NEW YORK
state department of
HEALTH

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Acting Commissioner of Health

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Executive Deputy Commissioner

January 8, 2015

Mr. Dennis Buckley, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Mr. Buckley:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-Up Audit Report 2014-F-12 entitled, "Improper Payments Related to the Medicare Buy-In Program" (2010-S-76).

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

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Department of Health Comments on the Office of the State Comptroller's Follow-Up Audit Report 2014-F-12 Entitled, Improper Payments Related to the Medicare Buy-In Program

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2014-F-12 entitled, "Improper Payments Related to the Medicare Buy-In Program" (Report 2010-S-76).

Background:

New York State is a national leader in its oversight of the Medicaid Program. Through the efforts of the Department and the Office of the Medicaid Inspector General (OMIG), over the last five years, New York State alone accounted for 54.9 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement. Over the last three calendar years, the administration's Medicaid enforcement efforts have recovered over $1.73 billion, a 34 percent increase over the prior three-year period.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 840,000 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,929 in 2013, consistent with levels from a decade ago.

Recommendation #1:

Formally and periodically remind HRA and the local districts to:

- ensure that eligibility determinations are made for all people enrolled in the Medicare buy-in program; and

- re-assess the eligibility of buy-in program recipients who lose their basic Medicaid program benefits. Remove ineligible people from the buy-in program timely.

Status - Implemented

Agency Action – In 2014, the Department issued a General Information System (GIS) message to remind all local districts of the need to conduct eligibility determinations for people enrolled in the Medicare buy-in program. The GIS included instructions on re-assessing the buy-in eligibility of recipients who lost their basic Medicaid benefits, using eMedNY reports that identify buy-in program recipients who no longer have Medicaid coverage, and the steps for removing ineligible recipients from the buy-in program in a timely manner.

Because of the high volume of buy-in cases in New York City, the Department also has regular, ongoing communications with HRA concerning eligibility re-assessment. Further, the Department established a process to send Upstate local districts monthly reminders of the availability of the eMedNY reports and the importance of re-assessing recipients' buy-in eligibility and timely

removing ineligible recipients from the program. Department officials also contact local districts when the eMedNY reports show increases from month to month.

The Department's efforts have helped reduce the average monthly premium payments made for individuals whose buy-in eligibility was not re-assessed from approximately $1.8 million per month during our initial audit to about $535,000 per month during the 18-month period of December 2012 to May 2014 (a decrease of about $1.3 million per month). However, about $9.6 million in premiums was still not re-assessed during the 18-month period ($535,000 x 18 months). We further determined some of the premiums were paid on behalf of individuals who were deceased (about $75,000). We, therefore, encourage Department officials to continue their efforts to work with local districts.

Response #1:

The Department confirms our agreement with this report.

Recommendation #2:

Recover the inappropriate premiums (totaling $1.9 million) paid after individuals in the buy-in program died and the duplicate premium payments (totaling $163,000).

Status - Partially Implemented

Agency Action – The Department has taken steps to recover some of the inappropriate premium payments identified during the initial audit. We determined $105,222 of the $1.9 million in premiums paid after individuals in the buy-in program died has been credited back to the State, and the Department is working with the federal Social Security Administration to resolve another $104,008 in payments. However, no further action has been taken on the remaining $1.7 million in inappropriate premium payments. (Since our initial audit, we identified an additional $569,000 in inappropriate premiums paid during the period March 1, 2011 through July 1, 2014 for individuals in the buy-in program who were deceased; we provided these payments to the Department for further review.)

We determined $72,174 of the $163,000 in duplicate premium payments has been recovered, and Department officials stated they are working with the Centers for Medicare and Medicaid Services (CMS) to resolve another $55,604 in payments. However, no further action has been taken on the remaining approximate $35,000 in duplicate premium payments.

Response #2:

The Department takes issue with the statement that "no further action has been taken on the remaining $1.7 million in inappropriate premium payments." The State does not have the authority to recover inappropriate Medicare premiums paid to CMS after the date of death. Rather, a credit can be made, but only after CMS takes steps to adjust its Medicare billing files. The Department took action by making an arrangement with CMS to accept, from the Department, a manual file of deceased individuals who have had Buy-In payments made after the date of death.

CMS has also agreed to review the records and, as appropriate, adjust its NYS Buy-In billing file. This will result in the State receiving a prospective credit equal to the inappropriate Medicare Buy-In payments. This is a manual process that will bypass the electronic verification used by CMS

from the Social Security Administration (SSA) for notification of date of death. Therefore, in the cases where SSA failed to notify CMS of death, CMS will close the Buy-In based on the file received from the Department. The Department sent the manual file to CMS on November 21, 2014. The file was composed of 454 records identified by OSC for the period March 1, 2011 through July, 1 2014. The Department will monitor CMS' progress with their review and adjustment process.

In addition, in September 2012, the Department took action to initiate Evolution Project (EP) 1753 after CMS notified states that they were able to reject transactions submitted by CMS. EP 1753 was designed to reject transactions from CMS that would accrete people to the NYS Buy-In program who did not have an active Medicaid case, including people with a previous NYS Medicaid case that had their Medicaid case closed due to death. Implementation of EP 1753 occurred on September 25, 2014 and is expected to greatly reduce the number of inappropriate Buy-In payments made to CMS for deceased individuals in the future.

With regard to duplicate cases, the Department continues to provide quarterly files of duplicate premium payments to CMS for their review and investigation. CMS has a standard operating procedure for investigation, consolidation, and resolving duplicate billing cases. Please note that CMS informed the Department that when the county and CMS enter separate transactions to pay the Buy-In premium for the same period, CMS will refund the payments made on the county initiated Buy-In transaction. These records should not be considered duplicates.

Recommendation #3:

Formally determine the reasons for duplicate premium payments and take steps as needed to prevent them in the future.

Status – Implemented

Agency Action – According to Department officials, duplicate premium payments occur when the Social Security Administration assigns more than one Health Insurance Claim Number (HICN) to a Medicare enrollee, and eMedNY pays a premium for each HICN. (The Social Security Administration is responsible for determining Medicare eligibility and assigns HICNs to identify Medicare beneficiaries receiving health care services.)

In February 2014, the Department initiated a process to identify duplicate premium payments. As part of the process, a file of potential duplicates is periodically sent to CMS. CMS reviews the potential duplicates and removes multiple HICNs, thereby eliminating future duplicate premium payments. At the end of our audit fieldwork, the most recent file sent to CMS was in June 2014 and it contained 43 potential duplicate cases.

Response #3:

The Department confirms our agreement with this report.

Recommendation #4:

Develop and implement changes to the eMedNY system to ensure accurate payment of claims for individuals who are eligible for buy-in coverage only.

Status – Implemented

Agency Action – In March 2014, the Department corrected the eMedNY pricing methodology to accurately pay claims for individuals who are eligible for buy-in coverage only.

Response #4:

The Department confirms our agreement with this report.

Recommendation #5:

Review the $5.5 million in improper claim payments we identified and recover funds where appropriate.

Status – Not Implemented

Agency Action – In the Department's formal response to our initial audit, officials stated they would review the claims we identified and seek recoveries as warranted. However, at the time of our follow-up review, the claims in question were not reviewed, and no recoveries were made.

Response #5:

In Office of the State Comptroller's Final audit report 2010-S-76, OSC auditors stated that the Qualified Medicare Beneficiary (QMB) portion of the overpayments was calculated based on difference between the Medicaid paid amount and the Medicare co-insurance and deductibles. The Medicare Catastrophic Coverage Act of 1988 requires Medicaid payment of Medicare premiums, deductibles and co-insurance for QMBs. This includes payment of co-insurance and deductibles for clinical social workers, podiatry and chiropractic. Additionally, Department Regulation 360-7.7 states that with eligibility for the Buy-In Program, QMBs are eligible for Medicaid payment of Medicare Part A and B premiums, deductibles and co-insurance. The Department has since reviewed the claims identified in this audit and found that these claims were appropriately paid. Therefore, no further recoveries are warranted.