Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

July 24, 2008

Report Number: A-02-07-01029

Ms. Jennifer Velez, Esq.
Commissioner
New Jersey Department of Human Services
222 South Warren Street
P.O. Box 700
Trenton, New Jersey 08625-0700

Dear Ms. Velez:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Medicaid Payments for Services Provided to Beneficiaries with Concurrent Eligibility in New Jersey and New York for July 1, 2005, Through June 30, 2006." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Jeffrey I. Jacobs, Audit Manager, at (212) 264-1321 or through e-mail at Jeffrey.Jacobs@oig.hhs.gov. Please refer to report number A-02-07-01029 in all correspondence.

Sincerely,

James P. Edert

James P. Edert
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner, Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID PAYMENTS FOR SERVICES PROVIDED TO BENEFICIARIES WITH CONCURRENT ELIGIBILITY IN NEW JERSEY AND NEW YORK FOR JULY 1, 2005, THROUGH JUNE 30, 2006

Daniel R. Levinson
Inspector General

July 2008
A-02-07-01029

Office of Inspector General

http://oig.hhs.gov

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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 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. The Department of Human Services (the State agency) manages the New Jersey Medicaid program.

Medicaid eligibility in each State is based on residency. If a resident of one State subsequently establishes residency in another State, the beneficiary's Medicaid eligibility in the previous State should end. The State Medicaid agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The State Medicaid agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. The State Medicaid agencies must promptly redetermine eligibility when they receive information about changes in a beneficiary's circumstances that may affect eligibility.

For the audit period July 1, 2005, through June 30, 2006, the State agency paid approximately $3.7 million on behalf of beneficiaries who were Medicaid-eligible and receiving Medicaid benefits in New Jersey and New York.

OBJECTIVE

The objective of our review was to determine whether the State agency made payments on behalf of beneficiaries who should not have been Medicaid-eligible due to their eligibility in New York.

SUMMARY OF FINDINGS

For the period July 1, 2005, through June 30, 2006, we estimate that the State agency paid $1,070,619 ($544,388 Federal share) on behalf of beneficiaries who should not have been eligible due to their Medicaid eligibility in New York. From a statistical sample of 100 beneficiary-months, totaling $52,313 in Medicaid services, the State agency made payments for 43 beneficiary-months, totaling $9,909, for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in New Jersey. The remaining 57 payments were for services to beneficiaries who were eligible to receive the benefit. We attribute the Medicaid payments made on behalf of beneficiaries who were not eligible in New Jersey to the insufficient sharing of eligibility data between the State agency and New York's Medicaid agency.

RECOMMENDATIONS

We recommend that the State agency work with the New York Medicaid agency to share available Medicaid eligibility information for use in:

- determining accurate beneficiary eligibility status and

- reducing the amount of payments, estimated to be $1,070,619 ($544,388 Federal share), made on behalf of beneficiaries residing in New York.

In written comments on our draft report, the State agency concurred with our recommendations. The State agency's written comments are included in their entirety as Appendix B.

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INTRODUCTION

BACKGROUND

Pursuant to Title XIX of the Social Security 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. The Department of Human Services (the State agency) manages the New Jersey Medicaid program.

Medicaid eligibility in each State is based on residency. If a resident of one State subsequently establishes residency in another State, the beneficiary's Medicaid eligibility in the previous State should end. The State Medicaid agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The State Medicaid agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. The State Medicaid agencies must promptly redetermine eligibility when they receive information about changes in a beneficiary's circumstances that may affect eligibility.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

The objective of our review was to determine whether the State agency made payments on behalf of beneficiaries who should not have been Medicaid-eligible due to their eligibility in New York.[1]

Scope

For the audit period of July 1, 2005, through June 30, 2006, we identified 10,804 beneficiary-months[2] with payments totaling approximately $3.7 million made by the State agency on behalf of beneficiaries who were Medicaid-eligible and receiving benefits in New Jersey and New York. From this universe, we selected a statistical sample of 100 beneficiary-months with payments totaling $52,313.

We did not review the overall internal control structure of the State agency. We limited our internal control review to obtaining an understanding of the procedures used to identify

[1]A separate report will be issued to the New York State Department of Health to address payments made on behalf of beneficiaries who should not have been Medicaid-eligible in New York due to their eligibility in New Jersey.

[2]A beneficiary-month included all payments for Medicaid services provided to one beneficiary during one month.

Medicaid-eligible individuals who moved from New Jersey and enrolled in the New York Medicaid program.

We performed our fieldwork at the State agency's offices in Mercerville, New Jersey, as well as at New York's Medicaid agency offices in Albany and New York, New York, from June 2007, through January 2008.

Methodology

To accomplish our audit objective, we obtained eligibility data from the New Jersey and New York Medicaid Management Information Systems (MMIS)[3] for the period of July 1, 2005, through June 30, 2006. We matched Social Security numbers and dates of birth from New Jersey's and New York's MMIS data to identify 6,405 beneficiaries who were Medicaid-eligible in the two states.

The State agency provided the MMIS payment data files for the beneficiaries with concurrent Medicaid eligibility and payments with dates of services that occurred during the 12-month period. For each beneficiary who was Medicaid-eligible and receiving Medicaid benefits in New Jersey and New York, we combined all dates of service for a single beneficiary-month and matched the payment data files, between States, by Social Security number, date of birth, and month of service.

We selected a simple random sample of 100 beneficiary-months with paid dates of services in both New Jersey and New York. In New Jersey, the statistical sample included payments totaling $52,313. The selected beneficiary-months were for services provided on behalf of beneficiaries with Medicaid eligibility in both States during the same month. See the Appendix for more information regarding the sampling methodology.

We used the State agency's MMIS data to verify that the beneficiaries were enrolled in the Medicaid program and that payments were made to providers. In addition, for each of the 100 beneficiary-months, we reviewed the Medicaid application files and/or other supporting documentation in both States to determine which State agency had established the appropriate Medicaid eligibility based on permanent residency for the sampled month. Based on the sample results, we estimated the total amount of payments that the State agency paid on behalf of beneficiaries who should not have been Medicaid-eligible.

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 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.

[3]MMIS is a mechanized claims processing and information retrieval system that States are required to use to record Title XIX program and administrative costs, report services to recipients, and report selected data to CMS.

FINDINGS AND RECOMMENDATIONSS

For the period July 1, 2005, through June 30, 2006, we estimate that the State agency paid $1,070,619 ($544,388 Federal share) on behalf of beneficiaries who should not have been eligible due to their Medicaid eligibility in New York. From a statistical sample of 100 beneficiary-months, totaling $52,313 in Medicaid services, the State agency made payments for 43 beneficiary-months, totaling $9,909, for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in New Jersey. The remaining 57 payments were for services provided to beneficiaries who were eligible to receive the benefit. We attribute the Medicaid payments made on behalf of beneficiaries who were not eligible in New Jersey to the insufficient sharing of eligibility data between the State agency and New York's Medicaid agency.

PAYMENTS ON BEHALF OF CONCURRENTLY ELIGIBLE BENEFICIARIES

We estimate that the State agency paid approximately $1,070,619 ($544,388 Federal share) for services on behalf of beneficiaries who should not have been eligible to receive Medicaid benefits due to their eligibility in New York.

Federal and State Requirements

Federal regulation 42 CFR § 435.403(j)(3) states, "The agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid." (Emphasis added.)

Federal regulation 42 CFR § 435.916 provides that the State agencies must redetermine the eligibility of Medicaid beneficiaries, with respect to circumstances that may change, at least every 12 months. The State agencies must have procedures designed to ensure that beneficiaries make timely and accurate reports of any change in circumstances that may affect their eligibility. The State agencies must promptly redetermine eligibility when they receive information of changes in beneficiaries' circumstances that may affect their eligibility.

Each State agency has specific criteria defining eligibility and residency. New Jersey Administrative Code, section 10:71-3.4 states that an applicant for or beneficiary of Medicaid only shall be a resident of New Jersey. Similarly, New York Social Services Law § 117.3(a) states that no public assistance benefits shall be paid to or for any person who is not a resident of the State.

The Medicaid application is a way to notify States' agencies of changes in a beneficiary's residency status. For example, the New Jersey assistance application informs beneficiaries of their responsibility to immediately report any changes to the information on the application, and warns them that anyone who knowingly lies or hides the truth in order to receive services is committing a crime and subject to federal and state penalties.

Beneficiaries With Concurrent Eligibility

From a statistical sample of 100 beneficiary-months, totaling $52,313 in Medicaid services, the State agency made payments for 43 beneficiary-months, totaling $9,909 for services provided to beneficiaries who should not have been eligible to receive Medicaid benefits in New Jersey.

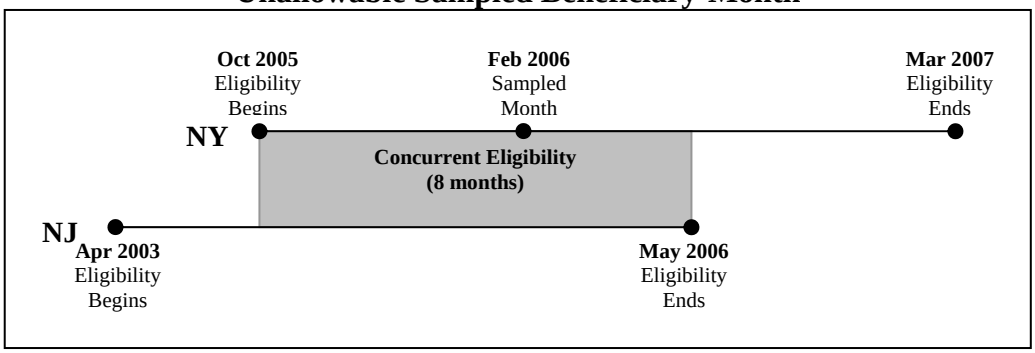
Summary of Sampled Beneficiary-Month Payments

Type of Payment	Beneficiary Months	Amount Paid
Allowable (Eligible Beneficiaries)	57	$42,404
Unallowable (Beneficiaries Who Should Not Have Been Eligible)	43	$9,909
Total	**100**	**$52,313**

Medicaid application files and other supporting documentation indicated that the State agency made payments for services on behalf of beneficiaries who were no longer New Jersey residents during the 43 beneficiary-months.[4]

In one example, a beneficiary, associated with a payment for one of the unallowable sampled beneficiary-months, moved from New Jersey and established residency in New York. The New York eligibility period was October 1, 2005, through March 31, 2007. The New Jersey eligibility period was April 1, 2003, through May 31, 2006.

Exhibit 1. Period of Concurrent Eligibility for an Unallowable Sampled Beneficiary-Month

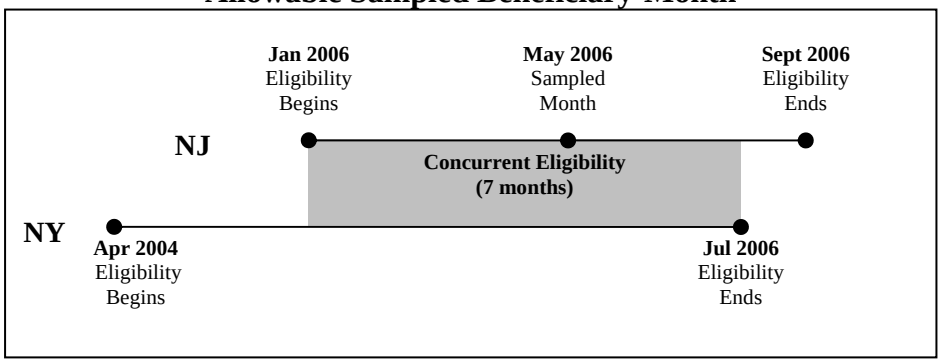


[4]Five of the 43 beneficiary-months were for Supplemental Security Income beneficiaries who were categorically eligible for Medicaid. The State agency was not responsible for determining Medicaid eligibility for these beneficiaries, but was responsible for ensuring that they resided within the State.

New York Medicaid records document that the beneficiary moved from New Jersey and established residency in New York prior to the sampled beneficiary-month (February 2006). As a result, the Medicaid payment made by the State agency on behalf of the beneficiary for the sampled beneficiary-month (February 2006) was unallowable.

In contrast, a different beneficiary, associated with a payment for an allowable sampled beneficiary-month, moved from New York and established residency in New Jersey. The New Jersey eligibility period was January 1, 2006, through September 30, 2006. The New York eligibility period was April 1, 2004, through July 19, 2006.

Exhibit 2. Period of Concurrent Eligibility for an Allowable Sampled Beneficiary-Month



New Jersey Medicaid records indicated that the beneficiary moved from New York and established residency in New Jersey in January 2006. The State agency provided the beneficiary's application for medical assistance as documentation of residency. Because the beneficiary was a New Jersey resident, the State agency appropriately made the Medicaid payment on behalf of the beneficiary for the sampled beneficiary-month (May 2006).

INSUFFICIENT SHARING OF ELIGIBILITY DATA

We attribute the payments made for services provided to beneficiaries who should not have been Medicaid-eligible to insufficient sharing of eligibility data between the State agency and the New York Medicaid agency. Although the State agency sometimes coordinated beneficiary eligibility with the New York Medicaid agency, the State agency did not promptly and systematically identify all changes in beneficiary eligibility and residency.

RECOMMENDATIONS

We recommend that the State agency work with the New York Medicaid agency to share available Medicaid eligibility information for use in:

- determining accurate beneficiary eligibility status and

- reducing the amount of payments, estimated to be $1,070,619 ($544,388 Federal share), made on behalf of beneficiaries residing in New York.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations. The State agency's written comments are included in their entirety as Appendix B.

APPENDIXES

SAMPLING METHODOLOGY AND RESULTS

UNIVERSE

The universe included beneficiary-months for services provided on behalf of Medicaid beneficiaries with concurrent eligibility in New Jersey and New York during the audit period of July 1, 2005 through June 30, 2006. The universe consisted of 10,804 beneficiary-months totaling $3,676,368 in Medicaid payments for services provided to beneficiaries in New Jersey.

SAMPLE DESIGN

We used a simple random sample for this review. We used the Office of Inspector General, Office of Audit Services' statistical sampling software RAT-STATS to select the random sample.

RESULTS OF SAMPLE

The results of our review are as follows:

Number of Beneficiary-Months	Value of Universe	Sample Size	Value of Sample	Number of Errors	Value of Errors
10,804	$3,676,368	100	$52,313	43	$9,909

Based on the errors found in the sample data, the point estimate is $1,070,619 with a lower and upper limit at the 90% confidence level of $578,198 and $1,563,040, respectively. The precision of the 90% confidence interval is plus or minus $492,421 or 45.99%.

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JOHN R. GUHL
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June 30, 2008

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 – Room 3900
New York, NY 10278

Report Number A-02-07-01029

Dear Mr. Edert:

This is in response to your correspondence of May 1, 2008 concerning the draft audit report entitled "Medicaid Payments for Services Provided to Beneficiaries with Concurrent Eligibility in New Jersey and New York for July 1, 2005 Through June 30, 2006". The opportunity to comment on this draft report is greatly appreciated.

The audit report contains one finding and one recommendation. The report makes the finding that New Jersey paid $1,070,619 ($544,388 Federal share) on behalf of beneficiaries who should not have been eligible due to their eligibility in New York. This is attributed to the insufficient sharing of eligibility data between the State agency and New York's Medicaid agency. While the auditor found that New Jersey could make operational improvements, there is no indication that New Jersey failed to comply with any requirements.

The State agrees additional coordination with other states is warranted and could improve eligibility status. Appropriate beneficiary notification of residency changes to the State agency would alleviate many eligibility issues. Also, it should be noted that some cases cited were generated by the Social Security Administration. Ultimately it appears that coordination at the Federal level would benefit all states and ultimately the Federal Government by reducing unnecessary payments for beneficiaries being eligible in two or more states simultaneously.

The recommendation from the draft audit report is that New Jersey should work with the New York Medicaid agency to share available Medicaid eligibility information for use in:

- determining accurate beneficiary eligibility status and

- reducing the amount of payments, estimated to be $1,070,619 ($544,388 Federal share), made on behalf of beneficiaries residing in New York.

New Jersey makes it a part of the application process to ask if the beneficiary is a resident of New Jersey, and if they are enrolled in any Medicaid program in any other state. New Jersey requires the beneficiary to inform the state of any change of circumstances (change of residence, job status, etc). New Jersey does perform redeterminations as defined by Federal regulation 42 CFR § 435.916 with respect to updating beneficiaries circumstances that may affect their eligibility status. We additionally use the National Change of Address (NCOA) system which compares addresses on our eligibility file to address changes submitted with the United States Postal Service (USPS). This system compares addresses monthly and the State agency distributes letters to beneficiaries monthly who have a different address from our eligibility file for residence verification and ultimately eligibility status. New Jersey does participate in the PARIS match program and does utilize this information to determine proper state eligibility status by contacting other states indicated on the report.

The opportunity to review and comment on this draft report is greatly appreciated. If you have any questions or require additional information, please contact me or David Lowenthal at 609-588-7933.

Sincerely,

John R. Guhl
Director

JRG: L
c: Jennifer Velez
David Lowenthal