

1. In determining whether it shall pay a reward and, if so, the amount of the reward, DMAHS shall take into account all relevant factors, including the significance of the information furnished in relation to the ultimate resolution of the case and the recovery.

2. The amount of the reward represents what DMAHS considers to be adequate compensation in the particular case, not to exceed 10 percent of the overpayments recovered in the case, or \$1,000, whichever is less.

3. If more than one individual or entity is eligible to receive a reward in a particular case, DMAHS shall allocate the total reward amount (not to exceed 10 percent of the overpayments recovered in that case, or \$1,000, whichever is less) among the participants.

4. DMAHS bases rewards only on recovered overpayments, not on amounts collected as interest, penalties and/or fines, and not on estimates of cost savings or cost avoidance.

5. DMAHS shall make payments as promptly as the circumstances of the case permit, but not until it has collected all overpayments, interest, penalties and fines.

6. No Division employee may make any offer or promise or otherwise bind DMAHS or DHS with respect to the payment or any reward under this subsection or the amount of the reward.

(f) An individual or entity may submit information on persons or entities engaging in, or that have engaged in, health care-related fraud and/or abuse against the programs listed in (a) above to Bureau of Program Integrity, Division of Medical Assistance and Health Services, PO Box 712, Trenton, NJ 08625-0712, or by calling the DMAHS Fraud and Abuse Hotline at 1-888-9 FRAUD-5 (1-888-937-2835).

1. A participant interested in receiving a reward shall provide his or her name, address, telephone number, and any other requested identifying information so that he or she may be contacted, if necessary, for additional information and, when applicable, for the payment of a reward upon resolution of the case.

(g) DMAHS shall not reveal a participant's identity to any person, except as required by law.

(h) If, after a reward is accepted, DMAHS finds that the awardee was ineligible to receive the reward, neither DMAHS nor DHS shall be liable for the reward, and the awardee shall refund all monies received.

(i) Receipt of a reward under this section by any applicant for, or beneficiary of, benefits under any program administered in whole or in part by the Division of Medical Assistance and Health Services, including, but not limited to, Medically Needy (N.J.A.C. 10:70), Medicaid Only (N.J.A.C. 10:71), New Jersey Care . . . Special Medicaid Programs (N.J.A.C. 10:72), NJ FamilyCare (N.J.A.C. 10:78) and NJ KidCare (N.J.A.C. 10:79), Pharmaceutical Assistance to the Aged and Disabled, Work First New Jersey/General Assistance or AFDC-Related Medicaid shall not affect that individual's eligibility or continued eligibility for those benefits.

New Rule, R.2000 d.288, effective July 17, 2000.

See: 31 N.J.R. 2673(b), 32 N.J.R. 2613(a).

Amended by R.2002 d.124, effective April 15, 2002.

See: 33 N.J.R. 4188(a), 34 N.J.R. 1546(a).

Rewrote (i).

Amended by R.2003 d.82, effective February 18, 2003.

See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

## SUBCHAPTER 14. RECOVERY OF PAYMENTS AND SANCTIONS

### 10:49-14.1 Recovery of payments correctly made

(a) Correctly paid benefits shall only be recoverable from the estate of an individual who was 65 years of age or older when the individual received medical assistance if:

1. The individual leaves no surviving spouse;

2. For estates of individuals who died between February 1, 1984 and October 20, 1992, the individual left no surviving child;

3. For estates of individuals who died on or after October 21, 1992, the individual leaves no surviving child who is under the age of 21 or any surviving blind or permanently and totally disabled children;

4. The amount to be recovered is in excess of \$500.00; and

5. The gross estate is in excess of \$3,000.

(b) Paragraphs (a)4 and 5 above shall apply to recoveries from the estates of individuals who died on or after July 20, 1981, but prior to December 22, 1995.

(c) For estates of individuals who died on or after April 1, 1995, in addition to the recoveries authorized under (a) and (b) above, any Medicaid payments correctly made on or after October 1, 1993, on behalf of individuals who received services on or after age 55 but prior to age 65, are recoverable from the estates of those individuals, subject to the conditions set forth in (a)1, 3, 4 and 5 and (b) above.

(d) Effective for estates created on or after October 4, 1999, the Division shall file any claim or lien against an estate under this section within 90 days after receiving actual written notice from the personal representative of the estate or any other interested party of the death of the Medicaid beneficiary.

(e) For estates of individuals who died on or after December 22, 1995, Medicaid claims under this section shall be deemed preferred claims, with a priority equivalent to that under subsection c. of N.J.S.A. 3B:22-2, that is, debts and taxes with preference under Federal or State law.

(f) The personal representative of the estate of a deceased Medicaid beneficiary or any other interested party, upon request to the Division, may obtain a "payoff statement" on the amount due under the claim, if that information is available to the Division at the time the request is received.

(g) Effective for estates pending on or created after October 4, 1999, if a family member of a deceased Medicaid beneficiary has, prior to the beneficiary's death, continuously resided in a home owned by the beneficiary at the time of the beneficiary's death, and that home was the beneficiary's primary residence, and was and remains the family member's primary residence, the Division may record a lien against the property, but will not enforce the lien until the property is voluntarily sold, or the resident family member either dies or vacates the property.

(h) For estates of individuals who died on or after October 1, 1993, which are subject to a recovery claim under this section which was either pending on or initiated after March 1, 1995, the estate representative may apply to the Division for a waiver or compromise of the claim based upon grounds of undue hardship, subject to the following policies and procedures:

1. Undue hardship can be demonstrated only if the estate subject to recovery is or would become the sole income-producing asset of the survivors, and pursuit of recovery is likely to result in one or more of those survivors becoming eligible for public assistance and/or Medicaid benefits.

2. There shall be a rebuttable presumption that no undue hardship exists if the hardship resulted from estate planning methods under which assets were divested in order to avoid estate recovery.

3. Upon receipt of written notice that the estate is subject to a recovery claim by the Division, the estate representative shall have 20 days from the date of receipt of the notice to file a request for a waiver or compromise of the Division's claim based upon undue hardship, together with evidence in support of the request. If that request is not received by the Division within the time limit specified, the Division shall not grant a waiver or compromise based upon undue hardship. Upon receipt of a timely request, the Division shall evaluate the request and the evidence submitted, and shall notify the applicant in writing of its decision within 45 days from the date that the request was received. If the estate representative wishes to contest the Division's decision, a written request for a hearing shall be submitted to the Division within 20 days from the date of receipt of that decision, in accordance with the provisions of N.J.A.C. 10:49-10. This request shall be forwarded by the Division to the Office of Administrative Law (OAL), which shall notify the parties of the hearing date and venue, and shall provide a description of the hearing process. Subsequent to the hearing, the formal decision of the OAL shall include a description of the process leading to the final agency decision and the appeal rights available to both parties.

(i) The Division may elect not to pursue a claim under this section against the estate of an individual who died on or after December 22, 1995, if it determines, in its sole discretion, that to do so would not be cost-effective.

(j) For all estate recoveries pending on or initiated after October 4, 1999, no lien of any kind, inchoate or otherwise, and no right of recovery can either exist or be pursued until all of the conditions set forth in N.J.S.A. 30:4D-7.2a are met, including the absence of any surviving spouse or of any minor, blind, or permanently and totally disabled children.

(k) For all estate recoveries pending on or initiated on or after October 4, 1999, even when the statutory conditions for lien filing and recovery are met, recovery shall not be pursued against property held by any bona fide purchaser who has paid fair market value for the property, but shall be sought from the estate.

(l) For purposes of this section, the term "estate" with respect to a deceased Medicaid beneficiary shall include:

1. All real and personal property and other assets included within the individual's estate, as defined in N.J.S.A. 3B:1-1; and

2. For individuals who died on or after April 1, 1995, the term "estate" shall also include any other real and personal property and other assets in which the Medicaid beneficiary had any legal title or interest at the time of death, to the extent of that interest, including assets conveyed to a survivor, heir or assign of the beneficiary through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement, as well as any proceeds from the sale of any such property which remain in the estate of the survivor, heir or assign of the beneficiary, to the extent of the beneficiary's interest;

i. Effective for future estates or estate recoveries pending on or after October 4, 1999, for purposes of this subsection, the term "life estate" shall mean a life estate created upon the death of a beneficiary;

ii. Effective for future estates or estate recoveries pending on or after October 4, 1999, for purposes of this subsection, the term "other arrangement" shall include, but not be limited to, any trust or annuity in which the beneficiary had an interest at the time of death, including a trust or annuity established by a third party, subject to the exclusions discussed in (n) below.

(m) Any lien filed on or after October 4, 1999 against an estate as described in (l)2 above shall describe the extent of the deceased Medicaid beneficiary's interest covered by the lien, if known to the Division at the time the lien is filed. For example, if a deceased Medicaid beneficiary at the time of his death owned real property as a tenant-in-common with another individual, the lien should state that it encumbers only 50 percent of the equity in the real property. If the deceased Medicaid beneficiary held a tenancy-by-the-entirety or joint tenancy with a right of survivorship, then the lien shall state that it encumbers all of the property. If the Division is not aware of the extent of the beneficiary's interest at the time that the lien is filed, the full amount of the Division's claim shall be listed on the lien.

(n) For purposes of this section, for future estates or estates pending on or after October 4, 1999, the term “estate” shall not include:

1. A life estate in which the beneficiary held an interest during his or her lifetime, but which expired upon the Medicaid beneficiary’s death;

2. An inter vivos trust established by a third party for the benefit of the now-deceased Medicaid beneficiary, provided that:

i. The trust is a discretionary trust, constructed in such a way that the Medicaid beneficiary could not compel distributions from the trust; and

ii. The trust contains no assets in which the Medicaid beneficiary held any interest within either five years prior to applying for Medicaid benefits, or five years prior to the Medicaid beneficiary’s death; or

3. A testamentary trust established by a third party (including the spouse of the now-deceased Medicaid beneficiary) for the benefit of the now-deceased Medicaid beneficiary, provided that:

i. The trust is a discretionary trust, constructed in such a way that the Medicaid beneficiary could not compel distributions from the trust; and

ii. The trust contains no assets in which the Medicaid beneficiary held any interest within either five years prior to applying for Medicaid benefits, or five years prior to the beneficiary’s death. Assets of the community spouse which formed a part of the community spouse resource allowance shall not be considered assets of the Medicaid beneficiary. Any assets of the community spouse other than those that formed part of the community spouse resource allowance shall be considered assets of the Medicaid beneficiary if acquired from the Medicaid beneficiary within five years prior to the date of application for Medicaid benefits or five years prior to the date of death of the Medicaid beneficiary.

Amended by R.1994 d.524, effective October 17, 1994.

See: 26 N.J.R. 2757(a), 26 N.J.R. 4184(b).

Amended by R.1999 d.332, effective October 4, 1999.

See: 31 N.J.R. 242(a), 31 N.J.R. 2883(a).

In (a), in the introductory text, substituted “the individual” for “he or she”, in (a)2, substituted “of individuals who died” for “coming into being”, inserted “1,” following “February”, and substituted “left” for “leaving”, in (a)3, substituted “of individuals who died” for “coming into being”, in (b), substituted “but prior to December 22, 1995” for “the effective date of P.L. 1981, c.217 (N.J.S.A. 30:4D-7.2a)”, and added (c) to (n).

#### Case Notes

Retroactive application of statute for recovery of Medicaid overpayments did not violate due process. In re: Kaplan, 178 N.J.Super. 487, 429 A.2d 590 (App.Div.1981).

#### 10:49-14.2 Sanctions—Special Status Program

(a) The “Special Status Program” either restricts the Medicaid or NJ FamilyCare beneficiary(s) listed on the HBID Card to a single provider, except in a medical emergency, or warns providers that the beneficiary’s card has been used by an unauthorized person or persons, or for an unauthorized purpose. If a warning letter is issued to a beneficiary, a message will be included in the eligibility message on the REVS/MEVS/eMEVS system alerting the provider to ask the Medicaid or NJ FamilyCare beneficiary for additional identification or to take other appropriate action.

1. The restriction is issued to Medicaid or NJ FamilyCare beneficiaries determined to have misused, abused or overutilized their Medicaid or NJ FamilyCare benefits. Overutilization occurs when a beneficiary has utilized Medicaid or NJ FamilyCare services or items at a frequency or amount that is not medically necessary. Examples of misuse or abuse include, but are not limited to, medically harmful or inappropriate use of different drugs or provider services, obtaining or attempting to obtain early refills of prescriptions in violation of N.J.A.C. 10:51-1.19(a)5, at more than one pharmacy, and forgery or alteration of prescriptions. A determination that there has been misuse, abuse or overutilization of benefits obtained by use of an HBID Card shall create a presumption that the beneficiary listed on the HBID Card, or a person responsible for a minor listed on the HBID Card, was responsible for such actions. If this presumption is successfully rebutted by or on behalf of the Medicaid or NJ FamilyCare beneficiary, he or she shall not be enrolled in the Special Status Program.

i. A beneficiary shall be permitted to change the designated provider upon demonstration of good cause and the Division may grant the request.

ii. The Division may change the provider to which the beneficiary is restricted if a pattern of continued misuse, abuse or overutilization by the beneficiary is evident, or if it is determined that the provider has engaged in fraud or abuse, or if the Division determines that such a change is in the best interest of the beneficiary and/or the programs it administers in whole or part.

iii. The beneficiary may request a contested case hearing in the following situations:

(1) If the beneficiary objects to being included in the special status program;

(2) If the beneficiary requests a change and the request is denied;

(3) If the agency causes undue delay in responding to the beneficiary’s request for change.

2. The warning letter is issued to Medicaid or NJ FamilyCare beneficiaries determined to have had their HBID Card used by an unauthorized person or persons, or

for an unauthorized purpose. The purpose of the warning is to notify providers that the beneficiary's HBID Card has been used by an unauthorized person or persons, or for an unauthorized purpose. A message will be available on the REVS/MEVS/eMEVS system alerting the provider to ask the Medicaid or NJ FamilyCare beneficiary for additional identification or to take other appropriate action. A determination that an HBID Card has been used by an unauthorized person or for an unauthorized purpose shall create a presumption that the beneficiary listed on the HBID Card, or a person responsible for a minor listed on the HBID Card, was responsible for such actions. If this presumption is successfully rebutted by the beneficiary, the beneficiary shall not be issued a warning letter.

Amended by R.1997 d.354, effective September 2, 1997.  
See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

Substituted reference to beneficiaries for references to recipients throughout.

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).  
See: 30 N.J.R. 1060(a).

In (a), inserted references to NJ KidCare and substituted references to Eligibility Identification Cards for references to Medicaid Eligibility Identification Cards throughout.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.  
See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

Amended by R.2003 d.82, effective February 18, 2003.  
See: 34 N.J.R. 2650(a), 35 N.J.R. 1118(a).

Rewrote (a)1.

Amended by R.2008 d.230, effective August 4, 2008.  
See: 40 N.J.R. 984(a), 40 N.J.R. 4531(a).

In the introductory paragraph of (a), substituted "HBID" for "Eligibility Identification (EI)", "letter" for "card" and "included in the eligibility message on the REVS/MEVS/eMEVS system" for "printed on the card", and inserted "to a beneficiary"; in the introductory paragraph of (a)1, substituted "restriction" for "restrictive card", "HBID" for "(EI)" twice, the second occurrence of "beneficiary" for "beneficiaries", and ", or a person responsible for a minor listed on the HBID Card, was" for "were", and inserted "or on behalf of"; and in (a)2, substituted "letter" for "card" twice, "HBID" for "(EI)" four times, "available on the REVS/MEVS/eMEVS system" for "printed on the card", the second occurrence of "beneficiary" for "beneficiaries" and ", or a person responsible for a minor listed on the HBID Card, was" for "were".

### 10:49-14.3 Authority to adjust, compromise, settle or waive claims, liens, and certificates of debt

(a) The Commissioner, Department of Human Services; Director, Division of Medical Assistance and Health Services; Assistant Director, Office of Program Integrity Administration; and the Commissioner or Deputy Commissioner, Department of Health and Senior Services, or anyone serving in an acting capacity in any of those positions shall have the authority to adjust, compromise, settle or waive any claim, lien or certificate of debt arising under this Act (N.J.S.A. 30:4D-1 et seq.), and to execute an appropriate release or document of discharge with respect to that claim, lien or certificate of debt.

(b) Such authority may be exercised by other officials only in the following limited circumstances:

1. The Administrator, Bureau of Administrative Control may compromise, settle or waive any claim or lien not arising under N.J.S.A. 30:4D-7(h) within the dollar limits specified by the Director, Division of Medical Assistance and Health Services; and

2. The Fiscal Agent may compromise, settle or waive claims arising under N.J.S.A. 30:4D-7(h) within the dollar limits specified by the Director, Division of Medical Assistance and Health Services.

Amended by R.1997 d.354, effective September 2, 1997.

See: 29 N.J.R. 2512(a), 29 N.J.R. 3856(a).

In (a), amended Office reference and added reference to Commissioner and Deputy Commissioner of Department of Health and Senior Services.

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

Substituted a reference to the Office of Program Integrity Administration for a reference to the Office of Quality Management and Program Integrity.

Adopted concurrent proposal, R.1998 d.487, effective August 28, 1998.

See: 30 N.J.R. 1060(a), 30 N.J.R. 3519(a).

Readopted the provisions of R.1998 d.154 without change.

### Case Notes

Recapture of the reimbursement for pharmaceutical services; agent erroneously processed claim. *South End Pharmacy, Inc. v. Division of Medical Assistance and Health Services*, 94 N.J.A.R.2d (DMA) 48.

### 10:49-14.4 Recoveries involving a county welfare agency (CWA)

(a) The purpose of this section is to define areas of responsibility and establish basic principles and procedures in those collection activities in which the Division of Medical Assistance and Health Services (DMAHS), the Division of Family Development (DFD) and/or a county welfare agency (CWA) may be involved. It is intended that maximum conservation of public funds be effected without duplication of effort. It is recognized that certain situations may fall into more than one of the following categories. Any such matter will be processed in accordance with the provisions of the first occurring applicable category.

(b) The following pertain to incorrectly granted assistance (cash and/or medical assistance):

1. In instances involving incorrect eligibility for medical assistance, whether or not in combination with cash assistance, the CWA shall determine the period(s) of ineligibility and ascertain from DMAHS the amount of medical assistance incorrectly granted. The CWA shall then attempt recovery of medical assistance incorrectly granted either by administrative collection, or by way of restitution in a criminal or disorderly persons proceeding.

i. Recoveries or attempts at recoveries can be made from those persons specified in N.J.S.A. 30:4D-7i.

2. When recovery cannot be obtained by these methods in a case generated by the Internal Revenue Service (IRS) unearned income component of the Income and Eligibility