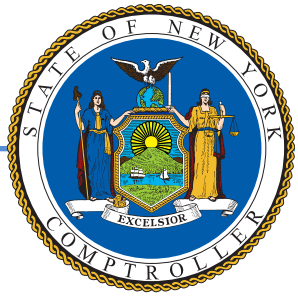
Department of Health

Medicaid Program: Medicare Part D Clawback Payments

Report 2018-S-46 | January 2020

OFFICE OF THE NEW YORK STATE COMPTROLLER
Thomas P. DiNapoli, State Comptroller
Division of State Government Accountability



Audit Highlights

Objective

To determine whether the Department of Health (Department) overpaid the Medicare Part D prescription drug phased-down state contributions. The audit covered the period January 1, 2017 through December 1, 2018.

About the Program

The Department administers New York's Medicaid program. Effective January 1, 2006, pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Medicare Part D provides prescription drug benefits for individuals who are dually eligible for Medicare and Medicaid ("dual-eligibles"). The Department is required to make a monthly payment (referred to as the phased-down state contribution, or "clawback" payment) to the federal government to cover part of the cost of prescription drugs for the State's full-benefit dual-eligible population.

Key Findings

Auditors identified opportunities for cost reduction of Part D clawback payments totaling $2.9 million for the period January 1, 2017 through December 1, 2018. Specifically, the audit found the Department needs to assess the appropriateness of the following payments:

- $1.65 million in payments on behalf of 2,315 recipients who were receiving Medicaid in another state.
- $451,348 in payments on behalf of 1,250 recipients who either were only eligible for partial Medicaid benefits or did not have any Medicaid coverage.
- $269,478 in payments on behalf of 645 recipients who appear to have been incarcerated.
- $259,584 in payments on behalf of 929 deceased recipients.
- $257,761 in payments on behalf of 714 recipients who no longer had Part D coverage.

Key Recommendations

- Review the $2.9 million in clawback payments and take the necessary steps to ensure appropriate adjustments are made before the 36-month time frame for refunds expires.
- Develop a process to verify the reasonableness and accuracy of clawback charges.

Office of the New York State Comptroller
Division of State Government Accountability

January 17, 2020

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

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage their resources efficiently and effectively. By so doing, it provides accountability for the tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Medicare Part D Clawback Payments*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Division of State Government Accountability

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Glossary of Terms

Term	Description	Identifier
Clawback	Phased-down state contribution	*Key Term*
CMS	Centers for Medicare & Medicaid Services	*Agency*
Department	Department of Health	*Auditee*
eMedNY	Department's Medicaid claims processing system	*System*
Full-benefit dual-eligibles	Individuals who are eligible for full Medicaid benefits and have coverage for Medicare Part D drugs under a prescription drug plan	*Key Term*
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003	*Act*
NYSOH	NY State of Health	*System*
PARIS	Public Assistance Reporting Information System	*System*
Part D	Medicare Part D prescription drug coverage	*Key Term*
PUPS	SSA's Prisoner Update Processing System	*System*
SSA	Social Security Administration	*Agency*

Background

The New York State Medicaid program is a federal, state, and local government-funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2019, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $67.4 billion. The federal government funded about 56.5 percent of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 43.5 percent.

The federal Centers for Medicare & Medicaid Services (CMS) oversees state Medicaid programs, and the Department of Health (Department) administers the program under Title XIX of the Social Security Act through its Office of Health Insurance Programs.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created Medicare Part D (Part D) to provide prescription drug benefits for Medicare-eligible individuals beginning on January 1, 2006. Under the MMA, state Medicaid programs no longer assume the costs associated with prescription drug benefits for individuals who are dually eligible for Medicare and Medicaid ("dual-eligibles"), and are required instead to make a monthly payment (referred to as the phased-down state contribution, or "clawback" payment) to CMS. This payment is to cover part of the cost of prescription drugs for the state's full-benefit dual-eligible population. According to federal law,[1] individuals are considered to be full-benefit dual-eligible if they are eligible for full Medicaid benefits and have coverage for Medicare Part D drugs under a prescription drug plan.

At least once per month, the Department must submit an MMA file to CMS identifying all individuals who are dual-eligible and indicating whether they are eligible for full or partial Medicaid benefits for a given month (for example, individuals with partial Medicaid benefits only receive assistance from Medicaid to pay for Medicare premiums or Medicare coinsurance and deductibles). The Department also submits a weekly MMA file of individuals whose eligibility status has changed. The Department creates the MMA files using recipient information, including eligibility, extracted from eMedNY, the Medicaid claims processing system.

CMS uses the MMA file to support various program needs including determining the amount of monthly clawback payments due from states. CMS sends an MMA response file back to the Department indicating the full-benefit dual-eligible population for which the State must pay a clawback for a given month. CMS then invoices the Department for the total clawback amount for the current month's full-benefit dual-eligibles in addition to any retroactive

1 Public Law 108-173

adjustments (credits or debits) for previous months. Department officials stated that CMS makes the final determinations on clawback payments. If the Department does not pay the clawback amount charged, the money is taken out of the federal funding of the Medicaid program.

While CMS makes the final determination on clawback payment amounts, the Department is able to contest charges it believes are incorrect. In addition, according to the CMS' *Medicare Modernization Act (MMA) State File Specifications and Data Dictionary* (MMA file manual), the Department can make retroactive adjustments to the information submitted on the MMA files, such as to report a new enrollee whose eligibility is retroactive, a recipient whose dual-eligibility status has changed, or a recipient who is deceased or ineligible for Medicaid for another reason. Adjustments to the MMA file can be submitted up to 36 months retroactively.

The Department made clawback payments totaling $2.4 billion for the period from January 1, 2017 through November 30, 2018.

Audit Findings and Recommendations

We found the Department has not ensured that all Part D clawback payments were correctly charged to the State and has not established processes to routinely review the appropriateness of clawback payments. As a result, for the period January 1, 2017 through December 1, 2018, we identified opportunities for cost reductions totaling $2.9 million in clawback payments made on behalf of 5,840 recipients.[2] These recipients do not appear to have met the definition of full-benefit dual-eligibles, as required by the federal clawback law, as follows:

- $1.65 million was paid on behalf of 2,315 individuals who were receiving Medicaid in another state.
- $451,348 was paid on behalf of 1,250 recipients who either were only eligible for partial Medicaid benefits or did not have any Medicaid coverage.
- $269,478 was paid on behalf of 645 recipients who appear to have been incarcerated.
- $259,584 was paid on behalf of 929 individuals who were deceased.
- $257,761 was paid on behalf of 714 recipients who no longer had Part D coverage.

When an individual has been submitted on the MMA file as a dual-eligible, the Department has 36 months to make any necessary eligibility changes to the file. As such, if clawback charges are found to be incorrect, the Department can contest them and ultimately submit adjustments in the MMA file – and receive credits from CMS on invoices – up to 36 months (three years) retroactively. For purposes of this audit, we requested the Department provide five years of MMA response files. The Department, however, could only provide complete data for 23 months – from January 1, 2017 to December 1, 2018 – explaining it does not maintain older MMA response files.

Given that our audit findings are based on a "snapshot" of just under two years, we acknowledge that they could be impacted by any corrective action taken by CMS or the Department (i.e., retroactive adjustments to the MMA files) subsequent to our audit period. However, we also note that, in nearly all cases we present in this report, the information needed to support cost reductions from CMS was available to the Department during the audit period. Further, based on its current processes, it is unlikely the Department would have identified and reviewed them on its own. Subsequent to our audit, the

2 Thirteen of the 5,840 recipients were identified in more than one category that prevented them from being a full-benefit dual-eligible (i.e., out of state, partial/no Medicaid coverage, incarceration, deceased, no Part D coverage).

Department began discussions with CMS to determine appropriate actions regarding most of the issues we identified.

Opportunities for Cost Reductions

Out-of-State Recipients

States submit quarterly files to the federal government, via the Public Assistance Reporting Information System (PARIS), of all active public assistance (e.g., food stamps, Medicaid) cases. The federal government gathers each state's information and performs a Social Security number match to identify individuals who may be receiving duplicate benefits in multiple states. This information is then returned to the states for further investigation, which in New York is completed by local social services districts. If a district finds a recipient is not a State resident, the Department removes the individual from the Medicaid program. Department officials stated that Medicaid benefits can only be discontinued prospectively, citing timely and adequate notice rules for ending an individual's Medicaid coverage.

Based on our review of PARIS files and MMA response files, for the period January 1, 2017 through December 1, 2018, we identified $1.65 million in clawback payments on behalf of 2,315 recipients who were also receiving Medicaid in another state. These recipients' New York Medicaid cases were eventually closed, primarily because the Medicaid program confirmed they did not reside in New York State or they failed to respond to a local social services district request to confirm residency or ongoing Medicaid eligibility. If these recipients were, in fact, the responsibility of another state's Medicaid program, they did not meet the definition of a full-benefit dual-eligible in New York, and clawback payments should be refunded.

As stated previously, CMS makes the final determination on clawback payments; however, the Department has not previously considered whether clawback payments were inappropriately made on behalf of individuals who have Medicaid in other states. Therefore, there is no process in place to identify and seek refunds from CMS for these payments. The Department should coordinate with CMS to determine if these clawback payments were incorrectly charged to New York State because the recipient, and the corresponding clawback payment, were the responsibility of another state's Medicaid program.

Individuals With Partial or No Medicaid Coverage

Clawback payments should only be made for Medicaid recipients who are eligible for full Medicaid benefits.[3] However, for the period January 1, 2017 through December 1, 2018, we identified clawback payments totaling $451,348 made on behalf of 1,250 recipients who had partial or no Medicaid coverage.

Of this amount, $403,399 was for recipients who originally had full Medicaid benefits but were retroactively switched to partial Medicaid benefits on the recipient eligibility file (e.g., coverage for Medicare coinsurance and deductible only). The Department did not account for this change to Medicaid coverage in the MMA file and, therefore, clawback payments were not refunded. In responding to this finding, Department officials stated that a recipient's change in status from a full-benefit dual-eligible to a partial-benefit dual-eligible does not trigger a retroactive adjustment record in its automated MMA file process. They indicated that, while the recipient eligibility file contains retroactive eligibility dates, actual Medicaid coverage cannot be downgraded retroactively, citing timely and adequate notice regulations for ending an individual's Medicaid coverage, and therefore, no retroactive adjustments to the MMA file should be made in these cases. However, CMS' MMA file manual states that a retroactive change record should be submitted to indicate these types of changes. The Department should work with CMS to clarify what the appropriate actions are and then submit timely adjustment records as appropriate.

The remaining $47,949 (of $451,348) in payments were made on behalf of recipients who did not have any Medicaid coverage during the month of the clawback payment. Based on discussions with Department officials, this was likely caused by a one-time error where NY State of Health (NYSOH), New York's online health insurance marketplace, transmitted information to eMedNY misidentifying recipients as having coverage when, in fact, they did not. However, after this eMedNY eligibility error was corrected, the Department did not ensure that refunds of the clawback payments were correctly processed in the MMA files. In response, Department officials stated the MMA files will be evaluated to ensure proper adjustments are made.

Incarcerated Recipients

Incarcerated individuals are not eligible for full Medicaid benefits, nor are they eligible for Part D coverage. Therefore, states are not required to pay clawbacks for incarcerated individuals. However, for the period January 1, 2017 through December 1, 2018, we identified $269,478 in clawback

3 Public Law 108-173

payments for 645 recipients who appear to have been incarcerated during the month of the clawback payment according to the MMA file.

Prompt identification of all incarcerated individuals is critical because when these individuals are identified, Medicaid benefits can only be suspended prospectively due to timely and adequate notice regulations for ending an individual's Medicaid coverage. To identify incarcerated recipients for suspension of Medicaid benefits, the Department performs a match of recipients to incarceration information from the Department of Corrections and Community Supervision, Division of Criminal Justice Services, and New York City Department of Corrections. We note, however, that upstate jails (non-New York City) are not required to report inmate-specific incarceration information and, therefore, the files used by the Department may be incomplete. Furthermore, the Department does not have a process for determining if a Medicaid recipient was incarcerated in a federal prison or in another state, increasing the risk of inappropriate clawback payments by the Department. In response to our audit, the Department stated it will obtain incarceration data from the Federal Bureau of Prisons.

We also determined CMS' MMA response file identifies recipients who cannot be automatically enrolled in a Medicare Part D plan due to incarceration. CMS officials stated they obtain this incarceration information from the Social Security Administration's (SSA) Prisoner Update Processing System (SSA PUPS file). While the MMA file contains only incarceration begin and end dates for such recipients who cannot be auto-enrolled in a Medicare Part D plan, the SSA PUPS file contains detailed prisoner information reported to the SSA, including confinement and release dates, facility name, facility address, and facility contact person. However, the Department is reluctant to use the SSA PUPS file, stating that it may return false positives, which could create barriers to coverage for individuals who are not actually incarcerated. Given the value of promptly identifying incarcerated individuals, we encourage the Department to consider using the SSA PUPS file to identify incarcerated recipients, followed by independent verification by contacting the corrections facility. In response to our audit, the Department has also sought guidance from CMS about the appropriateness of clawback payments when the MMA file lists recipients as incarcerated and unable to auto-enroll in a Part D plan.

Incarcerated individuals are considered out of the service area of their Part D plan and are therefore ineligible for Part D coverage. Accordingly, Part D plans should disenroll incarcerated individuals. If Part D plans do not disenroll incarcerated individuals timely, the State could end up paying clawbacks that it should not be responsible for paying. Additionally, the Department may not learn of recipients' incarcerations until well after the fact – while making monthly clawback payments on their behalf in the meantime. Currently, not all

clawback payments for incarcerated individuals are refunded to the State due to the limitations on retroactively closing recipients' Medicaid coverage and the Department's general lack of processes to review the appropriateness of clawback payments. For these reasons, it is likely that additional months of clawback payments not reviewed during this audit were also improper due to incarcerations. The Department should take steps to identify all clawback payments made on behalf of Medicaid recipients who were incarcerated in New York, another state, or a federal prison. The Department should then coordinate with CMS to determine the appropriateness of the payments.

Deceased Recipients

For the period January 1, 2017 through December 1, 2018, we identified clawback payments totaling $259,584 for 929 individuals who were deceased. To identify deceased individuals for whom the Department paid a clawback, we reviewed the Medicaid recipient eligibility file; Medicaid fee-for-service claims and managed care encounter claims, which contain a patient status code indicating a patient's death if it occurred at a medical facility; and VERIS software, which uses the SSA's Death Master File to identify deceased individuals by Social Security number.

The Department uses information from multiple sources to identify deceased recipients and remove them from the Medicaid program: obtaining the information either through NYSOH or through notification by local social services districts or, in the case of Social Security Income recipients, the SSA. According to Department officials, they also conduct quarterly matches of Medicaid recipients and the State's Electronic Death Registration System, a web-based system used by health care facilities and professionals to electronically register deaths.

We note that, for some of the cases identified in our review, the Department was aware of recipients' deceased status because a death date was listed in eMedNY. However, the clawback was not refunded as part of the MMA file process. The Department was not previously aware of this and does not know why a refund of the clawback payments was not given. However, as a result of our audit, the Department has sought guidance from CMS about how to ensure the State gets refunds for all cases where the Department is aware of recipient deaths.

In other cases, the Department was not aware of the death because the patient status code and VERIS are not used by the Department in its clawback process. In response to our audit, Department officials indicated they are unsure of the usefulness of patient status codes; however, the Department has not reviewed all the cases we identified to determine

the usefulness of using patient status codes to identify improperly paid clawbacks. Additionally, the Department believes that VERIS data, which comes from SSA, is not always reliable.

According to the MMA file manual, when a recipient is discovered to have died, a retroactive change record should be submitted to show the recipient's ineligible status for the months after death. The Department should review all available resources to identify deceased recipients and work with CMS to determine how to handle records when a recipient is identified as deceased but the clawback payment was not refunded.

Recipients Lacking Part D Coverage

Clawback payments should only be made for Medicaid recipients who have Part D coverage. The Department obtains Part D coverage information from CMS. Over time, adjustments to this coverage may occur, such as voids of coverage periods and changes to coverage begin or end dates. From January 1, 2017 through December 1, 2018, the Department made clawback payments totaling $257,761 for 714 recipients who no longer had Part D coverage on file in eMedNY for the month of the clawback payment. During our audit period, there was no refund given to the State for these clawback payments. Recipients were initially enrolled in a Part D plan; however, this coverage was voided or changed at a later date. According to Department officials, a void of a Medicare Part D coverage period acts as a nullification of that coverage.

A recipient's Part D coverage may be voided or changed for various reasons, including if a recipient dies, moves out of a plan's coverage area, or affirmatively declines Part D coverage because they would lose their other insurance coverage if they were to enroll in a Part D plan.

The Department does not review clawback payments against recipients' Part D information in eMedNY to verify coverage and ensure that payments are appropriate. Additionally, the MMA file does not allow the Department to indicate to CMS that an incorrect clawback payment may have been made pertaining to a recipient's lack of Part D coverage. As a result of our audit, the Department has begun a review of this issue and has sought guidance from CMS to ensure appropriate refunds are given if a recipient does not have Part D coverage.

Recommendations

1. Coordinate with CMS to confirm the recipients identified by the audit should have been excluded from the State's clawback payments, including:
    - the recipients who were receiving Medicaid in another state,
    - the recipients with retroactive changes from full to partial or no Medicaid coverage,
    - the incarcerated recipients,
    - the deceased recipients, and
    - the recipients with retroactive changes to Medicare Part D coverage.
2. Review the $2.9 million in clawback payments identified by the audit, and take the necessary steps to ensure any appropriate adjustments are made before the 36-month time frame for refunds expires.
3. Coordinate with CMS to determine whether a recovery process for improper clawback payments exceeding the 36-month limitation of CMS' electronic MMA file process can be implemented.
4. Develop processes to ensure all appropriate sources of deceased recipient information and incarceration information are reviewed and the weekly MMA file is updated to reflect the information accordingly.
5. Develop a process to monitor the accuracy of monthly clawback payments, including reviewing the accuracy of payments made on behalf of the five types of recipient groups listed in Recommendation 1.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether the Department overpaid the Medicare phased-down state contributions. The audit covered the period from January 1, 2017 through December 1, 2018.

To accomplish our objective and assess related internal controls, we interviewed officials from the Department and CMS and examined the Department's relevant Medicaid policies and procedures as well as applicable federal and State laws, rules, and regulations. We reviewed CMS' MMA file report specifications and data dictionary and the MMA response files to identify individuals for whom the Department was charged a clawback payment and to identify any refunds (credits) of clawbacks received by the State. We then used the MMA response files, Medicaid Data Warehouse, eMedNY, PARIS files, and VERIS to identify individuals who did not appear to be full-benefit dual-eligibles for the month of the clawback payment. We shared our methodology with the Department and the Office of the Medicaid Inspector General during the audit for their review.

Statutory Requirements

Authority

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

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of the report. In their response, Department officials concurred with many of the audit recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinders to certain misleading Department comments are included in the report's State Comptroller's Comments, which are embedded in the Department's response.

Within 180 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

NEW YORK STATE OF OPPORTUNITY. Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

December 10, 2019

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2018-S-46 entitled, "Medicaid Program: Medicare Part D Clawback Payments."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
Diane Christensen
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Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2018-S-46 entitled "Medicaid Program: Medicare Part D Clawback Payments"

The following are the New York State Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2018-S-46 entitled, "Medicaid Program: Medicare Part D Clawback Payments."

General Comments:

The following comments address specific statements made in various sections of the audit report.

Audit Findings and Recommendations Section

- *While CMS makes the final determination on clawback payment amounts, the Department is able to contest charges it believes are incorrect.*
- The Department does not have the ability to contest charges it believes are incorrect. Instead, any changes the Department makes to Medicaid eligibility and coverage that will trigger adjustments (debits/credits) that are made by the Centers for Medicare and Medicaid Services (CMS) on the response Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) files. The adjustments by CMS would then be reflected on the monthly enrollment and disenrollment counts on a subsequent CMS State Contribution for Prescription Drug Benefit billing notice. Except in instances of death, adjustments cannot be made retroactively for recipients for whom eligibility and coverage was adjusted.

State Comptroller's Comment 1 – During the course of the audit, we met with Department officials who stated the Department is able to "contest" clawback payments if it believes the State was charged incorrectly. It is clear and logical that if clawback payments were not refunded by CMS for individuals who, for example, were known to be deceased or without Part D that a state would have justification to contact CMS to seek a resolution if it could not resolve it on its own.

State Comptroller's Comment 2 – Per the Medicare Advantage Prescription Drug State User Guide, retroactive adjustments to the MMA file are allowed for recipients: not previously reported, having a change in dual status code, deceased, or found to be ineligible for another reason.

- *As a result, for the period January 1, 2017 through December 1, 2018, we identified opportunities for cost reductions totaling $2.9 million in clawback payments made on behalf of 5,840 recipients.*

  The cost reduction opportunities identified by OSC, which equal only 0.12 percent of the total phase-down payments made during the audit period, are not valid in many instances. First, the scope of the review is insufficient. Per OSC, the audit analyzed MMA response files for a determinate period from January 21, 2017 through December 1, 2018 and OSC acknowledges the findings "…could be impacted by any corrective action taken by CMS or the Department (i.e., retroactive adjustments to the MMA files)". In many cases, the needed adjustments cited by OSC were appropriately made after December 1, 2018 according to an already established process. Second, in many cases, the retroactive adjustments cited by OSC cannot be made due to Federal Medicaid regulatory notice requirements per 42 CFR 431.211 that do not allow states to reduce or terminate Medicaid benefits retroactively except when the beneficiary's situation includes an exception to advance notice requirements such as death (42 CFR 431.213).

State Comptroller's Comment 3 – The report presents a fair representation of the situation by acknowledging that it is possible findings could be impacted by subsequent MMA file transactions (we note, the Department was only willing to give our auditors MMA response files for the period January 1, 2017 through December 1, 2018 and stated CMS approval would be required for additional time frames). The report also acknowledges when Medicaid coverage cannot be closed retroactively, while also recommending specific follow-up actions, including coordinating with CMS to confirm the appropriateness of the clawback payments identified.

Furthermore, at the closing conference, Department officials stated that due to the large size of the MMA files, they were not able to confirm that adjustments (i.e., refunds of clawback payments) were made regarding our audit findings. Therefore, the Department has no assurances that all necessary adjustments were made to the MMA files after our audit period ended. We are pleased that the Department has requested additional resources, such as appropriate hardware, to data mine the MMA file going forward (see Department Response #2 on page 23).

- *These recipients do not appear to have met the definition of full-benefit dual-eligibles, as required by the federal clawback law, as follows:*

  An individual with Medicare and Part D enrollment who is eligible with qualifying Medicaid benefits will appear on the MMA file as a full dual-eligible. Any phase-down payment made for the month is correctly paid for the full dual-eligible consumer based on the file sent to CMS. If, after the file is sent, a retroactive eligibility change is made for the client, phase-down adjustments would be made on a future MMA file. When an individual has been submitted on the MMA file as a dual-eligible, the Department has 36 months to make any necessary eligibility changes. Any retroactive eligibility changes made are sent on subsequent MMA files. Any phase-down adjustments are credited to the state on future phase-down bills.

- *When an individual has been submitted on the MMA file as a dual-eligible, the Department has 36 months to make any necessary eligibility changes to the file. As such, if clawback charges are found to be incorrect, the Department can contest them and ultimately submit adjustments in the MMA file – and receive credits from CMS on invoices – up to 36 months (three years) retroactively.*

  As previously stated, the Department does not have the ability to contest charges it believes are incorrect outside of adjusting Medicaid eligibility and coverage that triggers the adjustments (debits/credits) made by CMS on the response MMA files.

State Comptroller's Comment 4 – See State Comptroller's Comment 1.

- *For the purposes of this audit, we requested the Department provide five years of MMA response files. The Department, however, could only provide complete data for 23 months – from January 1, 2017 to December 1, 2018 – explaining it does not maintain older MMA response files.*

  As OSC was previously advised, MMA response files are stored for two years on a mainframe as standard files, but the MMA response files are also archived for seven years. Retroactive adjustments between 25 and 36 months are performed because 36 months of data is stored on the MMA Master File. The Department advised OSC it could not provide any additional Medicare data without CMS approval.

Out of State Recipients Section

- *As stated previously, CMS makes the final determination on clawback payments; however, the Department has not previously considered whether clawback payments were inappropriately made on behalf of individuals who have Medicaid in other states. Therefore, there is no process in place*

to identify and seek refunds from CMS for these payments. The Department should coordinate with CMS to determine if these clawback payments were incorrectly charged to New York State because the recipient, and the corresponding clawback payment, were the responsibility of another state's Medicaid program.

These phase-down payments were correctly charged to the Department for the months in which the consumer was eligible prior to the case closing and cannot be refunded from CMS. Once the State determines an individual has moved out of state or is receiving Medicaid in another state per Public Assistance Reporting Information System (PARIS) matching, an advance closing notice is required prior to ending their New York Medicaid coverage. The Department cannot retroactively void or cancel Medicaid coverage as changes to eligibility must be made prospectively per 42 CFR 431.211. Per CMS guidance in the State Buy-In Manual, which the Department complies with as per 42 CFR 423.910(b)(2), two states will not be charged for Part D at the same time. Once the state of origin closes its Medicaid case, phase-down payments will become the responsibility of the new state of residence.

State Comptroller's Comment 5 – Audit recommendation #1 is to "Coordinate with CMS to confirm the recipients identified by the audit should have been excluded from the State's clawback payments, including: the recipients who were receiving Medicaid in another state …" We do not consider this recommendation to be implemented based on a CMS manual stating that two states are not charged for Part D at the same time. The Department should follow up with CMS on the individual cases we identified to confirm whether New York and another state paid clawback payments concurrently on behalf of the same Medicaid recipient.

Individuals With Partial or No Medicaid Coverage Section

- *Of this amount, $403,399 was for recipients who originally had full Medicaid benefits but were retroactively switched to partial Medicaid benefits on the recipient eligibility file (e.g., coverage for Medicare coinsurance and deductible only).*

  All of the cases in this category were correctly identified on the initial request MMA file as full benefit dual-eligibles for the time period in question. Subsequent retroactive eligibility changes from full benefit to partial benefit dual-eligible does not trigger a retroactive adjustment record in the automated MMA file process. As previously stated, adjustments will be made on subsequent MMA files.

  As the Department advised OSC during the course of the audit and at the closing conference, and as confirmed by CMS in its communication with OSC, although the payment system (eMedNY) allows code changes to be entered retroactively, when changing an individual from a full to partial dual-eligible, the Department must send timely and adequate notice prior to reducing or terminating a recipient's coverage except in instances of death. The effective date of a coverage code change is prospective, as noted in the detailed correspondence provided to OSC on multiple sample cases reviewed during the audit.

State Comptroller's Comment 6 – The Department's statement is misleading. There was no such confirmation with CMS regarding the appropriate corresponding changes to the MMA file when the Department retroactively changes an individual's coverage in eMedNY from full to partial dual-eligibility. Per the Medicare Advantage Prescription Drug State User Guide, retroactive adjustments to the MMA file are allowed for recipients having a change in dual status code.

- *The remaining $47,949 (of $451,348) in payments were made on behalf of recipients who did not have any Medicaid coverage during the month of the clawback payment.*

  As stated at the closing conference, the Department verified the retroactive changes were

previously corrected on a subsequent MMA file to adjust the months in question for all affected individuals.

State Comptroller's Comment 7 – At the closing conference, Department officials stated that due to the large size of the MMA files, they weren't able to confirm that adjustments (i.e., refunds of clawback payments) were made regarding our audit findings. Therefore, it is unclear how the Department verified that the above corrections were made to the MMA files.

Incarcerated Recipients Section

- *To identify incarcerated recipients for suspension of Medicaid benefits, the Department performs a match of recipient to incarceration information from the Department of Corrections and Community Supervision, Division of Criminal Justice Services, and New York City Department of Corrections.*

  The Department also receives daily notifications of incarceration for SSI-cash recipients through the State Data Exchange (SDX) from the Social Security Administration.

- *In response to our audit, the Department stated it will obtain incarceration data from the Federal Bureau of Prisons.*

  The Department stated it will request admission and release files from the Federal Bureau of Prisons.

- *However, the Department is reluctant to use the SSA PUPS file, stating that it may return false positives, which could create barriers to coverage for individuals who are not actually incarcerated.*

  The Department is reluctant to start using the Social Security Administration (SSA) Prisoner Updating Processing System (PUPS) file because it absolutely returned false positives and untimely information when it was used in the past (e.g., identifying individuals as incarcerated who were never incarcerated, were incarcerated many months or years earlier or were no longer incarcerated and residing in the community). Such inaccuracies and untimely information certainly created barriers to coverage for individuals who are not actually incarcerated.

State Comptroller's Comment 8 – We indeed acknowledged the Department's concerns on page 10 of the report. However, we also encouraged the Department to utilize this information, followed by independent verification by contacting the corrections facility.

- *In response to our audit, the Department has also sought guidance from CMS about the appropriateness of clawback payments when the MMA file lists recipients as incarcerated and unable to auto-enroll in a Part D plan.*

  Per §50.2.1.2 and §50.2.1.3 of the Medicare Prescription Drug Benefit Manual, until the plan disenrolls an incarcerated individual, they will be identified as enrolled in a Part D plan and will be charged a phase-down payment. Plans must independently investigate the individual's incarceration status before disenrolling so, if verified, the date of disenrollment may differ from the date on the MMA file. Once a plan disenrolls the individual, the state no longer makes phase-down payments even if coverage has not changed yet in the eligibility system.

State Comptroller's Comment 9 – We note that §50.2.1.2 and §50.2.1.3 (June 2017 revision) of the Medicare Prescription Drug Benefit Manual make no mention of the phase-down payment; therefore, the Department should follow up on the appropriateness of these clawback payments.

CMS will involuntarily disenroll individuals who are incarcerated based on data CMS receives from SSA. CMS will report the disenrollments to the plan via the daily Transaction Reply Report using

a specific Transaction Reply Code. For all such disenrollments, the effective date of disenrollment will be the first of the month after the incarceration start date.

Prescription Drug Plan (PDP) sponsors may receive notification of the individual's possible incarceration status via another source. In this situation, the PDP sponsor needs to investigate and follow processes in §50.2.1.3 (Medicare Prescription Drug Benefit Manual), determine if the member resides in the plan's service area and, if appropriate, involuntarily disenroll the member. If the incarceration information is received from a public entity or other source with direct access to confirmed incarceration data, such as a penal facility, state Medicaid agency or other state or federal agency, additional investigation is not necessary. Disenrollment is effective the first of the month following the sponsor's confirmation of a current incarceration. The PDP sponsor is required to send notification of the disenrollment to the member.

- *The Department should take steps to identify all clawback payments made on behalf of Medicaid recipients who were incarcerated in New York, another state, or a federal prison. The Department should then coordinate with CMS to determine the appropriateness of the payments.*

  As previously stated, the Department cannot take back payments prior to providing a recipient with timely and adequate notice and suspending or closing the individual's Medicaid coverage.

State Comptroller's Comment 10 – The Department has not yet indicated that it has coordinated with CMS regarding this matter. It appears the Department has not obtained information from CMS regarding why clawbacks are charged at the same time as CMS is indicating a recipient cannot be auto-enrolled in a Medicare Part D plan due to incarceration, nor has the Department indicated it has coordinated with CMS to determine the appropriateness of charging states for clawback payments when individuals are clearly no longer eligible for Part D due to incarcerations. Rather, the Department continues to take a passive approach in these matters, which impacts the State. We acknowledged several times in the report that the Department must provide a recipient with timely and adequate notice prior to suspending or closing the individual's Medicaid coverage.

Deceased Recipients Section

- *Additionally, the Department believes that VERIS data, which comes from SSA, is not always reliable.*

  The Department currently receives death match data directly from the SSA. For three individuals identified in the audit, the date of death verified through obituaries determined the VERIS data had an incorrect date of death.

State Comptroller's Comment 11 – The Department appears to be referring to three individuals from a sample given to the Department for review early in the audit. The three individuals were not included in our findings. On pages 11 and 12 of the report, we stated the Department does not use VERIS and, in response to our audit, the Department stated VERIS data is not always reliable as its justification for not using it. We note, however, that the Department was also provided with instances where VERIS was accurate and if used by the Department to flag potentially deceased individuals for review, it could have resulted in cost reductions to clawback payments. We are pleased the Department is taking necessary steps to enhance death matches with SSA going forward (see Department Response #4 on page 24).

Part D Coverage Section

- *From January 1, 2017 through December 1, 2018, the Department made clawback payments totaling $257,761 for 714 recipients who no longer had Part D coverage on file in eMedNY for the month of clawback payment.*

This statement is overly broad. The consumers were eligible for Part D at the time the phase-down payment was made and as previously stated, any adjustments (debits/credits) due to changes in eligibility are made on subsequent files. The information the Department has does not support OSC's statement that there were no credits for consumers who lost their Part D coverage as the billing details do not provide enough specificity to identify the particular consumer for which the phase-down was credited.

State Comptroller's Comment 12 – The Department's statement is misleading. Although the billing details do not provide enough specificity to identify consumers, the MMA files do have this level of specificity. We reviewed the MMA files and determined a credit was not given for the consumers in our findings population. We are pleased that the Department has also requested additional resources, such as appropriate hardware, to data mine the MMA file on a regular basis (see Department Response #2 on page 23).

- *As a result of our audit the Department has begun a review of the issue and sought guidance from CMS to ensure appropriate refunds are given if a recipient does not have Part D coverage.*

  The Department has sought guidance from CMS to better understand the processing by CMS for when a consumer no longer has Part D coverage, either voided or termed retroactively. Specifically, the Department is seeking clarification on the expected timeframes for the posting of credits for these consumers.

State Comptroller's Comment 13 – We are pleased the Department is taking steps to implement our recommendations.

Recommendation #1:

Coordinate with CMS to confirm the recipients identified by the audit should have been excluded from the State's clawback payments, including:

- the recipients who were receiving Medicaid in another state,
- the recipients with retroactive changes from full to partial or no Medicaid coverage,
- the incarcerated recipients,
- the deceased recipients, and
- the recipients with retroactive changes to Medicare Part D coverage.

Response #1:

The Department does not agree with the majority of this recommendation. Recipients who move out of state are closed prospectively due to the need for timely and adequate Federal regulatory notice requirements, which was confirmed by OSC in their communication with CMS. These recipients cannot be excluded from the State's phase-down payments until Medicaid coverage is discontinued following the proper notification period. The Department did verify with CMS that Part D will not be paid by two different states simultaneously. There are no refunds that can be made by CMS for New York State Medicaid recipients who simultaneously received Medicaid in another state, prior to the New York State Medicaid case closing.

State Comptroller's Comment 14 – It does not appear that a review of individual cases has occurred; therefore, the Department has not actually confirmed with CMS that no overpayments exist.

Recipients with retroactive changes from full to partial or no Medicaid coverage would not be excluded from phase-down. As stated at the closing conference, although the system (eMedNY) allows code

changes to be entered retroactively, when changing an individual's eligibility from a full eligible to a partial dual eligible, the Department must send timely and adequate notice prior to reducing an individual's coverage. The effective date of the eligibility change is prospective, as noted in the detailed correspondence provided to OSC of the multiple sample cases reviewed.

State Comptroller's Comment 15 – The Department has not coordinated with CMS to confirm this; see State Comptroller's Comment 6.

As stated previously, phase-down payments for incarcerated individuals cannot be excluded from the Department's phase-down payment for periods prior to notifying the recipient of the suspension of Medicaid benefits.

The Department will review the list of individuals identified as deceased and take the appropriate action if the information on the consumer's status was not already known and previously acted on.

The samples OSC provided indicated the Part D coverage was retroactively terminated by CMS. When retroactive changes are made to Medicare Part D enrollment, the phase-down adjustments are automatically made on the MMA file.

State Comptroller's Comment 16 – The Department has no assurances that adjustments are always occurring automatically; see State Comptroller's Comment 3.

Recommendation #2:

Review the $2.9 million in clawback payments identified by the audit, and take the necessary steps to ensure any appropriate adjustments are made before the 36-month timeframe for refunds expires.

Response #2:

Although the Department does not agree with OSC's methodology and disputes the accuracy of potential cost reductions identified by OSC, the Department will continue to ensure that adjustments to MMA files are made timely and accurately.

In addition, the Department requested additional resources, such as appropriate hardware, to data mine the MMA file on a regular basis.

State Comptroller's Comment 17 – We are pleased the Department is taking steps to implement our recommendation.

Recommendation #3:

Coordinate with CMS to determine whether a recovery process for improper clawback payments exceeding the 36-month limitation of CMS' electronic MMA file process can be implemented.

Response #3:

CMS will not accept changes greater than 36 months after an eligibility change that results in a dual eligible status change. Although it likely does not exist, the Department will request clarification from CMS as to whether a recovery process exists for improper phase-down payments that exceed the 36-month limit.

State Comptroller's Comment 18 – We note that CMS officials said there was not currently a process for recoveries beyond 36 months, but also said they were not aware of anything that would

prevent setting up a process beyond the 36-month time frame of the automated system. We also note that CMS did not agree to do this, rather the comments represent the opinions of those CMS officials at that time.

Recommendation #4:

Develop processes to ensure all appropriate sources of deceased recipient information and incarceration information are reviewed and the weekly MMA file is updated to reflect the information accordingly.

Response #4:

A sample of audit claims reviewed by the Department showed only 13 percent of the claims had a status code identifying the consumer as deceased. Additionally, all of the consumers were already identified as deceased through other data sources utilized by the Department. However, the Department will continue analyzing patient status codes for deceased status on additional samples to determine if the information is reliable and otherwise unknown through other data sources currently utilized by the Department.

State Comptroller's Comment 19 – We are pleased the Department indicates it will take steps to implement our recommendation. However, we note the Department is referring to a review that included four recipients who had a claim with a patient status code of deceased. We have not verified the accuracy of the Department's statement, as the sample was reviewed by the Department after the audit ended.

The Department is working on a project with the Office of Temporary and Disability Assistance to enhance the current Death Match with SSA. The change will include a match with Vital Statistics for Upstate counties that will systemically end coverage for deceased individuals who are the only individuals on the case. Individuals identified as deceased by Vital Statistics who are on a case with other individuals will be identified on a report and will be closed by Department staff.

As previously stated, the Department will request electronic admission and release information from the Federal Bureau of Prisons.

State Comptroller's Comment 20 – We are pleased the Department is taking steps to implement our recommendation.

Recommendation #5:

Develop a process to monitor the accuracy of monthly clawback payments, including reviewing the accuracy of payments made on behalf of the five types of recipient groups listed in Recommendation 1.

Response #5:

The audit found a 99.88 percent accuracy rate of the $2.4 billion in phase-down payments reviewed. Even though the Department does not entirely agree with the audit methodology, scope and cost reduction findings, the Department will:

1. Continue to review sample cases on MMA files to ensure phase-down payments maintain a high-level of accuracy and that adjustments occur appropriately. As previously stated, the Department has also requested additional resources, such as appropriate hardware, to data mine the MMA file on a regular basis; and
2. Review reports from eMedNY that indicate a consumer has no Part D coverage to verify if the absence of Part D is appropriate. However, the phase-down adjustments made if a plan disenrolls or CMS retroactively disenrolls or voids coverage of Part D, would be automatic

based on the ongoing process.

State Comptroller's Comment 21 – The audit identified instances where clawback payments were not refunded automatically despite the retroactive disenrollment or void of Part D coverage. At the closing conference, Department officials stated that due to the large size of the MMA files, they weren't able to confirm that adjustments (i.e., refunds of clawback payments) were made regarding our audit findings. Therefore, the Department has no assurances that adjustments are always occurring automatically. We are pleased the Department is taking steps to implement our recommendation.

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