

**MEDICAID WELFARE REFORM
IMPLEMENTATION REVIEW**

NEW JERSEY

MEDICAID WELFARE REFORM IMPLEMENTATION IN NEW JERSEY

As part of a national Department of Health and Human Services initiative, Federal government representatives conducted an on-site review of certain aspects of New Jersey's Medicaid program on October 15, November 3, November 10, November 15 and November 16, 1999. The review team consisted of Julie Alberino, Pat Ryan, Doretha Howard and Lillian Lee from the Health Care Financing Administration (HCFA) New York Regional Office, and Frank Ceruto from the Administration for Children and Families (ACF). This report contains information gathered through reviews of the State's documents, policies, and procedures, as specified below, case reviews and discussions with State Medicaid representatives, county social services representatives, and consumer advocates identified below. As such, this report is limited to the information gathered from these sources regarding New Jersey's Medicaid program as of November 16, 1999 with respect to the areas addressed. Subsequent to the review, State and local advocacy groups were given the opportunity to comment on the review team's findings. This report may reflect these comments in whole or in part as well as information that updates the findings to reflect actions the State has taken since the review.

The objective for this comprehensive assessment is to help New Jersey and other States ensure that welfare and Medicaid eligibility and enrollment procedures are effectively coordinated, comply with Federal requirements, and assure that low income families and children are enrolled and remain enrolled in Medicaid when eligible. HCFA is also using this review process to identify successful models of outreach and enrollment that can be shared with other States. These site visits were conducted at the President's request as part of HCFA's continuing effort to work with States to improve the Medicaid eligibility and enrollment processes.

Scope and Methodology of the Review

The review team visited the Division of Medical Assistance and Health Services, which is the medical assistance unit within the Medicaid single State agency, the Department of Human Services. Since the Department of Human Services is also the State Temporary Assistance for Needy Families (TANF) agency, staff from the TANF unit (Division of Family Development) came to the Division of Medical Assistance and Health Services office to participate in the information gathering process. Prior to the site visit, the State provided the review team with copies of Medicaid and TANF policies and procedures, and copies of Medicaid and TANF applications, and approval and denial letters. During the site visit, the State provided copies of additional materials, including two studies that the Medicaid agency had performed in relation to welfare reform, and a copy of the "Work First New Jersey" manual, which is a description of New Jersey's welfare reform program.

Staff interviewed during the onsite visit to the State agency were the Director of Medicaid Eligibility Policy, two eligibility policy analysts, a representative of the Division of Family Development, the Medicaid Eligibility Quality Control specialist, and two staff people from the Office of Information Systems. These persons provided information that enabled the review team to answer questions found in the *Assessment Tool for Medicaid Regional Office On-site*

Review of State Medicaid Enrollment and Eligibility Processes, which was developed by HCFA in September 1999 to provide guidance in conducting these reviews. The State staff also provided background information that proved useful during the review team's visits to three county offices.

Two members of the review team are also HCFA's representatives to the New Jersey HCFA/Advocates Medicaid Working Group. HCFA and Legal Services of New Jersey founded this group in the summer of 1999 in order to provide a forum for an ongoing exchange of information between HCFA and the advocate community. The group meets monthly and was consulted prior to and during the course of this review. In addition to representatives from Legal Services central office and several counties, the group also has members who represent the Association for Children of New Jersey, the New Jersey Primary Care Association, the Arc of New Jersey, the HIV coalition, the Association for the Betterment of Citizens with Disabilities, a provider of services to women with high risk pregnancies, a private pediatrician, the Eastern Paralyzed Veterans Association, and a behavioral health program. These advocacy groups were helpful in providing input into the selection of county offices to be visited, and providing anecdotal information about their clients' experiences with welfare reform.

The review teams visited Boards of Social Services in Essex, Passaic and Mercer counties. At these visits, management and front line staff were interviewed about the procedures they follow in assisting applicants for Medicaid, TANF, or both; interview procedures used with clients, follow-up procedures to develop applications; approval and denial procedures; hearing rights; and the ways their jobs had changed since the implementation of welfare reform and its concomitant de-linking of Medicaid from cash assistance; training experiences; and innovative procedures that they might have developed to meet the new demands of de-linking. In addition, a total of 60 case records were reviewed. The case samples encompassed Medicaid-only and Medicaid/TANF cases, both approvals and denials, and both redeterminations and initial applications.

Although the Office for Civil Rights (OCR) did not participate on the review team that conducted the site visits, OCR did provide HCFA with technical assistance regarding requirements for serving persons with limited English proficiency, serving persons who are visually or hearing impaired and physical accessibility for the disabled. OCR is participating actively on a HCFA review of the State Children's Health Insurance Program (SCHIP) in New Jersey, and is providing technical assistance to the Division of Medical Assistance and Health Services as part of that review. A copy of this report will be shared with OCR. OCR is able to provide States with technical assistance with regard to civil rights compliance issues (e.g., requirements for providing translators and translated written materials to applicants and beneficiaries who do not speak English under Title VI of the Civil Rights Act of 1964, accessibility for people with physical and mental disabilities under Title II of the Americans for Disabilities Act, etc.). The appropriate OCR regional offices for New Jersey are in New York City for the northern portion of the State and in Philadelphia for the southern portion of the State.

ELIGIBILITY AND ENROLLMENT PROCESSES

State Organization

The single State agency for both Medicaid and TANF in New Jersey is the Department of Human Services. Within the Department, the medical assistance unit is the Division of Medical Assistance and Health Services (DMAHS). The DMAHS also has responsibility for the SCHIP program. The TANF cash assistance unit is the Division of Family Development. The Medicaid program is State administered, but Medicaid applications are taken at local Boards of Social Services, where TANF applications are also taken. Since the applications are taken in the counties, each county establishes its own eligibility procedures, and operates its own internal computer systems. As a result, within the guidelines established by the State, there is considerable variation among the 21 counties.

Eligibility Categories

Section 1931 group

The welfare reform provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) amended Title IV-A of the Social Security Act (the Act) by eliminating the Aid to Families with Dependent Children (AFDC) program and replacing it with a new program, known as TANF. Prior to the enactment of PRWORA, receipt of AFDC conferred automatic eligibility for Medicaid. PRWORA severed the eligibility link between receipt of AFDC cash assistance and Medicaid. Section 114 of PRWORA added a new section 1931 to the Social Security Act. Under section 1931 of the Act, States are required to extend Medicaid eligibility to low income families who meet the pre-welfare reform AFDC income and resource standards and methodologies, i.e., the AFDC standards and methodologies in effect as of July 16, 1996. Under section 1931 of the Act, States have the option to lower their income standards, but not below the AFDC standards in effect as of May 1, 1988. States also have the option to increase their income or resource standards based on a percentage that does not exceed the percentage increase in the Consumer Price Index that have occurred since July 16, 1996. Section 1931(b) of the Act also gives States the option to use income and resource methods that are less restrictive than the methods used under the AFDC State plan as of July 16, 1996.

New Jersey covers the Section 1931 eligibility group as required. The Section 1931 group includes both families in receipt of cash assistance and families who meet the income and resource standards of New Jersey's Section 1931 group, regardless of whether the family applies for cash assistance. Prior to April 1, 1998, New Jersey continued to use the resource and income standards and methodologies of the old AFDC program to determine eligibility under Section 1931. New Jersey amended its State Medicaid plan (SPA #98-17) to provide for more liberal resource standards effective April 1, 1998. The State had requested an effective date of January

15,1998. However, HCFA required the State to use the later effective date, citing the fact that technically this amendment added a new eligibility group, and therefore, could only be effective as of the first day of the quarter in which it was submitted.

At the time of submitting State plan amendment #98-17, New Jersey elected to use less restrictive resource methodologies than those in effect as of July 16, 1996 as follows:

- The first \$1,000 of all countable resources is exempt in the eligibility determination. The remaining resources are compared to the resource standard in effect as of July 16, 1996.
- The equity value of one automobile is exempt up to \$9500.
- New Jersey also adopted a one year income disregard under Section 1931 to provide extended Medicaid coverage to families who otherwise might not be eligible.

These methodologies were less restrictive because, as of July 16, 1996, there was no disregard of countable resources; the equity value of a motor vehicle was exempt up to \$1500; and there was no disregard of earned income if the family had already received any other time limited disregards and the receipt of such income caused the family to otherwise lose Section 1931 eligibility. Prior to the submission of State plan amendment #98-17, the State used the income and resource methodologies in effect as of July 16, 1996.

The State also took advantage of the option to disregard the 100-hour rule as the standard used to define unemployment/underemployment. This State plan amendment, #99-10, was effective January 1, 1999. New Jersey initiated the early employment initiative, including disregarding the employment incentive income in the month of receipt, effective January 1, 1999.

Section 4913 Group

Section 211 of the PRWORA revised the definition of childhood disability under the Supplemental Security Income (SSI) program. The new SSI childhood disability is more stringent than the old definition, and resulted in the loss of SSI benefits for some children. Under section 4913 of the Balanced Budget Act (BBA), States must provide Medicaid to children who were receiving SSI benefits on August 22, 1996 but lost SSI on or after July 1, 1997 because of the revised definition of childhood disability provided they meet current SSI income and resource standards and the definition of childhood disability in effect prior to the 1996 revised definition.

The Social Security Administration (SSA) periodically sends to the States lists identifying the children who were receiving SSI on August 22, 1996 but lost their SSI because of the new definition of disability. The first list was sent in October 1998, the second list in April 1999 and the third list in early 2000. At the time of our review, the State was working on cases from the second list. At the time of receiving the first list, the State converted the children on it to the New Jersey Care - Special Medicaid Program for the disabled. This enabled the children to maintain Medicaid coverage until the time of their next scheduled redetermination. During redetermination, the State's own disability unit verifies that the child still met the pre-1996

definition of disability. If the child's medical condition had improved so that the definition of disability was no longer met, the child was evaluated for other programs, such as the Medicaid poverty level groups and SCHIP. The SCHIP program in New Jersey, known as New Jersey KidCare, provides for eligibility up to 350% of the Federal poverty level, regardless of disability status. The State did not have any statistics on children who had been terminated from Medicaid because of the more stringent disability definition, but eligibility staff reported anecdotally that they believed the number was very low, based on the fact that virtually all children who lost eligibility based on medical criteria should have gained eligibility in another category of Medicaid or KidCare. However, coverage under section 4913 protects Medicaid for the children who lost SSI eligibility due to changes in the definition of disability.

Since the State eligibility staff was unable to provide information on the actual number of terminated cases, they were not able to tell us, and we were not able to determine, the number of children who were still receiving Medicaid either under the 4913 category or under another eligibility category or that the terminations that did occur were proper or improper. Moreover, State systems staff informed the review team that the section 4913 eligible children do not have a unique code in the eligibility system. However, the county boards of social services were advised via Medicaid Communication 99-12 to annotate the protected status in the case records so that no child would lose the protection, even if they are identified under another eligibility group. Accordingly, if the protected child is served under another program, as part of a family group, for example, the worker is required to review eligibility under section 4913 for that child before any negative action is initiated. The lack of a unique eligibility code for these children could adversely affect them if they for some reason have a break in eligibility. In such a case, when the child comes back onto the Medicaid rolls, he or she may have lost section 4913 protection.

The State has incorporated the SSA Notification File into the SDX transaction process at the Office of Information and Telecommunications (OIT) and uses that file to screen all SSI terminations. When a termination transaction is received for a child who is listed on the Notification File, including those who are terminated subsequent to an appeal, the case is converted to New Jersey Care – Special Medicaid Program and referred to the county for outreach and eligibility determination. Reports of these conversions are created and forwarded to the counties on a regular basis. Alternatively, for a case that was previously converted pending appeal but is subsequently approved for SSI, the system automatically reestablishes SSI eligibility.

The State reported that if a child (or the family on the child's behalf) requested an SSI appeal, that child remained on the Medicaid roles as if he or she was still an SSI-disabled child. Since New Jersey is a section 1634 State, and if the child continued to receive SSI while the appeal was pending, the State had no reason to treat the child under a category other than as an SSI recipient. The State relies on the disposition reports from SSA to track the status of an SSI appeal. If the appeal is lost, the State should be reinstating the child into the section 4913 eligibility category. We are concerned that the lack of a unique identifier in the system may be interfering with this process, but we could not document, based on our case reviews, whether or not there was a problem in this regard.

Application and Enrollment

Opportunity to Apply for Medicaid

New Jersey has both a joint Medicaid-TANF application and a Medicaid-only application. According to State officials, the Medicaid-only application was originally designed for pregnant women and poverty level expansion children. At the time of this review, families were still subject to a resource test and were required to use the joint application even if they did not want cash, because only the joint application requested resource information. If an applicant had filed a joint application, and was determined to be ineligible for TANF, the applicant did not have to re-file; the Medicaid portion of the application was processed. This was verified during our case reviews. In November 2000, the State submitted a State plan amendment to implement the New Jersey Family Care under which the resource test is eliminated and all families and children who are not applying for TANF cash benefits may use a mail in application.

An individual in New Jersey can apply for Medicaid at a variety of sites. These are:

- county welfare agencies (called Boards of Social Services in some counties) and their satellite offices;
- outstationed locations (83 disproportionate share hospitals and 12 federally qualified health centers);
- a “one-stop” center in Bergen County;
- Medicaid-only offices (in larger counties, these offices are not co-located with the welfare offices; in smaller counties there may be a separate area in the welfare office);
- Community organizations that have been approved as KidCare enrollment sites (for children’s applications only).
- The statewide SCHIP vendor, which is authorized to receive mail in applications for children, including the poverty level expansion groups as well as the Medicaid expansion under SCHIP.

The State uses a joint Medicaid-TANF application, the PA-1-J, for families who are applying for both the TANF and Medicaid programs. Although the joint Medicaid-TANF application is very lengthy, it is designed for use as an interview instrument, so the client is not expected to fill it out without the assistance of an eligibility worker. This somewhat alleviates the barrier that may arise from the sheer length of the form. However, the length of the form is driven by the differing requirements of the TANF program from the Medicaid program. This is borne out by the fact that the Medicaid-only form and the KidCare form are much shorter and easier to complete.

Two other forms were in use in New Jersey at the time of our review:

- the PA-1-G, which is used to apply for Medicaid only, or for emergency assistance for SSI recipients; and,
- The KidCare application which can be used by any child applying for Medicaid or SCHIP. The KidCare application is much shorter than either the PA-1-J or the PA 1-G. At the time of this review, a new, even more simplified KidCare application was being pilot tested in the State. The review team was provided with a copy of this form. The State plans to further

refine the KidCare application based on the results of the pilot test. As part of the separate KidCare review conducted after the welfare reform review, the KidCare review team observed the simplified KidCare application being completed at some of the enrollment sites. The parents were able to complete the form with minimal assistance. One complaint noted was that the high gloss paper of the form was difficult to write on. The State has already begun to use regular paper for the form.

In order to find out first hand about the application process, the review team visited three county welfare offices in which Medicaid and TANF applications are taken. In all three offices, managers, supervisors and front-line eligibility workers were interviewed. The team noted that the front line workers displayed a customer-oriented focus. They were cognizant of the unique situations created by welfare reform; i.e., welfare and Medicaid are no longer linked, therefore, applicants require more explanation as to the application procedures. Clients are made aware that they can apply separately for Medicaid; eligibility workers reported that many applicants are not aware prior to coming to the office that Medicaid and welfare have been de-linked. Also, the workers stressed to the review team that many clients applying for Medicaid are now working, therefore, a 9 to 5 office schedule does not suit their needs. The counties had taken initiatives to address the needs of working clients. One county is providing appointments for face-to-face interviews one evening a week. Another county has expanded its existing home visit program to allow workers to make work site visits to meet with clients on the client's lunch hour or break time to complete the face-to-face interview requirement.

In the three local offices we visited, it was possible to obtain an application for Medicaid, TANF, food stamps, or all three on the first visit to the office and be interviewed on that day. However, all three offices strongly encouraged clients to phone in before coming to the office, in order to be told what documents to bring with them so that the entire application process can be accomplished in one visit. Advocates, public service announcements, posters in community locations and work sites are used to spread the word about calling first. Application dates were protected as of the date of the initial inquiry, using phone logs for call-ins, and dates for walk-in applications. The advantage to the client of making an appointment was that he or she wouldn't have to make a second trip to the office. Walk-ins did not usually have all required documentation with them, necessitating either a second trip to the office, or a work site visit by the eligibility worker.

In the case of a TANF/Medicaid application, when the applicant is required to fulfill a TANF job search requirement, the processing of the application goes on simultaneously with the job search. That is, no part of the application is held up pending the job search. If the client gets a job through the early employment initiative, the TANF portion of the application is withdrawn, and the Medicaid and Food Stamps portions continue to be processed. The Division of Family Development has issued a special alert to all local offices, which states, "There is to be no impediment to Medicaid and Food Stamps for work-related reasons." Eligibility workers and supervisors interviewed indicated that they were well aware of this directive.

Passaic County had the most advanced application system, by which all applications for all assistance programs available to New Jersey residents have been combined into one master application that is computer based. Clients provide information one time, and it is transferred

onto all applications for all programs that the client may be eligible for. The generic application is automatically screened for TANF, Medicaid, Food Stamps, Kid Care, charity care, general assistance, heating assistance, home and community based waivers, and long term care. At the end of the interview, applications are printed for the programs for which the client has been determined to be eligible, and signed by the client.

Eligibility determinations are made by authorized county eligibility workers, acting as agents of the State. These are merit system employees. Depending on the county, eligibility workers are either specialized (Medicaid-only workers, food stamp workers, TANF workers) or generalized (can take application for any or all programs). In the counties that still have specialized workers, the TANF worker is trained to use the PA-1-J, enabling her to take joint applications. In one county, these workers were actually in a higher civil service category than the Medicaid and food stamp workers. The other counties we visited had generalized workers. In very small counties, the worker also may have responsibility for the child support enforcement program. This was not the case in any of the three counties we visited.

Worker caseloads vary by county. In the largest county we visited, Essex County, each caseworker had between 700-800 active integrated cases. Each worker processed about 50-100 new cases per month, with the daily average being 2-3 new cases a day. The case remained with the same worker for as long as the recipient remained eligible in that county. The director of the Essex County office expressed a concern about the understaffing in his office. He stated that county budget cuts fell heavily on his staff, and he was anticipating layoffs in the near future, at the start of the fiscal year on July 1, 2000. Given the large caseloads already in effect in that office, and the fact that Essex is the largest county in the State and has the highest number of Medicaid beneficiaries, the review team shares this concern. In Mercer County, eligibility workers also reported that they interviewed an average of three applicants per day. In this county, the workers averaged 500-600 active cases. Passaic County workers also reported an average of 2-3 interviews per day.

Statistics provided by the Newark Star Ledger, as part of its analysis of the impact of welfare reform, showed that the number of children in New Jersey on Medicaid had declined by 1.3% from 1997 to 1998. However, in Passaic County, the number of children on Medicaid had increased by 11.5% in the same time period. In Mercer County the decrease was 2.3%. In Essex County the decrease was 1.5%. Passaic was one of only three counties to show an increase, and its percentage of increase was the largest. The state staff indicated that the decline had been ongoing since 1993, and so could not be wholly attributed to welfare reform. The state has conducted a study to try to identify the reasons for the overall decline in the number of persons eligible for both Medicaid and TANF. The study is described in the "Relevant Studies" portion of this report.

It is also necessary to consider these numbers in context. In April 1998, the State expanded Medicaid eligibility for children under age 19 to 133% of the Federal Poverty Level and initiated efforts apart from welfare reform to promote enrollment among eligible children. Thus, beginning at that point, one would have expected enrollment to rise substantially for children. Standards for parent eligibility remained fairly constant throughout this period. If separate data had been captured for parents, that data might better indicate the impact of welfare reform;

however, no separate parent-related data was available at the time of the review. The State subsequently presented parent data that indicates a statewide reduction of 68% in the adult caseload from 2/97 to 8/99. The review team was not able to determine the accuracy of this data.

Civil Rights

New Jersey has a State law that requires that all public documents must be available in both English and Spanish. However, there are now many other languages spoken throughout the State, bringing a need for interpreters who can communicate in languages such as Polish, French, Haitian Creole, Vietnamese, Cambodian, and many African languages. The review team found that the three counties visited had extensive lists of interpreters available among their own staff members, and had access to language banks and liaison arrangements with local community based organizations that could provide interpreters for less common languages on short notice. One county had two in-house sign language interpreters, one of whose training was paid for by the county. When we interviewed eligibility workers, they all displayed knowledge of how to access the language banks, and were readily able to produce the list of in-house interpreters and phone numbers of the community organizations with which liaison arrangements were operative. The three offices the team visited were physically accessible to the disabled. Ramps, elevators, wide doorways, handicapped parking spaces, and appropriately modified rest rooms were observed.

Timeframe for initial eligibility determinations

Federal regulations require that Medicaid eligibility determinations must be made within 45 days from the date of application or within 90 days in cases of disability. New Jersey has adopted stricter time frames. Under these time frames, Medicaid eligibility must be determined within 30 days for non-disability cases and 60 days for disability cases. We reviewed a sample of 60 cases, which encompassed Medicaid-TANF, Medicaid only, child only, pregnant women, and long term care cases. Both disabled and non-disabled cases were included. We found that 58 of the 60 cases met Federal time frames. The other two cases involved beneficiaries in nursing homes, who exceeded the resource levels at the time of application. Rather than denying the case and requiring reapplication at a later date when resources had been depleted, the county elected to hold the case while the beneficiary continued to pay privately for the nursing home care, and determine the case after the resources have dropped to the eligibility resource level. When questioned, county workers indicated that it was better not to inconvenience the family by requiring a whole new application, and stated that was the reason the cases had been put into pending status.

MAINTAINING COVERAGE FOR FAMILIES WHO LEAVE WELFARE

Provide Transitional Medicaid for Families

Under Federal requirements, States must provide up to twelve months of transitional Medicaid to families under certain conditions. States must provide six months of coverage to families who lose Medicaid under Section 1931(b) due to excess hours or earnings from employment of the caretaker relative, or because a member of the family lost the applicable disregards. States must

provide an additional six months of coverage when the family income remains below 185% of the Federal poverty level (FPL). New Jersey meets these requirements, and provides additional coverage as indicated below.

New Jersey provides transitional Medicaid for individuals no longer Medicaid-eligible under Section 1931 for up to 24 months. The State does not claim Federal financial participation (FFP) for the additional 12 months. The State had two separate welfare reform demonstrations in the 12 years preceding welfare reform, and its transitional Medicaid program has existed for those 12 years.

Enrollment Process for Transitional Medicaid

Families become enrolled in transitional Medicaid in a number of ways.

- some families are identified at their scheduled Medicaid redetermination date;
- others are identified through their “Work First New Jersey” caseworker; and,
- others are identified when they file a change in earnings report (required by TANF within 10 days of a change in earnings) with the TANF agency and it shows earnings that will result in a TANF closure.

Families identified through an earnings report automatically receive transitional Medicaid. In these cases, no member of the family has to come into the County Welfare Office. The system establishes transitional Medicaid and automatically computes the date on which transitional benefits will end, for these earnings-related cases. This procedure applies in all counties. For families identified by a Medicaid redetermination or through the case worker, input into the system triggers transitional Medicaid.

If a client withdraws from TANF or fails to cooperate with a TANF requirement and therefore loses TANF, those closing codes correctly do not trigger transitional Medicaid automatically, since in most of these cases the client remains eligible for Medicaid under section 1931. To assure that Medicaid continues, and that clients know it should continue, Work First New Jersey case managers are conducting proactive outreach to all their clients so that the client is made aware of the benefits that should continue when TANF terminates. This precautionary measure helps assure that the client will immediately contact the county if his or her Medicaid and/or Food Stamps incorrectly terminate. Moreover, the “Work First New Jersey” Manual reminds the case workers that “Any family member losing eligibility for Medicaid shall be evaluated for potential Medicaid eligibility under other Medicaid components prior to termination from Medicaid.” (Subchapter 5 of the “Work First New Jersey” manual). This requirement is also found in the New Jersey Administrative Code at 10:90-5.6.

State Medicaid staff conducted a study of TANF terminations where transitional Medicaid should have started and found that over 90% of the people who should have begun transitional Medicaid were in fact getting the transitional benefit. Since this was a state study, the review team could not verify the findings without repeating the study, which was well beyond the scope of this review process. DFD and DMAHS were developing a joint outreach project at the time our review was conducted, in order to reach the 10% (currently estimated to be about 26,000

families) of potential transitional clients who were found not to be receiving transitional Medicaid. The only documentation a family must provide as a condition of ongoing eligibility for transitional Medicaid is earnings information, which may be in the form of pay stubs or a letter from the employer. At the time of this review, it was still required that the client come into the office with this information, although some counties were beginning to pilot having the information mailed in.

Loss of Transitional Medicaid

All counties except Warren have signed a Memorandum of Understanding with the State to re-screen families for eligibility in Medicaid or SCHIP at the expiration of transitional Medicaid. The agreement was operational in the 20 counties other than Warren by June 1999. This rescreening most often requires new documentation, since at the expiration of transitional Medicaid (i.e., at the end of 24 months of transitional benefits in New Jersey) it is the rule, rather than the exception, that the most recent redetermination is 12 months old. The case is treated as a redetermination, and requires new documentation, or a confirmation from the family that the documentation on file has not changed. The confirmation can be made in writing or by phone to the caseworker.

The State does not terminate transitional Medicaid for individuals who fail to meet reporting requirements, because the State has said it has no reporting requirements. Under New Jersey's most recent welfare reform demonstration, which expired in 1997, there was no reporting requirement, there were redeterminations at 6, 12 and 24 months. When the demonstration expired, the State elected to keep this redetermination schedule for transitional Medicaid benefits, rather than implement new reporting requirements. As is discussed elsewhere in this report, various counties are looking into the feasibility of moving to an every twelve-month redetermination schedule to ease the burden on families. HCFA would find such a schedule acceptable.

The State has a computerized tracking and coding mechanism for converting Medicaid eligible cases to transitional coverage and converting transitional Medicaid back to section 1931 or other eligibility category automatically if family circumstances change. This mechanism works only as long as cases receiving TANF remain in the FAMIS (family assistance management information system) system. There is no way to track cases receiving Medicaid-only other than manually, although as counties move to the Universal Application System (UAC), it will be possible to track these cases.

PROCEDURES RELATED TO DENIALS AND TERMINATIONS

Denial of Medicaid during TANF Application and Enrollment

If TANF is denied, the Medicaid portion of the joint application is processed without the need for a new application. All eligibility workers interviewed in all counties visited stated that this is in fact what happens. However, in one county, the Deputy Director stated that he had identified some instances in which the Medicaid application is inadvertently denied under these circumstances. When this happens, the error is generally caught during supervisory review

before the denial letter is sent out. All denials require supervisory review. The Deputy Director said this situation is becoming less frequent as time goes on and as eligibility workers become more familiar with the requirements of welfare reform. The review team did not find any evidence in its sample case reviews that denials had occurred as described by the Deputy Director. However, in a small sample, it is possible that such cases would not surface.

State officials interviewed stated that if TANF is denied due to failure to verify criteria, Medicaid is denied only if the criteria that were not verified are also required for Medicaid eligibility. If TANF is denied for a work-related requirement, the Medicaid application goes forward to be determined based on Medicaid eligibility criteria. Our review of case records showed that this was in fact the case, at least based on the limited sample reviewed.

If the family decides not to go forward with its TANF application, Medicaid eligibility is determined without a new application, so long as the family provided the information necessary to make a Medicaid determination. Otherwise, the family would have to be recontacted for the necessary information. In our case reviews, we did not find any cases where a new Medicaid application had to be taken as a result of a family's deciding not to proceed with the TANF process. The review team did see a few cases where the TANF portion of a joint application had been denied, but the Medicaid portion had been approved.

When an application is for a child only, the form used is the New Jersey KidCare application. The newest version of this application makes it clear that the parent's Social Security Number (SSN) is optional; however, earlier versions of the application requested the parent's SSN without stating that this was optional. Since the KidCare application is the only Medicaid application that can be mailed in for an eligibility determination, it is important that the information requested be clearly described. Since the earlier version of the form is no longer used, the problem has been corrected. HCFA, OCR, and HRSA are currently conducting a review of the KidCare program. It is possible that further modifications to the KidCare application will be made as a result of that review.

The New Jersey Pregnant and Infants application erroneously contains a note stating that the submission of SSNs for all household members is mandatory. New Jersey's joint TANF-Medicaid and Medicaid-only applications correctly require only the SSNs of household members applying for benefits. The termination/denial/suspension notice for Medicaid advises the individual that he/she may be eligible for other Medicaid programs and to contact the local county office. This language is confusing, since eligibility workers must evaluate the client for all possible Medicaid eligibility categories prior to termination or denial. Since the review team did not find evidence that the workers were erroneously terminating individuals, we believe the State's intention is to refer individuals to programs such as "Health Access New Jersey," but the wording of the notice is misleading. The State needs to amend this notice to clarify what is meant.

Termination of Medicaid and the Medicaid Eligibility Redetermination Process

Redeterminations for Medicaid (both TANF related and Medicaid only) are done on a regular schedule. State officials informed us that in all but Essex and Hudson Counties, the schedule is every six months. In Essex and Hudson, the counties are experimenting with redeterminations every 12 months to coincide with Food Stamp redeterminations. Medicaid recipients with earnings receive letters bi-monthly asking if there has been a change in circumstances. They can respond by mail or phone; no in person visit is needed.

Redeterminations require a face to face interview. At the time of our review, none of the counties the review team visited were making use of ex-parte reviews for redetermination purposes. The beneficiary is required to provide proof of wages in the form of pay stubs or a letter from the employer, rent receipts, family composition, and school attendance for children. Proof of school attendance is required for TANF only. The list of required documentation sent to the family with the redetermination notice instructs them as to what documentation to bring. When we interviewed the county eligibility workers, they verified that when one family member loses eligibility, the remaining eligible family members are not affected. If the entire family loses eligibility, the case is re-evaluated for all other categories of Medicaid and KidCare. County workers stated that since KidCare eligibility is available to children in families earning up to 350% of the Federal poverty level, eligibility for the children is generally maintained when the family is terminated for excess income. In two of the counties we visited, eligibility determinations in other than the section 1931 category had to be manually calculated; in Passaic county the process was automated for all categories. The manual process is checked by a supervisor. Supervisors confirmed this on interview. Case review showed supervisor sign-off on manual calculations. All denials were also countersigned by a supervisor.

Both the case workers we interviewed and State eligibility staff advised the review team that when TANF is terminated for a family, that termination affects Medicaid only if the termination is for a reason that also applies to Medicaid, such as moved out of State, required information applying to both programs not provided, failure to appear for redetermination. Otherwise, based on caseworker ability, families may or may not be aware that Medicaid usually continues when TANF is terminated.

If a TANF sanction is applied for a child-support related reason, the parents lose Medicaid as well as TANF, but the children do not lose benefits. Review of State policies and procedures, as well as interviews with State and county staff verified this policy.

REACHING FAMILIES POTENTIALLY ELIGIBLE FOR MEDICAID

Outstationed Eligibility Workers

Federal regulations require States to have outstationing arrangements and provide an opportunity for pregnant women and children to apply for Medicaid at locations other than welfare offices. New Jersey officials provided us with a list of all outstation locations. The list includes 60 hospitals and 10 Federally Qualified Health Centers (FQHC). The advocate group has

commended the outstationed workers for the service they provide to pregnant women and children in expediting their eligibility determinations. In addition to the above outstationing sites, the State has developed a network of community based organizations which are being trained to take KidCare applications. Some of these community-based organizations were visited by HCFA staff as part of the program review of KidCare, and will be discussed in the report of that review. These community-based sites were not visited during the Medicaid-TANF review. However, one of the review team members was also a member of the KidCare review team. She visited two of the community sites, and observed the application process. The workers at these sites stated that they were trained by the State to take applications, and demonstrated competency in the process.

Public Charge

The State has developed brochures (copies were provided to the review team) that clearly state that receipt of Medicaid and KidCare benefits does not result in classification by the Immigration and Naturalization Service as a public charge. In addition, the State disseminated information to all counties on the public charge policy. The review team noted the presence of this information at the county offices visited. When the review team interviewed eligibility workers at the three counties we visited, we found that they were able to articulate their knowledge that receiving Medicaid and KidCare does not make an immigrant a public charge. The State eligibility director has been on two local radio programs geared to the immigrant community to publicize the public charge policy. She has also been active with an immigration policy network within the State to further publicize the public charge policy and encourage families to apply for Medicaid or KidCare. A Medicaid representative participated on a panel at the public charge conferences in New York and New Jersey that were sponsored by the Regional Director of the Department of Health and Human Services. The review team also asked the advocates whether there was a public charge problem. While the advocates acknowledged that their clients in general do not trust the Immigration and Naturalization Service, they stated that the public charge policy had been heavily publicized, and they did not find the State's dissemination to be deficient.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

New Jersey has a combined Medicaid expansion (KidCare A) and a Title XXI SCHIP program (KidCare B, C, and D, depending on percentage of Federal poverty level). As a result of these four sub-classifications, children are covered if family income is up to 350% of the Federal poverty level.

Eligibility determinations for KidCare A, the Medicaid expansion, are made by the State. The State's SCHIP contractor, Birch and Davis make eligibility determinations for KidCare B, C, and D. KidCare applications are mailed to Birch and Davis for this purpose.

Families typically apply at one of the community based organizations, or at the county welfare office, but the family can request an application by mail or phone and mail it in if this is more convenient. The family can also apply for KidCare at all WIC (Women, Infant and Children

food program) sites in New Jersey. Each county maintains liaison with the KidCare/SCHIP contractor.

In order to make the Medicaid/SCHIP application process as seamless as possible, those families wishing to apply for health benefits only for their children can do so on the KidCare application, which is then screened by the county or the contractor, as appropriate, to determine the proper program. If that program is Medicaid, the contractor passes the application to the State for the formal eligibility determination. HCFA contacts with the advocacy group in New Jersey have confirmed that families are in fact able to use the KidCare application to apply for Medicaid.

The State conducted a study that showed that one in ten KidCare participants is referred from the county welfare agencies. Since the counties are required to screen all Medicaid denials for potential SCHIP/KidCare eligibility, the State believes that the study referred to above demonstrates that the counties are meeting this responsibility. If the contractor receives a KidCare application with income information that shows potential TANF eligibility, State procedures require that the child immediately be enrolled in either Medicaid or KidCare so that health care will not be delayed. The family is then contacted and advised to go to a TANF site to apply for cash benefits. Contact with various advocates in New Jersey indicated that this process is working. In addition, the county staff in the counties visited also stated that the process is effective. However, we did not have the opportunity to observe it personally.

A separate program review of the Title XXI KidCare program is underway in New Jersey. The report of that review will provide extensive information about the SCHIP program in New Jersey.

OPTIONAL POLICIES FOR MEDICAID ELIGIBILITY

When this review was conducted, New Jersey did not provide continuous or presumptive eligibility for children under age 19. In the quarter ending 12/31/99, the State submitted amendments to both its Medicaid (SPA 99-22) and SCHIP (#99-21/04) State plans to allow presumptive eligibility for children. These plan amendments were approved by HCFA with an effective date of 1/1/2000.

The State pays premium and cost-sharing amounts for employer sponsored health insurance under Medicaid when it is cost effective to do so. New Jersey began to do this effective July 1, 1991 under State plan amendment #91-23.

New Jersey has also adopted a one year income disregard under Section 1931 to provide extended Medicaid coverage to families who otherwise might not be eligible.

ENSURING ADMINISTRATIVE EFFICIENCY AND MEDICAID QUALITY CONTROL

Negative Case Action Program

State officials stated that New Jersey does not conduct a negative case action review. The position was eliminated during budget cuts approximately 10 years ago, and was never reinstated. Staff is aware that this is a violation of Federal requirements, and acknowledged that HCFA has previously cited the State for failure to meet this requirement. The State had not given a high priority to correcting this deficiency due to other pressing matters such as fiscal agent reprocurement and Y2K activities. However, in May 2000, State officials contacted the HCFA regional office to inform them that the negative case action program is to be reinstated. The state expects to be able to reinstitute the program on or about July 1, 2000. The state quality control staff is working closely with HCFA's statistician on the sampling methodology and the methodology to be used.

State Organization

The single State agency for Medicaid and TANF in New Jersey is the Department of Human Services. Within the Department, the Medicaid unit is the Division of Medical Assistance and Health Services. The TANF unit is the Division of Family Development. Both the Medicaid and TANF program eligibility determinations are administered at the county level, with close State supervision. All counties have assigned State liaisons to monitor daily activities and assure compliance. A regular system of State bulletins (Medicaid Communications) is sent to the county offices and has been effective in disseminating policy changes without delay. These Medicaid communications were examined by the review team at both the State and county offices.

Coordination and Training

Program information for each case is coordinated through the management information system. When a joint application is used, all relevant information is input into the system.

All staff interviewed at the local level reported that they had received extensive training (ranging from 3-6 weeks of full time training, followed by close on the job supervision until deemed competent by a supervisor). All reported ongoing in-service training, with appropriate written handouts given for future reference. All counties reported that there is a second party case review process. We verified this on case reviews; a supervisor signed off all determinations.

Computer Systems

Computer systems support the policies previously described in this report. System enhancements have been made to reflect new section 1931 groups, and allow for the Medicaid portion of an application to remain open if TANF is denied. SCHIP systems have been developed. The TANF and Medicaid programs reside on the same mainframe; however, the process is separated to protect against erroneous terminations. In one county, workers stated that they have data entry capability to override system functions such as erroneous terminations. Review team members could not substantiate this, as the system was down for the entire day that the team was on-site in that county.

One aspect of the computer system that was cited by the workers as burdensome was that the eligibility computations for all groups other than section 1931 had to be done manually. We are

concerned that manual computations introduce the possibility of human error, somewhat mitigated by the second party case review process.

CONSUMER ADVOCACY GROUPS

The HCFA regional office has an ongoing relationship with a consumer advocacy group that was jointly created by HCFA staff and Legal Services of New Jersey staff in the summer of 1999. A wide range of consumer groups, representing all segments of the Medicaid population, participates in monthly meetings. Representatives come from several county legal services offices, the Arc of New Jersey, the Primary Care Association, providers, the Association for the Betterment of Citizens with Disabilities, the Eastern Paralyzed Veterans Association, Union County HIV coalition, and the behavioral health program of the University of Medicine and Dentistry of New Jersey. The group was instrumental in assisting in our selection of county offices to be visited, and in directing our attention to specific areas on which to focus. In addition, the advocates shared their perceptions of the situations arising as a result of welfare reform. The advocates also informed us that within their own ranks there was some confusion about the ramifications of welfare reform and Medicaid-TANF delinking. For example, legal service attorneys in some counties did not understand what de-linking meant. HCFA staff was able to address this confusion, and provide technical assistance to this group.

It is important to note that the advocates work closely with the State on Medicaid issues. Several of the advocates have volunteered their time to participate in advisory groups dealing with various aspects of the Medicaid program. Advocates have indicated to the review team members that, in general, they have good access to Medicaid officials. On occasion, the advocates, especially the legal services advocates, have assisted clients in resolving individual problems with Medicaid or KidCare. The advocates have not raised any systemic concerns to HCFA regarding Medicaid-TANF de-linking.

Subsequent to the review, Legal Services of New Jersey and Union County Legal Services had the following specific comments:

Application Process and Joint Application Form:

The advocates noted that the application process duplicates requests for documentation (once during a "screening process" and again during the face-to-face interview) and that information is not shared between workers, e.g., Medicaid and housing assistance. The advocates also stated that the joint Medicaid/TANF application is complicated and requires extensive documentation. They recommended a "user-friendly" easily understood application that could be mailed in with minimal documentation, accompanied by self-verification. The advocates made note of New Jersey's work to streamline the application for NJ Family Care (which includes the SCHIP program and the section 1931 low income parents) and recommended that the State extend this application to all Medicaid applicants. The advocates further noted the use of a uniform application form being used in Passaic County that appears to work well for informing the applicant in one interview about their specific program eligibility for benefits and encouraged the use of this in all offices with accompanying training for staff.

Office Hours:

Advocates expressed concern that the offices of the county boards of social services (the only locations where people may apply for Medicaid) have inconvenient hours of operation that often make it impossible for a person to apply for Medicaid, contrary to the indications given by the State. According to the advocates, very few offices in New Jersey stay open late on a weekday evening. Those offices that have official hours after 5:00 p.m. do not see any clients after 5:00 p.m. In addition, some offices, if not at all, close entirely from 12:00 p.m. to 1:00p.m. each day for lunch and do not stagger their employees' lunch hours to accommodate applicants for any public benefits during this hour. The advocates recommended the standard adoption of convenient hours of operation for all offices that serve persons applying for public benefits. The advocates recommended the State consider lunch time hours and hours before and after normal working hours.

RELEVANT STUDIES CONDUCTED OUTSIDE OF THIS REVIEW

Churning Study

New Jersey conducted a “churning study” in the spring of 1999. The purpose of the study was to gain some insight into the decline in Medicaid and AFDC/TANF eligibility since January 1993. The study concentrated on children. A database of 68,000 children across the 21 counties in the State was developed. This database encompassed children who were terminated from Medicaid for reasons other than obtaining the age of 21 years. Four counties were selected for sampling, representing both northern and southern portions of the State and major urban/less urban areas. A random sample of 1464 children in 997 cases (some cases had more than one child) was selected from the database.

Case numbers and names were forwarded to the respective county welfare agencies to retrieve the case records. Records were then reviewed by the Medicaid and DFD quality control workers with the intent to determine the reasons for termination in the sampled cases and individuals. When necessary, reviewers consulted with county staff to better understand procedures.

All terminated children were placed into one of four categories:

- should have been referred to Medicaid on TANF termination (some in this category actually were referred) – 18%
- handled appropriately – 19%
- applicant’s responsibility (failed to cooperate) – 47%
- unknown factors – 15%

At the time of our review, the State was involved in the next phase of this study, which is to investigate the reasons for both applicant non-compliance and non-referral in cases that should have been referred.

Arthur Andersen/Robert Wood Johnson Study

For eight weeks in the summer of 1999, the Robert Wood Johnson Foundation and Arthur Andersen Business Consulting collaborated with New Jersey Department of Human Services and Monmouth County Division of Social Services personnel in a performance improvement analysis. This analysis was designed to diagnose key problems and opportunities for change in the New Jersey Medicaid Eligibility System; validate the root causes of identified problem areas and prioritize improvement opportunities through data collection and interviews; create action plans for high priority improvement opportunities. At the time of the study, it was found that TANF workers were not as knowledgeable as they should have been about eligibility rules, resulting in some misinformation being given to clients. For example, applicants were not always made aware that the requirements for Medicaid eligibility were different from those for cash assistance. This misinformation may have contributed to the high number of “non-compliance” terminations. Moreover, the workers were not always redetermining eligibility for other categories of Medicaid when transitional Medicaid ended. A number of recommendations were made as a result of this study, notably to redesign the locally generated eligibility notices, improve worker training, and improve tracking mechanisms. The State is implementing these recommendations in Monmouth County first and will later expand to the rest of the State if the pilot project is successful.

PROMISING EFFECTIVE PRACTICES

The customer service oriented approach taken by front line workers at all local offices visited is a tribute to the commitment shown by the State to making welfare reform work. We found that county workers were willing to make home visits and work place visits, work expanded hours and in general assist clients in any way possible. Even in Essex County, where workers’ case loads are very high, there is a commitment to good customer service. Attention was given to allowing flexibility in appointment schedules so as not to interfere with work hours. The expanded hours available to clients in Mercer County have worked well, and consideration should be given to encouraging other counties to follow Mercer’s lead.

New Jersey has implemented an extremely positive approach in Passaic County. The county has developed a single online interview and application process which allows the caseworker to access all programs in the system simultaneously. The system minimizes opportunity for human error, because it prompts the worker to ask the next relevant question, based on the client’s answer to the previous question. The system will produce simultaneous and multiple applications (TANF, Medicaid, Food Stamps, child support, general assistance, and SCHIP). Furthermore, the system has already been designed to accommodate all Federal and State welfare reform changes. The system can readily and rapidly be modified in the event of future program changes. Additionally, the program design tracks individuals on assistance with respect to the TANF 60-month limit. A program has also been designed to track individuals placed in employment for the purpose of monitoring program compliance and facilitating statistical

research. We sat through an online demonstration of the system, using actual client data and found that this single point of entry access for the individual results in a seamless delivery of public services.

The design of the system eliminates question redundancy and provides for data sharing between programs. The result is a reduction in administrative costs, a streamlining of the bureaucratic processes to which an individual applicant is subjected, and an improved delivery of services to the public. The office director noted that the system had cost very little to implement and had more than paid for itself.

CONCERNS/NEXT STEPS

- 1) Federal regulations at 42 CFR 431.812 require States to conduct a negative case action program as part of its MEQC program. We are concerned that New Jersey does not conduct a negative case action program. However, since the time of this review, the State and HCFA have had several meetings about the negative case action program; the State has designed a negative case action program and was given verbal approval by HCFA on July 10, 2000. The State will meet with HCFA to discuss making minor revisions to the proposed program and HCFA expects that negative case action program will be re-instituted by August 2000.**

State Comment:

New Jersey has designed a negative case action (NCA) review that will be phased into operation in three distinct stages. New Jersey's NCA monitoring activities will focus on the Medicaid intake and application processing practices of its local agencies and vendors. The goal of these NCA monitoring activities is to assure that individuals receive and/or retain the Title XIX medical assistance for which they are eligible.

The first stage was developed and became operational in April 2000. Selection of households is outreached through this activity each month. The child(ren) of these households are scheduled to be disenrolled (terminated) from Title XIX funded Medicaid coverage because their parent/applicant failed to submit an eligibility renewal form timely.

The second stage of the NCA review process to be implemented will focus on children's cases that have been denied, terminated, or "timed out" (needed information is not supplied by the family timely). A monthly sample selection will be reviewed to determine the correctness of the adverse action and then provide alternatives to Title XIX Medicaid coverage. The parents/applicants will also be interviewed regarding their awareness/eligibility for other medical coverage.

The third stage of the NCA review process to be phased in will be a review of the aged, blind and disabled segments of the Title XIX population. Again, a number of negative actions (denials, terminations and withdrawals) will be selected each month. The correctness of decisions will be reviewed and the families will be contacted to assess potential eligibility for other state administered medical coverage available to household members.

This redesigned negative case action review methodology is set up so that important issues are identified concerning the impact a denial or loss of medical coverage has on beneficiaries. It is expected that the collected information will provide additional insight in answering the following questions:

- Why do Medicaid beneficiaries fail to renew (maintain) Medicaid coverage?
- What medical coverage options do applicants have when they are denied Medicaid coverage?
- What medical coverage options do beneficiaries have when their Medicaid coverage is terminated?

HCFA Response:

The HCFA regional statistician has been working with the State in developing sampling methodologies for this negative case action pilot. We will continue to provide technical assistance as New Jersey quality control staff implement phases two and three of the pilot. We commend the State for taking the opportunity to design a negative case action pilot that focuses on why families do not complete the redetermination process and we believe the findings will prove useful to the State's simplification efforts.

2) One county (Essex) reported what seemed to them to be an excessive amount of system downtime. This finding did not affect the other counties, nor did it affect the timeliness of determinations in the reporting county.

State Comment:

This report was not shared with Essex County at the request of HCFA in order to maintain confidentiality. Following issuance of the final report, the Division will review with Essex County the finding and establish a corrective action plan as necessary.

HCFA Response:

We encourage the State to follow-up with Essex County as soon as possible to determine the scope of the problem and whether a corrective action plan is needed.

3) We are concerned that staffing levels in Essex County that already may be low may further drop as a result of planned layoffs. Even presently case workers in Essex County have very full caseloads (between 700 and 800 each, with 50- 100 new cases to process each month) which may be hindering effective case management. Any reduction in staff could have an adverse effect on the county's ability to meet its responsibilities in determining eligibility for Medicaid and other benefit programs.

State Comment:

This report was not shared with Essex County at the request of HCFA in order to maintain confidentiality. Following issuance of the final report, the Division will review with Essex County the finding and establish a corrective action plan as necessary.

HCFA Response:

We encourage the State to address this concern as soon as possible to determine if a corrective action plan is needed.

4) The State does not have a way to uniquely identify section 4913 children in its eligibility system. This makes it impossible for the state to track these children, particularly if they have a break in eligibility, to ensure that they receive continued eligibility under section 4913.

State Comment:

It is true that the State does not code these cases uniquely on the eligibility system, but the county boards of social services were advised by Medicaid Communication 99-12 to annotate the protected status in the case records so that no child would lose the protection, even if they are identified under another eligibility group. Accordingly, if a protected child is served under another program, as part of a family group, for example, the worker is required to review eligibility for that child under Section 4913 before any negative action is initiated.

HCFA Response:

We are concerned that annotating the case records as the only means of identifying protected status does not afford the best assurance of continued coverage, particularly if the case record is misplaced or destroyed, but primarily because manual processes are subject to human error. We encourage the State to code these cases on the eligibility system or, at the least, have some central system of case identifiers and tracking mechanism to ensure protected status is continued. We will follow-up on this matter as part of our tracking of the directives in the April 7, 2000 State Medicaid Directors letter.

5) County workers reported a need for manual computations in non-TANF related Medicaid cases. It would seem that this cumbersome process could be rectified by a modification to the computer system. In addition to being cumbersome, the manual process is more vulnerable to human error, which could lead to erroneous denials and terminations.

State Comment:

The State is currently exploring options to develop a statewide, networked Medicaid tracking system for the CBOSS. The functionality would be modeled after that which is currently available in Bergen, Passaic and Monmouth counties. A proposal for such a system is incorporated into a RWJ grant proposal entitled "Supporting Families after Welfare Reform," which was recently submitted.

Arc of New Jersey Comment:

The draft report cites an overall decline in the number of New Jersey children on Medicaid. However, in Passaic County – the county that seems to have the most advanced computer-based generic application system – there was an 11% increase in the number of children on Medicaid. We are concerned about the likelihood that a considerable number of eligible children in the other counties may not be receiving Medicaid. We would like to see the other counties institute the type of system that has been so successful in Passaic County.

HCFA Response:

HCFA staff has seen the referenced system in Passaic and Bergen counties, and we agree that the system would greatly benefit all of the counties in the State. Advocates have expressed support for other counties' implementing the type of system that has been successful in Passaic and Bergen. If the State does not receive the grant, other options for making eligibility determinations less cumbersome and prone to potential human error should be explored.

6) We are concerned that clients may not be adequately informed that Medicaid can be accessed even if the family does not want or need the cash assistance of the TANF program.

State Comment:

The Division of Medical Assistance and Health Services and the Division of Family Development are collaborating on a number of initiatives to ensure that clients are adequately informed about Medicaid options. Statewide training, including sessions on transitional benefits, was provided to the staff of the CBOSS. Communications were disseminated reinforcing the delinking of Medicaid from TANF and the importance of working with clients to ensure that eligibility is not lost at point of vulnerability, such as employment or loss of transitional benefits. DFD established a hotline and initiated outreach to individuals who were scheduled for termination. Materials and information concerning transitional benefits were mailed to each family and the division contracted with faith-based organizations to follow-up for those who did not respond. In addition, beginning March 15, 2001, the Division of Medical Assistance and Health Services will begin a new round of training for CBOSS staff, to explain the various medical assistance programs, and to again emphasize the importance of referring families, single individuals and childless couples who are not eligible for Medicaid to the new program now available in New Jersey through New Jersey Family Care.

Legal Services of New Jersey Comments:

Advocates consulted before and after this review reiterated our concern. Specifically, they are concerned that recipients are not informed that they still may be eligible for Medicaid when TANF is terminated, particularly when cases are closed for reasons other than increased earnings (e.g. the recipient withdraws from TANF or does not complete a TANF redetermination requirement). Advocates emphasized the importance of effective training of front line staff and

supervisory personnel to assure that families are not terminated from Medicaid when they leave TANF and that they are informed that they may remain eligible to receive Medicaid.

To further improve Medicaid retention when TANF is discontinued, advocates have suggested the following:

- Computer adjustments to the Management Information System to automatically block the closure of TANF cases until Medicaid eligibility is separately determined and recorded.
- Computer adjustment to automatically continue Medicaid when TANF is discontinued for non-Medicaid related reasons.
- Computer program added to the system to produce a screen warning for staff to check Medicaid eligibility when a TANF case is being closed.
- Creation of a special unit to review TANF/Medicaid terminations until such time as this review can be automated.
- Allow caseworkers to automatically initiate a Medicaid application when TANF is discontinued, using data already in the system.

HCFA Response:

We are pleased that the State has taken steps to increase recipient awareness but the response does not specify when these initiatives were taken. If these actions were part of ongoing staff training provided prior to this review, based on the review team's findings, the State needs to do more outreach and other activities to educate families.

The State should conduct a follow-up to determine how effective these actions have been in educating families and if additional activities should be undertaken. HCFA is making public service announcements available to all States to assist in their public education efforts, particularly that families do not need to receive cash assistance to be eligible for Medicaid. If the State would like more information about these public service announcements, please contact Christopher Howe at chowe@hcfa.gov. In addition, the State may want to consider developing video training materials for county staff, so that new employees at the county level can immediately take advantage of training that was previously given to the experienced employees, and the experienced employees may have easy access to refresher training.

Our April 7, 2000 Dear State Medicaid Director letter had a set of questions and answers attached to it presenting practical suggestions on how States can meet their responsibilities under law to ensure that computer systems are not improperly denying enrollment in, or terminating persons from, Medicaid. As we stated, if programming changes cannot be made immediately, an interim system to override computer errors (such as supervisory review) must be put in place to ensure that eligible individuals are not denied or losing Medicaid. We are available to assist the State develop an effective interim solution.

7) The New Jersey application for pregnant women and infants incorrectly states that the SSN for all household members is required. The State must amend this application to request SSNs of only those household members who are applying for Medicaid.

State comment:

The New Jersey application for pregnant women and infants will be modified to indicate that provision of an SSN is only mandatory for applicants.

HCFA Response:

The State's current application does not comply with Federal rules governing the request of SSNs and can be a deterrent to coverage for children living with immigrant family members. New Jersey did not provide a target date for the revision of the application. We advise the State that it must revise its application immediately to bring it into compliance with Federal requirements.

8) The termination/denial/suspension notice for Medicaid advises the individual that he/she may be eligible for other Medicaid programs and to contact the local county office. This language is confusing, since eligibility workers must evaluate the client for all possible Medicaid eligibility categories prior to termination or denial. Since the review team did not find evidence that the workers were erroneously terminating individuals, we believe the State's intention is to refer individuals to programs such as "Health Access New Jersey," but the wording of the notice is misleading. The State needs to amend this notice to clarify what is meant.

State comment:

We concur. The county generated notices are not customer friendly and as you point out, in some regards could be misleading. We are currently considering the revised client letters that were developed in the Monmouth County pilot as a model for statewide use.

HCFA Response:

Since the notices are confusing and could be misinterpreted by families, we encourage the State to act quickly to put clarifying language in place so that families are properly referred to programs that may provide continued coverage.

9) At the time of this review, the State was engaged in phase two of the churning study, in which it was investigating the reasons why 18% of those in the study had not had Medicaid redeterminations on TANF termination. The State should report its phase two findings to HCFA.

State comments:

The State has contracted with the Center for Health Policy at Rutgers to evaluate and trend our current disenrollment data. In addition, the Quality Control staff recently completed a 100% case review and follow-up of cases in New Jersey KidCare that failed to cooperate in the redetermination process. We are also exploring options for conducting surveys and/or focus

groups as part of our enrollment sustainment initiatives. The State has undertaken a new outreach project to contact all former TANF families whose cash assistance cases were closed for lack of cooperation to assure that if there are any cases in which Medicaid was erroneously terminated, it will be reinstated. The Churning Study set the direction for our current projects, but the sample is dated and no further action is contemplated.

HCFA Response:

We note that the Churning study was valuable and asked for findings from phase two of the study when it is completed. The State has supplied HCFA with information about the reasons for Medicaid terminations as part of its response to the directives in our April 7 guidance. We commend the State for undertaking further initiatives to sustain Medicaid enrollment.

10) New Jersey requires a face-to-face interview for redeterminations. We are concerned that New Jersey is not making use of ex parte information when conducting redeterminations. The State must assure that it complies with HCFA's instructions in this regard, particularly as detailed in HCFA's recent guidance of April 7, 2000.

State comment:

The CBOSS redetermines eligibility for all programs for which the family is eligible; i.e., TANF, Food Stamps, and Medicaid in the same interview. Moreover, financial and other data concerning these programs resides on the same data base; i.e., FAMIS. The State is currently developing a mail-in Medicaid redetermination option. As a result, for TANF/Food Stamp clients who are terminated for failure to schedule a face-to-face interview, a Medicaid redetermination can be accomplished through the mail. In addition, the redetermination period is being changed from 6 to 12 months. The FAMIS will be modified to accommodate both cycles. Accordingly, if a family fails to cooperate with a 6-month TANF redetermination, Medicaid would continue until the next Medicaid redetermination date. Additionally, if a TANF/Food Stamp redetermination is completed, the Medicaid redetermination date will be reset to 12 months in the future.

HCFA response:

The review team found that caseworkers were not conducting ex parte redeterminations regardless of the fact that financial and other data are available on the FAMIS system. In practice, the State requires families to bring documentation with them to the face-to-face redetermination interview. The State must ensure that county redetermination policies and practices, including ex parte redeterminations, are in accordance with our April 7th guidance. We will follow-up with the State's progress as part of our tracking of State implementation of the directives contained in the April 7th guidance.

HCFA supports the State's efforts to make the redetermination process more family-friendly by eliminating the face-to-face requirement, allowing a mail-in redetermination process and maximizing the time period between redeterminations.

1/19/2001