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November 18, 2014

Howard A. Zucker, M.D., J.D.
Acting Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Improper Payments Related to the
Medicare Buy-In Program
Report 2014-F-12

Dear Dr. Zucker:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we have followed up on the actions taken by officials of the Department of Health to implement the recommendations contained in our audit report, *Improper Payments Related to the Medicare Buy-In Program* (Report 2010-S-76).

Background, Scope and Objectives

The Department of Health (Department) administers the New York State Medicaid program. Medicaid provides a wide range of medical services to individuals who are economically disadvantaged and/or have special health care needs. Many of the State's 6.5 million Medicaid recipients are also enrolled in Medicare, the federal health care program for people 65 years of age and older and people under 65 years old with certain disabilities. Medicare often requires its enrollees to pay certain out-of-pocket costs, such as monthly premiums, annual deductibles, and coinsurance on claims. For individuals dual-enrolled in Medicaid and Medicare, Medicaid typically pays Medicare deductibles and coinsurance.

To further assist certain low-income people pay out-of-pocket Medicare expenses, the federal government established the Medicare buy-in program. Under the buy-in program, Medicaid pays the Medicare premiums of most dual-eligible individuals. Further, some people qualify for the Medicare buy-in program, although they do not qualify for Medicaid. For these individuals with "buy-in only" coverage, Medicaid is required to pay their out-of-pocket Medicare expenses, including premiums, deductibles, and coinsurance if they meet various buy-in program eligibility requirements.

Determinations of Medicare buy-in program eligibility are made by the New York City Human Resources Administration (HRA) and the 57 other county Departments of Social Services outside of New York City (local districts). Annual Medicaid payments for the Medicare buy-in program total approximately $1.3 billion.

A person can lose his or her buy-in eligibility for many reasons, including: no longer a State resident, no longer meeting the income test, or death. If a person is no longer eligible for the buy-in program, local district workers are required to make certain changes in the Medicaid claims processing system (eMedNY) to end the person's buy-in eligibility and stop the payment of Medicare expenses. Additionally, if a local district closes a recipient's eligibility for their basic Medicaid coverage, but does not assess that person's buy-in program eligibility, Medicaid would improperly pay Medicare premiums if the person was no longer eligible for the buy-in program. In recent years, the Department developed a system to automatically end (or "auto-close") buy-in coverage and stop premium payments when someone lost their eligibility for Medicaid coverage for certain reasons, such as no longer a State resident. In 2012 and 2013 the Department increased the number of "auto-close" reasons to further reduce the number of improper buy-in payments; however, manual intervention is still required in some cases.

We issued our initial audit report on October 26, 2012. Our objective was to determine if Medicaid properly paid Medicare premiums and medical claims for people in the Medicare buy-in program. Our initial audit determined that, from March 2006 through February 2011, Medicaid made nearly 260,000 improper payments, totaling about $26.8 million, for people enrolled in the Medicare buy-in program. Most of the improper payments ($21.1 million) were for Medicare premiums for people who were ineligible for the buy-in program. The improper payments resulted from insufficient Department oversight and poor local district practices. In addition, weaknesses in the eMedNY system led to overpayments totaling about $5.5 million in medical claims (such as for coinsurance) for persons with "buy-in only" coverage. We also identified duplicate premium payments totaling about $163,000. We recommended that the Department recover the overpayments, improve its oversight of local districts, and enhance eMedNY system controls to ensure accurate payment of Medicare expenses for individuals enrolled in the buy-in program.

The objective of our follow-up was to assess the extent of implementation, as of July 31, 2014, of the five recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials made progress in addressing the problems we identified in our initial audit report. However, further actions are still needed as millions of dollars in questionable and improper Medicaid payments continue to be paid for people in the Medicare buy-in program. Since our initial audit, we identified $9.6 million in additional premium payments for individuals in the buy-in program whose eligibility was not re-assessed. We also identified $569,000 in additional premiums that were paid on behalf of individuals who had died. Of the initial report's five audit recommendations, three were implemented, one was partially implemented, and one was not implemented.

Follow-Up Observations

Recommendation 1

*Formally and periodically remind HRA and the local districts t*o:

- 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.

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 approximate $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.

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.

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.

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.

Major contributors to this report were Christopher Morris and Mark Breunig.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Dennis Buckley
Audit Manager

cc: Ms. Diane Christensen, Department of Health
Mr. James Cox, Medicaid Inspector General