Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NEW JERSEY DID NOT ALWAYS CLAIM MEDICAID REIMBURSEMENT FOR MEDICARE PART B PREMIUMS IN ACCORDANCE WITH FEDERAL REQUIREMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

James P. Edert
Regional Inspector General

August 2013
A-02-10-01025

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at https://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In New Jersey, the Department of Human Services (DHS) administers the Medicaid program.

Section 1843 of the Act allows State programs to enter into an agreement with CMS known as the buy-in program. The purpose of the Medicaid buy-in program is to permit States to provide medical insurance protection to designated categories of needy individuals who are eligible for Medicaid and/or meet certain eligibility requirements.

Pursuant to Chapter 1, Section 110 of the CMS *State Buy-In Manual*, DHS provides Medicaid buy-in assistance to eligible beneficiaries included in its buy-in agreement with CMS. Eligibility requirements for these groups are included in section 1902(a)(10)(E) of the Act. In New Jersey, these groups include Qualified Individual (QI) Beneficiaries, Qualified Medicare Beneficiaries, and Specified Low-Income Beneficiaries. Medicaid-eligible individuals who do not belong to any of these groups are considered Medical Assistance Only Beneficiaries. Each of these categories has specific income requirements. In addition, pursuant to Chapter 1, Section 110, of the CMS *State Buy-In Manual*, premium payments made on behalf of Medical Assistance Only Beneficiaries do not qualify for Federal Medicaid reimbursement. Further, pursuant to Section 3492.5 of the CMS *State Medicaid Manual*, redetermination of buy-in eligibility for QI Beneficiaries must be performed on a yearly basis.

In New Jersey, county boards of social services work with DHS to determine Medicaid eligibility. In addition, DHS works with the Department of Health and Senior Services (Health Department) to enroll senior citizens and disabled individuals who qualify as QI Beneficiaries and Specified Low-Income Beneficiaries into the buy-in program.

OBJECTIVE

The objective of our audit was to determine whether DHS claimed Federal Medicaid reimbursement for selected Medicare Part A and Part B premiums in accordance with Federal requirements.

SUMMARY OF FINDINGS

DHS' claims for Federal Medicaid reimbursement reconciled to their billing records. However, DHS did not always claim Federal Medicaid reimbursement for premiums in accordance with Federal requirements. Of the 1,167 beneficiaries that we reviewed with claims in high risk areas,

DHS properly claimed Federal Medicaid reimbursement for 34 Medicare Part A beneficiaries and 176 Part B beneficiaries. However, DHS improperly claimed Federal Medicaid reimbursement for Medicare Part B premiums paid on behalf of 957 beneficiaries, totaling $523,919. Of the payments made on behalf of these 957 beneficiaries, payments for 99 beneficiaries contained more than 1 deficiency.

Specifically, DHS improperly claimed Part B premiums for the following high-risk areas:

- 720 Medical Assistance Only Beneficiaries for whom CMS did not initially assign an eligibility category;

- 140 QI Beneficiaries for whom the Health Department did not redetermine program eligibility;

- 53 QI Beneficiaries for whom the Health Department enrolled in the buy-in program but did not maintain documentation to support the individuals' program eligibility;

- 19 QI Beneficiaries whose income exceeded Federal eligibility thresholds;

- 133 QI Beneficiaries whose premiums did not meet Federal requirements for retroactive payments; and

- 13 individuals incorrectly categorized as QI Beneficiaries.

The improper payments occurred because DHS did not have procedures to ensure that premiums paid for Medical Assistance Only Beneficiaries were not claimed for Federal Medicaid reimbursement. Further, DHS did not ensure that the Health Department enrolled only QI individuals in the buy-in program that met Federal eligibility requirements.

RECOMMENDATIONS

We recommend that DHS:

- refund $523,919 to the Federal Government,

- implement procedures to ensure that premiums paid for Medical Assistance Only Beneficiaries are not claimed for Federal Medicaid reimbursement, and

- work with the Health Department to ensure that it enrolls only individuals in the buy-in program who meet Federal eligibility requirements.

DEPARTMENT OF HUMAN SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, DHS partially agreed with our first recommendation (financial disallowance), disagreed with our second recommendation, and described corrective actions it has taken to address our third recommendation.

After reviewing DHS's comments, we maintain that our findings and recommendations are valid. DHS is responsible for ensuring that Medicaid reimbursement for Medicare premiums are made in accordance with Federal requirements, and the claims we identified did not meet these requirements.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. Pursuant to section 1905(b) of the Act, the Federal Government pays its share of each State's claimed medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. In New Jersey, the Department of Human Services (DHS) administers the Medicaid program.

Medicaid's Role in Paying Medicare Part A and/or Part B Premiums

Section 1843 of the Act allows State programs to enter into an agreement with CMS known as the buy-in program. The purpose of the Medicaid buy-in program is to permit States to provide medical insurance protection to designated categories of needy individuals who are eligible for Medicaid and/or meet certain eligibility requirements. The Medicaid buy-in program has the effect of transferring part of the medical costs for eligible individuals from the federal- and State-financed Medicaid program to the federally-financed Medicare program. Specifically, the buy-in program allows participating State Medicaid programs to enroll certain individuals in the Medicare Part A and/or Part B programs and to pay the monthly premium(s) on behalf of these individuals. The State can then claim the monthly premium expenditures on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

Buy-In Program Eligibility Groups

Pursuant to Chapter 1, Section 110 of the CMS *State Buy-In Manual*, DHS provides Medicaid buy-in assistance to eligible beneficiaries included in its buy-in agreement with CMS. Eligibility requirements for these groups are included in section 1902(a)(10)(E) of the Act. These groups include:

- Qualified Individual (QI) Beneficiaries: For classification as a QI Beneficiary, an eligible individual's income is above 120 percent, but less than 135 percent, of the Federal poverty level; his or her resources do not exceed twice the Supplemental Security Income (SSI) limit determined by the Social Security Administration; and he or she is not otherwise eligible for Medicaid. Pursuant to section 3492.2 of the CMS *State Medicaid Manual*, States can provide up to 3 months of retroactive eligibility into the buy-in program for a QI Beneficiary, provided the retroactive period is no earlier than January 1st of that calendar year. In addition, section 3492.5 of the CMS *State Medicaid Manual*,

redetermination of buy-in eligibility for QI Beneficiaries must be performed on a yearly basis.

- Specified Low-Income Beneficiaries: For classification as a Special Low-Income Medicare Beneficiary, an eligible individual's income is above 100 percent, but does not exceed 120 percent, of the Federal poverty level; and his or her resources do not exceed twice the SSI limit.

- Qualified Medicare Beneficiaries: For classification as a Qualified Medicare Beneficiary, an eligible individual's income does not exceed 100 percent of the Federal poverty level, and his or her resources do not exceed twice the SSI limit.

Pursuant to Chapter 1, Section 110, of the CMS *State Buy-In Manual*, premium payments made on behalf of Medical Assistance Only Beneficiaries do not qualify for Federal Medicaid reimbursement. New Jersey provides buy-in assistance to these beneficiaries–individuals who are Medicaid-eligible but do not belong to any of the above groups.

Part B beneficiaries participating in the buy-in program are assigned eligibility category codes designating the beneficiaries' classification by either CMS or New Jersey program officials.

State Buy-In Program in New Jersey

In New Jersey, county boards of social services work with DHS to determine Medicaid eligibility. In addition, DHS works with the Department of Health and Senior Services (Health Department) to enroll senior citizens and disabled individuals who qualify as QI Beneficiaries and Specified Low-Income Beneficiaries into the buy-in program.[1]

During the 2-year period July 1, 2007, through June 30, 2009, DHS claimed Federal Medicaid reimbursement for Medicare Part A and Part B premiums totaling $515,799,877 ($284,901,731 Federal share).[2] During this period New Jersey's FMAP ranged from 50 percent to 61.59 percent.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to determine whether DHS claimed Federal Medicaid reimbursement for selected Medicare Part A and Part B premiums in accordance with Federal requirements.

[1] Pursuant to section 10:72-1.1(b) of the New Jersey Administrative Code, the enrollment process for QI Beneficiaries and Specified Low-Income Beneficiaries is administered through the Health Department.

[2] Specifically, DHS claimed $99,383,664 ($53,196,456 Federal share) for 10,189 Part A beneficiaries and $416,416,213 ($231,705,275 Federal share) for 178,022 Part B beneficiaries.

Scope

We reviewed the State agency's claims for Federal Medicaid reimbursement of Medicare Part A and Part B premium payments totaling $515,799,877 ($284,901,731 Federal share) made during the period July 1, 2007, through June 30, 2009.

During our audit, we did not review the overall internal control structure of DHS or the Health Department. Rather, we limited our internal control review to those controls related to the objective of our audit.

We performed our fieldwork at DHS's and the Health Department's offices in Trenton, New Jersey.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- interviewed CMS officials to gain an understanding of the Medicare buy-in program;
- interviewed DHS and Health Department officials to discuss the State's policies and procedures for calculating and claiming Federal Medicaid reimbursement for Medicare Part A and Part B premiums;
- reconciled the State agency's claims for $515,799,877 ($284,901,731 Federal share) of Federal Medicaid reimbursement to DHS billing records;[3]
- performed survey work to identify areas with a high risk for improper reimbursement;
- selected for review a judgmental sample of 1,167 beneficiaries[4] with premiums totaling $1,001,398 ($649,766 Federal share) from the high-risk areas we identified;
- reviewed, for each of the sampled beneficiaries, the DHS and/or Health Department case file records; and
- determined whether DHS claimed Federal Medicaid reimbursement for the Medicare premium(s) in accordance with Federal requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. 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

[3] DHS's billing records are comprised of monthly CMS bills for payment of the Medicare Part A and Part B premiums for individuals enrolled in the Medicare buy-in program.

[4] The 1,167 beneficiaries selected consisted of 34 Part A beneficiaries and 1,133 Part B beneficiaries.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

DHS' claims for Federal Medicaid reimbursement reconciled to their billing records. However, DHS did not always claim Federal Medicaid reimbursement for premiums in accordance with Federal requirements. Of the 1,167 beneficiaries that we reviewed with claims in high risk areas, DHS properly claimed Federal Medicaid reimbursement for 34 Medicare Part A beneficiaries and 176 Part B beneficiaries. However, DHS improperly claimed Federal Medicaid reimbursement for Medicare Part B premiums paid on behalf of 957 beneficiaries, totaling $523,919. Of the payments made on behalf of these 957 beneficiaries, payments for 99 beneficiaries contained more than 1 deficiency.

Specifically, DHS improperly claimed Part B premiums for the following high-risk areas:

- 720 Medical Assistance Only Beneficiaries for whom CMS did not initially assign an eligibility category;

- 140 QI Beneficiaries for whom the Health Department did not redetermine program eligibility;

- 53 QI Beneficiaries for whom the Health Department enrolled in the buy-in program but did not maintain documentation to support the individuals' program eligibility;

- 19 QI Beneficiaries whose income exceeded Federal eligibility thresholds;

- 133 QI Beneficiaries whose premiums did not meet Federal requirements for retroactive payments; and

- 13 individuals incorrectly categorized as QI Beneficiaries.

The improper payments occurred because DHS did not have procedures to ensure that premiums paid for Medical Assistance Only Beneficiaries were not claimed for Federal Medicaid reimbursement. Further, DHS did not ensure that the Health Department enrolled only QI individuals in the buy-in program that met Federal eligibility requirements.

UNALLOWABLE FEDERAL REIMBURSEMENT

Unallowable Payments for Medical Assistance Only Beneficiaries

Section 1843 of the Act permits States to enroll Medicaid-eligible individuals in Medicare Part B and pay Part B premiums on their behalf under the State's buy-in agreement with CMS. Pursuant to sections 1903(a)(1) and 1905(a) of the Act, FMAP is available to assist States with the premium payments for certain groups of beneficiaries. Medical Assistance Only Beneficiaries are Medicaid-eligible individuals who do not belong to any of those groups.

Chapter 1, Section 110, of the CMS *State Buy-In Manual* states that premium payments made on behalf of Medical Assistance Only Beneficiaries do not qualify for FMAP.

Section 180 of the Manual requires States that cover Medical Assistance Only Beneficiaries in their buy-in agreements to identify such individuals and states that failure to identify such beneficiaries may result in erroneous Federal reimbursement to the States for Part B premiums. The buy-in program uses eligibility codes to identify the specific category of assistance for each individual enrolled in the buy-in program. Section 410 of the Manual specifies that Medical Assistance Only Beneficiaries be identified by using an eligibility code of "M."

Of the 741 Medical Assistance Only Beneficiaries that we reviewed, 720 were beneficiaries for whom CMS left their eligibility code blank when they were initially enrolled in the buy-in program.[5] Within a few weeks, DHS assigned these beneficiaries an eligibility code of "M." However, for the period that these individuals had a blank eligibility code, DHS claimed and received Federal Medicaid reimbursement for their Part B premiums. As a result, DHS claimed unallowable Federal Medicaid reimbursement totaling $331,610 for Part B premiums paid on behalf of these 720 Medical Assistance Only Beneficiaries.[6]

Eligibility Redeterminations Not Performed

Pursuant to section 3492.5 of the CMS *State Medicaid Manual*, a redetermination of eligibility must be performed on a yearly basis to evaluate whether QI Beneficiary is entitled to continue participating in the State's buy-in program.

Of the 317 QI Beneficiaries that we reviewed, DHS claimed unallowable Federal Medicaid reimbursement totaling $74,421 for Part B premiums paid on behalf of 140 QI Beneficiaries for whom the Health Department did not redetermine the beneficiaries' program eligibility. All 140 QI Beneficiaries had been enrolled in the buy-in program for more than 1 year; however, as of October 2010, the Health Department had not redetermined their eligibility.

Insufficient or No Documentation

Pursuant to 42 CFR § 431.17, DHS must maintain records of facts essential to determination of initial and continuing Medicaid eligibility. Section 2497.1 of the CMS *State Medicaid Manual* states that FMAP is available only for allowable expenditures made on behalf of eligible recipients. Expenditures are allowable only to the extent that, when a claim is filed, there is adequate supporting documentation to ensure that all applicable federal requirements have been met.

Of the 317 QI Beneficiaries that we reviewed, DHS claimed unallowable Federal Medicaid reimbursement totaling $72,364 for Part B premiums paid on behalf of 53 QI Beneficiaries for

[5] These individuals were initially enrolled in Medicare Part B by CMS to the buy-in program pursuant to a "Public Welfare accretion."

[6] The State agency did not refund the Federal reimbursement received for the initial enrollment premiums paid on behalf of these beneficiaries.

which the Health Department did not maintain documentation to support the beneficiaries' eligibility.[7]

Ineligible Beneficiaries

Section 1902(a)(10)(E)(iv) of the Act defines QI Beneficiaries as persons who are entitled to Medicare Part A; have income of at least 120 percent of the federal poverty level, but less than 135 percent; resources that do not exceed twice the limit for Supplemental Security Income eligibility; and are not eligible for Medicaid.

Of the 317 QI Beneficiaries that we reviewed, DHS claimed unallowable Federal Medicaid reimbursement totaling $23,914 for Part B premiums paid on behalf of 19 QI Beneficiaries whose income exceeded Federal eligibility thresholds. For example, the Health Department enrolled one beneficiary in the buy-in program in October 2008; however, the beneficiary's total annual income ($15,046) exceeded Federal eligibility thresholds by more than $1,000.[8]

Unallowable Retroactive Payments for Qualified Individual Beneficiaries

Pursuant to section 3492.2 of the CMS *State Medicaid Manual*, States can provide up to 3 months of retroactive eligibility into the buy-in program for a QI Beneficiary, provided the retroactive period is no earlier than January 1st of that calendar year.

Of the 317 QI Beneficiaries that we reviewed, DHS claimed unallowable Federal reimbursement totaling $16,871 for Part B premiums paid on behalf of 133 QI Beneficiaries with retroactive periods that extended prior to January 1st of the calendar year or with retroactive periods greater than 3 months. For example:

- One QI Beneficiary applied to the buy-in program in January 2008; however, the Health Department retroactively enrolled the beneficiary to October 2007, prior to January 1st of the 2008 calendar year.

- One QI Beneficiary applied to the buy-in program in May 2007; however, the Health Department retroactively enrolled the beneficiary to January 2007, 1 month more than the allowable 3-month retroactive period.

Incorrect Eligibility Category

Of the 317 QI Beneficiaries that we reviewed, DHS claimed unallowable Federal Medicaid reimbursement totaling $4,739 for Part B premiums paid on behalf of 13 individuals incorrectly categorized by the Health Department as QI Beneficiaries. These beneficiaries had incomes below QI Beneficiary qualifying levels; however, they qualified for the buy-in program as

[7] For 9 beneficiaries, the Health Department did not have a case file. For 44 beneficiaries, the Health Department's case file did not contain sufficient documentation to support the beneficiaries' eligibility.

[8] In 2008, the Federal poverty level was $10,040. Therefore, to be eligible as a QI Beneficiary for this period, an individual's annual income could not exceed $14,040 - 135 percent of $10,040.

Specified Low-Income Beneficiaries. Because they were incorrectly categorized as QI Beneficiaries, DHS improperly claimed 100 percent FMAP for their Part B premiums rather than the appropriate FMAP.[9] For example, one beneficiary applied to the buy-in program in September 2008. The beneficiary's total annual income of $12,312 was almost $200 below the QI Beneficiary eligibility threshold; however, the beneficiary was qualified to enroll in the buy-in program as a Specified Low-Income Beneficiary.

CAUSES OF THE UNALLOWABLE FEDERAL MEDICAID REIMBURSEMENT

The improper payments occurred because DHS did not have procedures to ensure that premiums paid for Medical Assistance Only Beneficiaries were not claimed for Federal Medicaid reimbursement. Further, DHS did not ensure that the Health Department enrolled only QI individuals in the buy-in program that met Federal eligibility requirements. Health Department officials attributed the unallowable claims to clerical errors in the calculation of income limitations when determining a beneficiary's eligibility. Further, the officials stated that they were not aware of Federal requirements regarding eligibility redeterminations and the allowable period for retroactive premium payments. In addition, the Health Department did not ensure that it maintained adequate documentation to support the eligibility of individuals that it enrolled in the buy-in program.

RECOMMENDATIONS

We recommend that DHS:

- refund $523,919 to the Federal Government,
- implement procedures to ensure that premiums paid for Medical Assistance Only Beneficiaries are not claimed for Federal Medicaid reimbursement, and
- work with the Health Department to ensure that it enrolls only individuals in the buy-in program who meet Federal eligibility requirements.

DEPARTMENT OF HUMAN SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, DHS partially agreed with our first recommendation (financial disallowance), disagreed with our second recommendation, and described corrective actions it has taken to address our third recommendation.

DHS agreed that $192,309 of the $523,919 recommended disallowance should be refunded. However, DHS stated that the remaining $331,610, associated with beneficiaries whose eligibility codes were initially blank and subsequently changed to "M" by CMS, should not be refunded because it was CMS that failed to provide the proper eligibility codes. DHS believes

[9] The FMAP in New Jersey for the period July 1, 2007, through September 30, 2008, was 50 percent; during the period October 1, 2008, through March 31, 2009, it was 58.78 percent; and during the period April 1, 2009, through June 30, 2009, it was 61.59 percent.

that it is unreasonable to expect it to administratively track blank eligibility codes and retroactively reimburse CMS when it was CMS who failed to initially categorize these beneficiaries. Specifically, DHS stated that it was not cost effective for it to incur additional administrative costs to correct and adjust these claims. DHS's comments appear in their entity as the Appendix.

After reviewing DHS's comments, we maintain that our findings and recommendations are valid. DHS is responsible for ensuring that Medicaid reimbursement for Medicare premiums are made in accordance with Federal requirements, and the claims we identified did not meet these requirements.

APPENDIX

APPENDIX: DEPARTMENT OF HUMAN SERVICES COMMENTS

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
PO BOX 712
TRENTON, NJ 08625-0712

JENNIFER VELEZ
Commissioner

VALERIE HARR
Director

May 7, 2013

James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services Region II
Jacob K. Javits Federal Building
26 Federal Plaza – Room 3900
New York, NY 10278

Report Number: A-02-10-01025

Dear Mr. Edert:

This is in response to your letter dated February 25, 2013 concerning the Department of Health and Human Services, Office of the Inspector General's (OIG) draft report entitled *"New Jersey Did Not Always Claim Medicaid Reimbursement for Medicare Part B Premiums in Accordance With Federal Requirements"*. Your letter provides the opportunity to comment on this draft report.

The objective of this review was to determine if the State claimed Federal Medicaid reimbursement for selected Medicare Part A and Part B premiums in accordance with Federal requirements during the audit period of July 1, 2007 through June 30, 2009.

The draft audit report concluded that New Jersey's claims for Medicaid reimbursement reconciled to its billing records. However, the State did not always claim Medicaid reimbursement for premiums in accordance with Federal requirements. Of the 1,167 beneficiaries that were reviewed with claims in "high risk areas", the State improperly claimed Medicaid reimbursement for Medicare Part B premiums paid on behalf of 957 beneficiaries, totaling $523,919.

We appreciate the opportunity to provide this response to the draft OIG audit report. Following are the auditors' recommendations and the Division of Medical Assistance & Health Services (DMAHS) responses:

Recommendation 1:

The OIG recommends that New Jersey refund $523,919 to the Federal Government:

The State concurs with some but not all of the findings concerning Part B premiums and that $192,309 of the requested refund of $523,919 should be refunded to CMS. We have addressed each category of deficiencies as follows:

1. **Unallowable Payments for Medical Assistance Only Beneficiaries – $331,610:**

   The Centers for Medicare and Medicaid Services (CMS) is responsible for assigning Buy-In eligibility Codes (BEC) and bills the DMAHS accordingly. Included in the monthly billings are amounts for "blank" BECs which are paid on the DMAHS quarterly Form 64 claim. Subsequently, CMS in conjunction with the DMAHS assigns an "M" code indicating the beneficiary is a "Medical Assistance Only Beneficiary" and the State is not entitled to Federal reimbursement. The auditor's position is that DMAHS received unallowable reimbursement for these beneficiaries for the period when the "blank" code was issued and the assigning of the correct "M" code.

   DMAHS believes that it is unreasonable to expect DMAHS to administratively track these "blank" codes and retroactively reimburse CMS when it is CMS's failure to initially provide the proper BEC that has caused the overpayment. The monthly CMS billing include numerous errors including duplicate billings and "blank" BECs which DMAHS is required to pay without any adjustments for duplicates. DMAHS believes these errors are generally offsetting so that requiring DMAHS to add an administrative layer to the billing process is counterproductive and not cost effective.

2. **Eligibility Redeterminations Not Performed - $74,421:**

   The State agrees that eligibility for 140 Qualified Individuals (QI) beneficiaries was not re-determined on a timely basis and that the above amount be refunded to CMS.

3. **Insufficient or No Documentation - $72,364:**

   The State agrees there was not sufficient documentation for 53 QI beneficiaries to support their eligibility and that the above amount be refunded to CMS.

4. **Ineligible Beneficiaries - $23,914:**

   The State agrees that eligibility for 19 QI beneficiaries was improperly determined when their income exceeded Federal eligibility thresholds. The above amount should be refunded to CMS.

5. **Unallowable Retroactive Payments for Qualified Individual Beneficiaries - $16,861:**

   The State agrees that the retroactive period for 133 QI beneficiaries were improperly determined resulting in unallowable Federal reimbursement of $16,861 which should be refunded to CMS.

6. **Incorrect Eligibility Category - $4,739:**

   The State agrees that 13 individuals were incorrectly categorized as QI beneficiaries instead of as Specified Low-Income Beneficiaries (SLMB). Consequently, the DMAHS improperly claimed 100% FFP rather than the lower FFP for SLMB. The above amount should be refunded to CMS.

Recommendation 2:

The OIG recommends that DMAHS implement procedures to ensure that premiums paid for Medical Assistance Only Beneficiaries are not claimed for reimbursement:

The State does not agree with this recommendation. As previously stated, it is not cost effective for the DMAHS to incur additional administrative expense to correct and adjust billings for improper BECs provided to DMAHS by CMS.

Recommendation 3:

The OIG recommends that DMAHS work with Department of Health to ensure that it enrolls only individuals in the buy-in program who meet Federal eligibility requirements:

The administration of the SLMB/QI programs was transferred in July 2012 to the Division of Aging Services, a new division within the Department of Human Services (DHS). The following process changes have been made to ensure that all enrollees in the buy-in program meet Federal eligibility requirements:

- QI clients receiving Part B premium assistance receive renewal applications two months prior to the start of the next calendar year thereby ensuring timely redeterminations.

- Division administrators have been instructed that QI applicants are not eligible to receive retro-active Part B benefits prior to January 1st of each calendar year and SLMB applicants are eligible for retro-active benefits prior to the calendar year.
- SLMB beneficiaries now receive redetermination applications two months before their annual renewal date to ensure timely redeterminations.
- The DMAHS provides the Division of Aging Services with a new Yearly Income Standards chart in March or April of each year. Consequently, applications received prior to receiving the new chart are determined using the prior year's chart which could lead to improper eligibility determinations. Division administrators have been instructed to review applications processed prior to receipt of the Income Standards chart to ensure the client met the current income standards.

If you have any questions or require additional information, please contact me or Richard Hurd at 609-588-2550. I would like to thank the OIG audit team for their professionalism throughout the audit and our review of their findings and recommendations.

Sincerely,

Valerie Harr
Director

VH:H
c: Jennifer Velez
Richard Hurd