with the SSA. The SVES verification is only done for new recipients, not for those going through the annual redetermination process. We reviewed the SVES verification process for 454 recipients and found that 9 had no information relating to the verification, 17 had a request for verification but no reply information, and 40 returned a failed match relating to their SSN. Despite failing or not completing this verification process, all 66 still continued to receive benefits. We found that only 4 of the 40 failed match recipients were sent a letter by the vendor requesting proof of the recipient's SSN. We reviewed the case files for each of these 40 recipients and found that 14 had no social security cards on file; 16 had social security cards on file but no proof the cards were reviewed; and 10 submitted their social security cards six or more months after the SVES verification process was completed. While the SVES process communicates electronically with the SSA, the follow-up to the response is a manual process. An agent of the vendor must follow-up with the recipient to request and review the required information to verify eligibility. Requesting and reviewing the required information is imperative to ensuring only eligible recipients are enrolled in NJFC.

### **Recommendation**

We recommend the division require the counties and the vendor to identify and review all inaccurate SSNs. We further recommend that the vendor improve its SVES verification process to ensure that all SSNs are validated.



### **Deceased Recipients**

#### **\$728,747 in capitation payments and fee-for-service claims were expended for recipients after their date of death.**

We matched recipients receiving NJFC benefits as of May 23, 2016 to VERIS, a social security number validation service, and noted 41 recipients had capitation payments (\$510,834) and fee-for-service claims (\$217,913) after their reported date of death. In 30 of these cases, we found additional verification of their death, such as an online obituary or death certificate. Of these 30,

28 recipients had improper capitation payments and fee-for-service claims totaling approximately \$418,221.

### **Recommendation**

We recommend the division require the Medicaid Eligibility System (MES) to be reconciled with the VERIS system on a periodic basis to better identify recipients who may have died during their eligibility period. Once their death is verified, these recipients should be removed from the MES immediately, preventing any further capitation payments and fee-for-service claims.



## **Health Benefits Coordinator Employees**

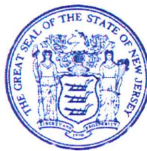
**The health benefits coordinator (vendor) does not closely monitor its own employees enrolled in NJFC.**

We tested to determine the eligibility of employees of the vendor who were receiving NJFC benefits. We matched the NJFC recipient population as of May 23, 2016 to individuals on the vendor's payroll in the second quarter of calendar year 2016. We noted 29 employees who were enrolled through the vendor and receiving benefits. We identified five employees (17 percent) whose eligibility we questioned due to late redeterminations and/or not meeting the income criteria, but they remained actively enrolled in NJFC through July 30, 2017. For example, one employee, with a family size of four, qualified at the time she applied in the second quarter of 2015, however, she failed to report her spouse's subsequent employment income of \$19,217. This income was earned in the quarter following her enrollment, making the household income for the quarter \$25,562, rendering her ineligible for NJFC benefits. We further noted her 2016 application was submitted in May of 2016 with a note in the system indicating the application had been sent to a supervisor. Her redetermination date was listed as June 1, 2016, however, no action on her redetermination was taken. Based on the household wages reported in New Jersey, she would not have qualified to receive NJFC benefits, but she still remained active. By signing the application, the recipient agrees to disclose all changes in circumstances relating to eligibility, including changes in income. Employees of the vendor are involved in various aspects of the benefits process, and have an understanding of eligibility criteria. All five employees we identified used their benefits during the period we reviewed.

### **Recommendation**

We recommend that the vendor closely monitor the eligibility of its own employees receiving NJFC benefits. The division should also monitor the continued eligibility of the vendor's employees enrolled in NJFC. Furthermore, the division should seek recovery of ineligible benefit payments from these employees.





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September 17, 2018

John J. Termyna  
Assistant State Auditor  
Office of Legislative Services  
Office of the State Auditor  
125 South Warren Street  
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Dear Mr. Termyna:

The Department of Human Services (the Department) is in receipt of a draft audit report issued by your office titled ***"Department of Human Services' Division of Medical Assistance and Health Services, NJ FamilyCare Eligibility Determinations."*** The objective of the audit was to determine if initial NJ FamilyCare (NJFC) eligibility determinations and subsequent redeterminations were proper and whether adequate procedures are in place in the counties and with the vendor. We appreciate OSA's recommendations on how the Department can strengthen the eligibility determination process. Thank you for the opportunity to comment on the draft report.

Please accept the following responses to the draft audit findings:

**OSA Recommendation**

"We recommend the division ensure all redeterminations are performed timely and benefits are terminated when appropriate. In addition, a process for entering redetermination dates when recipients are batched and electronically transferred to MES should be established. Furthermore, the division should ensure that end-dates are entered in the system for all recipients."

**Response**

The Department agrees that redeterminations are an important part of managing the Medicaid program. In 2016, the Department's Division of Medical Assistance and Health Services (DMAHS) reinstated a requirement that all eligibility is subject to redetermination. Redeterminations had been suspended in 2015 with the endorsement of the federal Centers for Medicare and Medicaid Services (CMS) due to the large volume of cases (300,000) added the eligibility system in the first year of Affordable

Care Act implementation. There was widespread recognition that redeterminations would not be timely for such a large number of new cases. As such, DMAHS considered 2015 a transition year to adjust to the volume and reinstated redeterminations the following year.

Today, DMAHS provides a monthly Redetermination Report to County Welfare Agencies (CWAs). CWAs manage redeterminations of cases that are assigned to their county. The report provides dates by which redeterminations are due, and the CWAs actively work with Medicaid enrollees to collect renewal applications and make determinations about renewal eligibility. DMAHS closely monitors this process through its fiscal staff and provides administrative funding to counties to support this work. This change is reflected in the NJFC disenrollment statistics, which hovered in the 60,000 to 70,000 per year range in federal fiscal years 2015 and 2016, but increased to nearly 100,000 in federal fiscal year 2017 as the redetermination process came back online.

When redeterminations were suspended, DMAHS concurrently suspended the practice of including end dates in the data system. If end dates were in place but redeterminations were suspended, beneficiaries would have been disenrolled from NJFC when they hit their end date even though they were not contacted and were not given the opportunity to prove their continued eligibility due to the redetermination suspension.

Today, DMAHS ensures that monthly Redetermination Reports provided to counties provide a list of cases that do not have redetermination dates. The counties are required to research these cases and add an end date or close them.

In addition, as recommended by the Office of the State Auditor, the Medicaid Eligibility System (MES) has recently been updated to allow DMAHS to upload redetermination dates in batch for all new cases, including Federally Facilitated Marketplace (FFM) cases that come to the State through CMS. This process has been in effect for the last two months and will prevent new batched cases from being uploaded without redetermination dates.

DMAHS appreciates OSA's recommendation that end dates be added to the system for all users; however, implementing this practice at this time would cause some recipients to be disenrolled from NJFC because of the current status of their redeterminations. Most overdue redeterminations are related to county capacity issues, not beneficiary issues. To address this issue, DMAHS is requiring each county to create a corrective action plan to process any redeterminations backlogs with the intent of revisiting end dates when the backlogs have been processed and sufficient capacity is in place in the counties to ensure the redetermination process is adequate prior to an end-date disenrollment.

### **OSA Recommendation**

"We recommend that the counties and the vendor review New Jersey and federal tax returns to aid in their verification of an applicants' total income and the determination and re-determination of NJFC eligibility. We further recommend the Division update its



agreement with Taxation to include other categories of income reported on the tax returns.”

### **Response**

NJFC applicants must list all income on their applications, including but not limited to wages, self-employment income, unemployment, pensions, Social Security, retirement accounts, alimony, farming/fishing, and rental/royalty income. Beneficiaries must provide this same information upon redetermination. The CWAs and vendor use several sources to verify income. Case workers access the Departmental Online Verification Engine (DOVE), which compiles information relevant to eligibility determinations from nine different systems. DOVE includes information from the Department of Labor's Wage Reporting System (wages), and LOOPS (unemployment income) and DABS (disability benefits) databases. Through these systems, the CWAs and vendor access income information from the previous quarter, which provides a better indication of eligibility than the prior year's tax return. Eligibility determinations are based on current and prospective income.

We agree that tax returns are a valuable tool for income verification, especially concerning self-employment income, periods of ineligibility from the previous year, and out-of-state and other sources of income. As recommended, DMAHS will be reviewing the current agreement with the Division of Taxation to determine whether additional tax return information can be accessed. Today, DMAHS will utilize tax returns for income verification to the extent possible. However, DMAHS's ability to use tax returns is limited in several ways. First, DMAHS may only access state tax information from the Division of Taxation. Federal tax information may only be disclosed by the Internal Revenue Service under specified guidelines. Second, the Division of Taxation limits who can access tax returns to specific vendor employees. Under its agreement with the Division of Taxation, DMAHS provides the Division the names of all vendor employees with access to tax information and these employees must execute a confidentiality and non-disclosure agreement. Third, the Division of Taxation does not provide access to tax returns, but to certain components of the returns based on its agreement with DMAHS.

As to OSA's finding that DMAHS is not in compliance with Medicaid Communication No. 14-12 concerning utilization of the Federal Data Services Hub (FDSH), DMAHS uses the FDSH to verify Social Security numbers, dates of birth, citizenship, and death. DMAHS does not meet the IRS security guidelines to access federal tax information from the FDSH.

The draft audit report cites instances where recipients applied for benefits on or after January 1, 2016, but whose 2015 New Jersey Gross Income Tax returns indicated that they had income in excess of the eligibility guidelines for their household size. Because eligibility determinations are based on current and prospective income, the 2015 tax returns were not determinative of eligibility in 2016. DMAHS reviewed the 49 vendor-processed cases that OSA provided where OSA believes that individuals receiving too much income were receiving NJFC benefits. In these cases, the vendor relied on more current information, such as DOVE and current pay stubs, to determine eligibility. Using

this information, the majority of these applicants were properly determined eligible, as their income had changed at the time of their application in 2016.

For example, the OSA report cites a case where an individual's tax return showed taxable income of \$404,055 on a 2015 tax return. This individual's eligibility was terminated in December 2015 based on reported income. However, the individual was granted eligibility again in April 2016 after the EDA verified from a profit and loss statement for the first quarter of calendar year 2016 that the individual's current income met program requirements.

DMAHS found that in 12 of the vendor-processed cases, relying on 2015 New Jersey Income Tax information would have resulted in a more accurate reflection of the household's ongoing income at the time the eligibility determination was made. The OSA audit also notes that approximately 30 percent of individuals sampled would not have been eligible according to the 2016 tax returns. As stated, DMAHS will consider ways to enhance its access to tax information and income verification.

Moreover, going forward, when DMAHS identifies or is made aware of cases of concern regarding excessive unreported income or similar issues, it will review eligibility, end coverage if warranted, and refer these cases to the Medicaid Fraud Division, housed in the Office of the State Comptroller, as appropriate. As part of its oversight role, the Medicaid Fraud Division is charged with auditing and investigating health care providers, managed care organizations and Medicaid recipients to identify and recover improperly expended Medicaid funds and to ensure that only those who qualify are enrolled in Medicaid. The Medicaid Fraud Division is independent of DMAHS and makes its own determinations about which cases to review and pursue.

### **OSA Recommendation**

"In addition to the annual eligibility redeterminations, we recommend the Division require periodic matching of NJFC recipients to New Jersey's wage reporting system. We further recommend that the Division require periodic matching of recipients with LEIE database to identify potentially ineligible recipients."

### **Response**

While DMAHS appreciates OSA's recommendation that the State require periodic matching of NJFC recipients to New Jersey's wage reporting system, Federal regulations do not require additional verifications of income beyond the redetermination process. As such, Eligibility Determination Agencies (EDAs) are not staffed to complete this function. However, all NJFC beneficiaries are required to immediately notify the EDAs of any changes in their household income or other eligibility criteria. This requirement is memorialized in the Rights and Responsibilities section of the NJFC application. Beneficiaries acknowledge by signature their obligation to notify the EDA when there is a change in circumstances. Moreover, when the EDAs identify situations where ineligible persons received benefits, they may pursue incorrectly paid benefits under N.J.A.C. 10:49-14.4. DMAHS will continue to enforce these requirements.



DMAHS also notes that the State has CMS approval for continuous eligibility for children under 42 C.F.R. 435.926. This regulation allows children to maintain eligibility for up to one year, regardless of any change in income. Periodic matching would be inapplicable for this population.

As OSA notes in its report, the LEIE database tracks individuals currently excluded from providing or billing for services under NJFC and other federally funded healthcare programs, and does not exclude individuals from receiving NJFC benefits. For this reason, DMAHS does not have authority to deny coverage based on billing related data included in the LEIE database, but will consider OSA's suggestion that the LEIE database contains a high risk population that should be periodically matched.

### **OSA Recommendation**

"We recommend the Division require the counties and the vendor to identify and review all inaccurate SSNs. We further recommend that the vendor improve its SVES verification process to ensure that all SSNs are validated."

### **Response**

DMAHS agrees with OSA's recommendation that EDAs should correct invalid Social Security numbers (SSNs) in the MES to the extent possible. DMAHS recently implemented a systemic SSN verification system in the worker portal for new applicants. Whenever an online application is received, the SSN is verified within 24 hours in the portal, and this information will then be systemically uploaded into the MES, which will reduce data entry errors. All NJFC paper applications will be data entered into the worker portal within the next few months, and all redeterminations will be completed in the portal in the upcoming year. As a result, data entry errors should not present an issue because the verified number will already be uploaded to the MES and all cases without valid SSNs (legal immigrants and newborns) will be required to have a valid SSN at the time of redetermination.

OSA's reports a finding that \$177.5 million in payments were associated with recipients who had invalid or duplicate SSNs in the MES; however, DMAHS does not believe that these payments were improper. The fact that an individual's SSN is inaccurate in the MES is not an indication of ineligibility for NJFC. Molina, DMAHS's fiscal agent, does not rely on SSNs in the MES; it renders payments based on Medicaid numbers. Medicaid numbers are only issued when the beneficiary satisfies NJFC eligibility requirements, including possessing a valid SSN when necessary. Although a valid SSN is used to determine eligibility when required, it is possible that the MES may show an inaccurate or duplicate SSNs if the numbers are entered into the MES incorrectly. Also, in cases where the CWAs do not have a SSN for an eligible beneficiary (such as newborns and legal immigrants), the county worker will enter a date of birth or another number in the SSN field as prompted by the MES. If the SSN information is not updated when these individuals subsequently obtain SSNs, these numbers rather than SSN numbers appear in the MES. Thus, the presence of a birth date in place of an SSN or an inaccurate or duplicate SSN in the MES does not impact payment and would no more contribute to an improper expenditure than the misspelling of a recipient's name. Indeed, DMAHS's review of recipients identified in the OSA audit did not reveal any

instances where the presence of an inaccurate or duplicate SSN resulted in improperly expended funds. However, DMAHS recognizes the importance of maintaining accurate information in the MES, and will require EDAs to correct invalid SSNs.

The OSA audit identified 40 recipients on vendor-processed cases where the SVES match returned a failed SSN Verification result. In many of the vendor cases that were reviewed, the reason for the failure was due to a transposition error in the data-entered SSN or birth date of the individual. In those instances, the SSA returned the corrected SSN to the vendor. However, the eligibility processor would have needed to manually correct the SSN and resubmit the SVES match to resolve the error.

As recommended, DMAHS has improved the SVES verification process. In February 2017, the vendor modified the automated process to include more detail as to the reason that the match failed. With this information, the individual determining eligibility knows what follow-up is needed, including whether a Request for Verification letter is needed to resolve the failure. In addition, the SVES process was enhanced to automatically correct the SSN in those instances where the SSA returned the corrected SSN in the SVES response. Thus, no manual intervention is needed in the majority of instances. The process was further enhanced to prevent the individual doing the eligibility determination from completing the eligibility determination on a case where there is an unresolved SVES failure. These measures have helped to ameliorate inaccurate SSNs issues.

### **OSA Recommendation**

“We recommend the Division require the MES to be reconciled with the VERIS system on a periodic basis to better identify recipients who may have died during their eligibility period. Once their death is verified, these recipients should be removed from the MES immediately, preventing any further capitation payments and fee-for-service claims.”

### **Response**

DMAHS has developed an extensive program to identify and verify Medicaid recipient deaths and the reported date of death. DMAHS utilizes the New Jersey Bureau of Vital Statistics and Social Security Administration as the main sources of death information to match against New Jersey Medicaid recipients. All Medicaid recipient deaths matched in this manner have their Medicaid eligibility terminated within one week of the reported death. This action results in the termination of the deceased recipient's coverage and recovery of any payments made after the date of death. As of May 23, 2016, the Medicaid recipient deaths reported in the draft audit were unknown to the Bureau of Vital Statistics because New Jersey was not the issuer of the death certificate and/or the death was not reported to Social Security Administration.

The VERIS system appears to be a worthwhile resource in finding Medicaid recipient deaths that are not known to the two sources of death currently utilized by DMAHS. It is important to note, however, that the VERIS system findings are not always reliable and that all VERIS system findings require intensive verification. The VERIS system reported many Medicaid recipients as deceased who were not deceased when DMAHS



researched the original list provided by OSA. However, DMAHS agrees with the audit recommendations to periodically utilize the VERIS system to help identify and research possible Medicaid recipient deaths that were not reported to DMAHS from the Bureau of Vital Statistics and Social Security Administration. DMAHS is always open to finding new avenues to improve the process of identifying all Medicaid recipient deaths.

In addition, DMAHS has devoted substantial time and effort to identify and recover payments for claims with service dates after beneficiary dates of death. Once the date of death is entered into the system, DMAHS and its fiscal agent, Molina, have developed and implemented a process that voids claims with post-death service dates. In addition, DMAHS and Molina have implemented recovery projects to void older claims not captured by this process. From October 2012 through May 2018, recovery projects have resulted in voiding claims in the amount of \$10.56 million in federal and state funds. As a result of these voided claims, \$10.11 million has been recovered.

OSA recommends that recipients be removed from the MES immediately when their death is verified. DMAHS does not remove these recipients from MES upon verification of death because such action would prevent eligible claims incurred prior to death from being paid. Rather, their eligibility segment is terminated with the correct date of death and an indicator that the termination is due to death. This action triggers the processes to terminate managed care and recover any managed care and fee for service payments made after the date of death. In response to OSA's findings, DMAHS has terminated the Medicaid eligibility and recovered managed care and fee-for-service payments for all verified deceased Medicaid recipients found by OSA's audit.

### **OSA Recommendation**

"We recommend that the vendor closely monitor the eligibility of its own employees receiving NJFC benefits. The Division should also monitor the continued eligibility of the vendor's employees enrolled in NJFC. Furthermore, the Division should seek recovery of ineligible benefit payments from these employees."

### **Response**

As recommended by OSA and at the direction of DMAHS, the Health Benefits Coordinator (HBC) has enhanced its monitoring of employees receiving NJFC benefits. HBC has implemented the following adjustments to its processes:

The vendor has updated its Oversight Policy for existing employees with the following steps:

- Added renewal dates to the current employees case log which will prompt the vendor when a renewal date approaches;
- As Conduent employees enrolled in NJFC must have their coverage renewed annually, notices will be sent to the employee and the oversight manager that it is time to renew;
- The monthly list of Conduent employees up for annual renewal will be tracked for non-compliance to the mandatory NJFC redetermination and employees who do not comply will be terminated from the program;

- The vendor has updated and redistributed the Conduent Employees with NJFC/County Coverage Policy which includes stronger non-compliance enforcement. All employees sign the policy and a copy is maintained as part of their employee file;
- The vendor has increased the frequency of Report 58, which identifies employees who have NJFC or County coverage, from quarterly to monthly. This report enables the vendor to promptly identify employees who did not self-identify during the new hire training period;
- Compliance staff will audit the oversight process quarterly.

The vendor also updated its Employee Policy with the following changes:

- During new hire orientation, all employees are notified of the oversight policy and must self-identify that they are enrolled in NJFC to the oversight manager within 24 hours;
- A new email box (NJBHC-Employee cases) has been created for employees to send supporting documents and to report any changes to their cases. This email box provides an electronic record of employees' submissions while maintaining confidentiality;
- The vendor has implemented a two-week window in which to comply with all aspects of renewals. Non-compliance can lead to corrective action.

Thank you again for the opportunity to review and respond to OSA's draft audit report. If you have any questions or require additional information, please contact Mark Talbot at 609-984-5540 or Richard Hurd at 609-588-2550.

Sincerely,



Carole Johnson  
Commissioner

c: Meghan Davey  
Richard Hurd  
Daniel Prupis  
Mark Talbot