Department of Health

Medicaid Program: Reducing Medicaid Costs for Recipients Who Are Eligible for Medicare

Report 2021-S-16 | September 2023

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) took sufficient steps to control the Medicaid costs of recipients who were eligible for Medicare based on age but were not enrolled in Medicare. The audit covered the period from July 2016 through June 2021.

About the Program

The Department administers the State's Medicaid program. Individuals who are eligible or appear eligible for Medicare are required to apply for Medicare as a condition of receiving Medicaid. When Medicaid recipients are also enrolled in Medicare, Medicare becomes the primary payer and Medicaid the secondary. As a secondary payer, rather than pay for the medical service itself, Medicaid can pay a recipient's Medicare premiums, deductibles, and coinsurance amounts, which allows for a significant cost avoidance for the Medicaid program. Local Departments of Social Services (Local Districts) are required to identify Medicaid recipients who are at least 65 years of age, or will be turning age 65 within a 3-month time frame, and have them apply for Medicare. The Social Security Administration (SSA) determines Medicare eligibility and enrolls individuals. SSA also administers the Supplemental Security Income (SSI) program, a federal cash benefit to assist low-income individuals. In New York, all SSI recipients are eligible to receive Medicaid. When SSA receives an SSI application for someone who is 65 years of age, it also checks the individual's Medicare eligibility and enrolls eligible individuals.

Key Findings

We determined the Department had not taken sufficient steps to effectively control the Medicaid costs of recipients who appear eligible for Medicare based on their age. Although the Department issued guidance to Local Districts regarding the requirement for Medicaid recipients reaching age 65 to apply for Medicare, we found the Department did not ensure Local Districts complied. Also, the Department does not require Local Districts to have Medicaid recipients with SSI apply for Medicare because, according to Department officials, SSA already performs Medicare eligibility checks. However, according to SSA officials, a recipient may not receive Medicare if, for example, the individual provides SSA insufficient information.

For the audit period, we identified 13,318 Medicaid recipients who appeared eligible for Medicare based on age but were not enrolled in Medicare. Medicaid could have potentially saved $294.4 million on behalf of these recipients for clinic, inpatient, and practitioner claims that could have been covered by Medicare as the primary payer had the recipients been enrolled in Medicare at the time they turned 65. Of the 13,318 recipients, 10,566 were not in receipt of SSI (representing $191.7 million of the potential savings). We sampled 181 of these recipients and determined that, for 145 recipients (80%), Local Districts lacked evidence that these recipients applied for Medicare. Of the 13,318 recipients, the remaining 2,752 received SSI (representing $102.7 million of the potential savings), which the Department does not require Local Districts to take action on.

Key Recommendations

- Follow up with recipients who appeared eligible for Medicare and ensure they apply for Medicare, as appropriate.
- Work with Local Districts to develop and implement procedures to ensure all recipients are asked to apply for Medicare when they appear eligible.
- Evaluate the cost–benefit of developing and implementing processes to periodically identify recipients with SSI who appear eligible for Medicare and refer them to SSA for Medicare eligibility determinations.

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

September 14, 2023

James V. McDonald, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. McDonald:

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 *Reducing Medicaid Costs for Recipients Who Are Eligible for Medicare*. 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

Contents

Glossary of Terms

Term	Description	Identifier
Department	Department of Health	*Auditee*
COVID-19	Coronavirus disease 2019	*Key Term*
COVID-19 period	The period during the public health emergency, covering January 2020 through June 2021	*Key Term*
CMS	Centers for Medicare & Medicaid Services	*Agency*
Dual-eligibles	Individuals enrolled in both Medicare and Medicaid	*Key Term*
eMedNY	The Department's Medicaid claims processing and payment system	*System*
Encounter	Record of a health care service provided to a recipient	*Key Term*
FFS	Fee-for-service	*Key Term*
HRA	Human Resources Administration	*Agency*
Local District	Local Department of Social Services	*Agency*
MSP	Medicare Savings Program	*Key Term*
PHE	COVID-19 public health emergency declared in March 2020	*Key Term*
Pre-COVID-19 period	The period when Medicaid recipients would have had time to reasonably complete the Medicare application process prior to the PHE, covering July 2016 through December 2019	*Key Term*
SSA	Social Security Administration	*Agency*
SSI	Supplemental Security Income	*Key Term*

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. The Department of Health (Department) administers the Medicaid program in New York. For the State fiscal year ended March 31, 2022, New York's Medicaid program had approximately 7.8 million recipients and Medicaid claim costs totaled about $74.6 billion (comprising $27.5 billion in fee-for-service health care payments and $47.1 billion in managed care premium payments). The federal government funded about 57.1% of New York's Medicaid claim costs, and the State and the localities (the City of New York and counties) funded the remaining 42.9%.

The Department uses two methods to pay health care providers for Medicaid services: fee-for-service (FFS) and managed care. Under the FFS method, the Department pays health care providers directly for services rendered to Medicaid recipients. Under the managed care method, the Department makes monthly premium payments to managed care plans for Medicaid recipients enrolled in the plans. In return, managed care plans arrange for the provision of health care services and reimburse providers for services provided to their enrollees. Managed care plans submit claims, known as encounters, to the Department's Encounter Intake System to inform the Department of each service provided to their enrollees.

Many of the State's Medicaid recipients are also eligible for Medicare. Medicare is the federal health insurance program administered by the Centers for Medicare & Medicaid Services (CMS) for people who are age 65 or older and people under 65 who have certain disabilities or medical conditions. Different parts of Medicare cover different services. For instance, Medicare Part A covers inpatient hospital stays, care in skilled nursing facilities, hospice care, and some home care services; and Medicare Part B covers outpatient care, certain doctor's services, medical supplies, and preventive care.

Most people age 65 or older who are citizens or permanent residents of the United States are eligible for Medicare. They are eligible for Medicare Part A at no cost if they or their spouse has paid Medicare taxes long enough while working. Individuals who are deemed ineligible for Medicare Part A at no cost may opt to purchase Medicare Part A coverage during a designated enrollment period. Individuals who are eligible for Medicare Part A at no cost can enroll in Medicare Part B by paying a monthly premium.

Social Services Law stipulates that individuals who are eligible, or reasonably appear to meet the criteria of eligibility, for Medicare must apply for Medicare as a condition for receiving assistance under the Medicaid program. This helps control costs to the Medicaid program by shifting some of the cost burden from the Medicaid program to Medicare. Recipients who fail to comply with the requirement will have their Medicaid eligibility denied or discontinued following timely notice.

Local Departments of Social Services (Local Districts) have primary responsibility for enforcing the Medicare application requirement at the community level. Toward this end, the Department issued guidance to the Local Districts in 2017, which established procedures for them to routinely identify individuals who are fully eligible for Medicaid and who are at least 65 years of age or will be turning age 65 within a 3-month time frame and to have them apply for Medicare. Outside of New York City, the Local Districts include the county offices of social services. Within New York City, the five boroughs comprise one Local District administered by the Human Resources Administration (HRA).

Note: The federal Families First Coronavirus Response Act adopted continuous coverage requirements in March 2020 in response to the coronavirus disease 2019 (COVID-19) public health emergency (PHE). This means recipients who were enrolled in Medicaid in March 2020 or later generally did not have their coverage terminated and were not required to apply for Medicare as a condition of their Medicaid eligibility. For purposes of this audit, we designated the July 2016–December 2019 time frame as the period when recipients would have had time to reasonably complete the Medicare application process before the PHE (pre-COVID-19 period) and January 2020–June 2021 as the period during the PHE (COVID-19 period).

The Department also has its own procedures in place and engages with other stakeholders to exchange data to identify Medicaid recipients who should apply for Medicare. The Department sends monthly reports to CMS of recipients who do not appear to have Medicare who are over age 65 and those who will turn 64 years 7 months of age by the last day of the month being reported. In addition, lists of individuals not receiving Medicare are sent through a data exchange between CMS and the Department. The Department also queries CMS for detailed Medicare beneficiary information on Medicare Parts A and B eligibility and enrollment. Further, the Department submits a monthly file to the Social Security Administration (SSA) of individuals who are turning age 65, so SSA can reach out to these individuals explaining the process of applying for Medicare. Furthermore, the Department identifies and sends letters to recipients turning age 65 requiring them to apply for Medicare. Additionally, the Department works with agencies that contract with facilitated enrollers, who work with Medicaid recipients directly to help them apply and enroll in Medicare. The facilitated enrollers submit monthly reports to the Department documenting their outreach efforts to recipients who were required to apply for Medicare based on age. The reports contain case information for each recipient, such as descriptions of attempts made to reach the recipient, Medicare application status of the recipient, and case status (open or closed).

SSA is responsible for determining the eligibility of individuals who apply for certain federal benefits, such as Medicare, and enrolling those who are eligible. Many Medicaid recipients are also in receipt of Supplemental Security Income (SSI), a federal cash benefit administered by SSA to assist low-income individuals. In New York State, all SSI recipients are eligible to receive Medicaid.

Medicare requires enrollees to pay certain out-of-pocket costs, such as monthly premiums, annual deductibles, and coinsurance for covered services. Generally, people enrolled in Medicare Part A do not have to pay a monthly premium for Medicare Part A if they, or a spouse, paid the required payroll (Medicare) taxes

while they were working. People enrolled in Medicare Part B, however, typically pay monthly premiums (in 2021, the Part B premium was $148.50 per month). In addition to Medicare's monthly premiums, there is an annual deductible and coinsurance for most services.

In general, for individuals enrolled in both Medicare and Medicaid (referred to as dual-eligibles), Medicare is the primary payer and Medicaid is the secondary payer. This cost-sharing arrangement transfers significant medical costs from the Medicaid program to the Medicare program. It also helps certain Medicaid enrollees obtain Medicare benefits without the burden of having to pay out-of-pocket Medicare costs. As a secondary payer, Medicaid pays dual-eligible recipients' cost-sharing obligations of deductibles and coinsurance. Additionally, Medicaid can pay certain recipients' Medicare premiums through the Medicare Buy-In program.

Audit Findings and Recommendations

We determined the Department had not taken sufficient steps to effectively control the Medicaid costs of recipients who appear eligible for Medicare based on their age. Although the Department has issued guidance to Local Districts regarding the requirement for Medicaid recipients reaching age 65 to apply for Medicare, we found that the Department did not ensure Local Districts complied. We identified 13,318 Medicaid recipients who appeared to be eligible for Medicare based on age and citizenship status but were not enrolled in Medicare. For the period July 2016 through June 2021, Medicaid could have potentially saved $294.4 million on behalf of these recipients for clinic, inpatient, and practitioner claims that could have been covered by Medicare as the primary payer if they were enrolled in Medicare when they first became eligible at age 65. Of the 13,318 recipients:

- 10,566 recipients appeared eligible for Medicare and were not in receipt of SSI. We calculated a total potential cost savings to the Medicaid program of about $191.7 million had the recipients been enrolled in Medicare at the time they turned 65. We sampled 181 recipients with claim payments during the pre-COVID-19 and COVID-19 periods totaling about $31.2 million and determined that, for 145 recipients, Local Districts did not have supporting documentation that these recipients applied for Medicare. Medicaid could have potentially saved nearly $21 million (after deducting Medicare out-of-pocket costs and Medicare premiums paid through the Medicare Buy-In program) had the sampled recipients been enrolled in Medicare when they first appeared eligible at the age of 65. For the remaining 10,385 recipients outside of the sample, we calculated a potential cost savings of about $170.7 million if these recipients were determined to be eligible for Medicare.
- 2,752 recipients appeared eligible for Medicare and received SSI. Our review disclosed weaknesses in the Department's and Local Districts' oversight of SSI recipients. Specifically, the Department does not require Local Districts to have these individuals apply for Medicare. As a result, the Department potentially missed savings of about $102.7 million had these recipients applied for Medicare and were determined to be eligible.

If the Department takes the necessary steps to encourage these recipients to apply for Medicare, there could be material savings to the Medicaid program (not only on the claim types included in the audit scope [clinic, inpatient, and practitioner claims], but on other claims as well), even if a small percentage of these recipients enrolled in Medicare.

Medicare Eligibility of Medicaid Recipients Without SSI

We identified 10,566 recipients who were not in receipt of SSI and appeared to be eligible for Medicare based on age and citizenship status during either the pre-COVID-19 or COVID-19 period but were not enrolled in Medicare.

Pre-COVID-19 Medicare Eligibility

For 6,786 recipients who appeared to be eligible for, but were not enrolled in, Medicare during the pre-COVID-19 period, Medicaid made payments totaling over $225 million from July 2016 through June 2021. We calculated a total potential cost savings to the Medicaid program of about $154.4 million had the recipients been enrolled in Medicare at the time they turned 65.

For a judgmental sample of 111 recipients, we reached out to the respective four Local Districts to determine if there was proof of Medicare applications on file. While the Local District officials generally agreed that the sampled recipients appeared eligible for Medicare and should have been asked to apply, for 84 recipients (76%), there was no proof of a Medicare application on file. Had the 84 recipients been enrolled in Medicare at the time they turned 65, the Department could have potentially saved about $13.5 million. We found these Medicare non-enrollments were largely due to Local Districts' lack of administrative oversight or error, such as incorrect or missing documentation (e.g., missing citizenship/immigration documentation), leading the Local Districts to not ask the recipients to apply for Medicare or submit proof of a Medicare application.

For example, one recipient who was not asked to apply for Medicare turned 65 in August 2018 and had claim payments totaling over $1.3 million from August 2018 through April 2021. The Local District stated the recipient should not be excluded from the requirement to apply for Medicare, but because the Local District failed to ask the recipient to apply, and there was no proof of a Medicare application on file, the recipient did not enroll in Medicare, causing Medicaid to potentially pay $704,269 more than it should have. Department procedures require Local Districts to end Medicaid eligibility of recipients who do not apply for Medicare as required; therefore, it is important for Local Districts to act promptly.

For the remaining 6,675 outside of the sample, we calculated additional potential cost savings of about $140.9 million had the recipients applied and enrolled in Medicare. In response to our preliminary findings, Department officials stated they plan to send written guidance reminders to all Local Districts and are considering follow-up discussions with certain Local Districts to ensure they fully understand the guidance.

COVID-19 Period Medicare Eligibility

From January 2020 through June 2021, Medicaid made payments totaling almost $57 million on behalf of 3,780 recipients who appeared to be eligible for Medicare during the COVID-19 period. We calculated a total potential cost savings to the Medicaid program of about $37.3 million had the recipients been enrolled in Medicare at the time they turned 65.

For a judgmental sample of 70 recipients from six Local Districts, we found 61 (87%) did not have proof of a Medicare application on file – coverage that otherwise would have potentially saved Medicaid about $7.5 million had these recipients applied for

and enrolled in Medicare. Local District officials generally agreed that the recipients appeared eligible for Medicare. Although the recipients were not required to apply for Medicare during the PHE, the Department could have potentially saved an additional $29.8 million for the remaining 3,710 recipients had the recipients applied for and enrolled in Medicare when they first appeared eligible. (Note: while application for Medicare was not a condition of Medicaid enrollment during the PHE, one Local District we spoke to still offered recipients the opportunity to apply for Medicare.)

Furthermore, the federal government adopted legislation that separated the continuous Medicaid coverage requirement from the PHE effective April 2023, at which time, the State was required to begin issuing Medicaid eligibility redetermination notices for Medicaid renewals effective July 2023 (known as "unwinding" of the continuous coverage provisions). According to the Department, renewals for more than 7.7 million Medicaid recipients must be completed by May 2024 to comply with the unwinding process timeline. This means that the 3,780 Medicaid recipients we identified will need to go through the renewal process to retain their Medicaid coverage, which includes applying for Medicare if they appear eligible. The Department issued guidance regarding the unwinding process to the Local Districts in February 2023.

The Department should take steps to improve its support of Local Districts and ensure that the recipients we identified apply for Medicare, especially since there will be more recipients than usual going through the application process, including recipients who newly meet the requirement to apply and those who became eligible during the COVID-19 period.

Medicare Eligibility of Medicaid Recipients With SSI

Generally, recipients who are approaching 65 years of age must apply for Medicare to keep their Medicaid eligibility. According to SSA officials, when they receive an SSI application from an individual who is 65 years of age, as part of their process, they also conduct a check to confirm the recipient's Medicare eligibility. According to Department officials, because SSA has already performed the check, this essentially meets the requirement to ask recipients to apply for Medicare, and recipients will not lose Medicaid coverage for this reason. A Local District official substantiated this and stated they do not follow up with SSI recipients to apply for Medicare because the Department does not require them to. However, according to SSA officials, a recipient may not receive Medicare if they provide SSA insufficient information.

We, therefore, question the effectiveness of the Department's protocol for Medicare enrollment of Medicaid recipients with SSI. Furthermore, if SSA deems SSI recipients ineligible for Medicare prior to age 65, the Department typically does not follow up with these individuals except once they turn 65 (e.g., by sending letters outlining the requirements).

We found Medicaid recipients with SSI are not always promptly enrolled in Medicare once they become eligible. We identified 2,752 SSI recipients with clinic, inpatient, and practitioner claims totaling $137.3 million who did not have Medicare but appeared eligible for Medicare based on age and citizenship status during the period July 2016 through June 2021. We determined the Department could have potentially saved about $102.7 million on claim payments had the Department proactively taken appropriate steps to follow up on SSI recipients.

We reviewed monthly facilitated enroller reports, covering August 2018 through December 2022, to examine their Medicare enrollment outreach to recipients. Of the 2,752 Medicaid recipients with SSI who appeared eligible for Medicare based on age, 2,169 (79%) did not appear on the facilitated enroller reports and, therefore, the facilitated enrollers did not perform outreach to these recipients. The Department could have potentially saved over $91.6 million for the 2,169 recipients had the facilitated enrollers reached out and helped them apply for Medicare. Of the remaining 583 SSI recipients who were listed on the reports, facilitated enrollers failed to establish contact with 461 (79%) and the cases were closed. Further, Department officials stated that facilitated enrollers will stop reaching out to recipients unless the recipients are placed on the report for a reason other than age. We determined 406 (88%) of the 461 recipients still had not obtained Medicare as of April 2023, accounting for almost $7.4 million in potential cost savings for our audit period. While the facilitated enroller process helps some Medicaid recipients apply for – and ultimately receive – Medicare, there are still many Medicaid recipients who either are not included in the facilitated enroller reports or are not successfully contacted by the facilitated enrollers. Assistance from facilitated enrollers is also important because it can help ensure that Medicare applications submitted to SSA are complete, reducing the risk of recipients not receiving Medicare due to incomplete applications or insufficient information. The Department needs to take additional steps to ensure Medicaid recipients with SSI are identified and assisted with the Medicare application process.

We also selected a sample of 47 of the 2,752 recipients with SSI who appeared eligible for Medicare at some point during the pre-COVID-19 period. The sample was chosen based on higher potential cost savings, totaling approximately $11.2 million. We requested that the Department send the sample to SSA for a Medicare eligibility review in August 2022. According to the Department, SSA officials responded that they would not review the sample because the Privacy Act of 1974 prohibits the disclosure of records without the recipients' consent, and appropriate forms would need to be completed before any information could be released. In addition to recipient consent, Department officials responded that the Medicaid program would be required to pay associated fees for copies of recipients' records based on SSA's policy. The Department accepted SSA's response even though the reasoning does not address why SSA could not review the sample and take appropriate action without disclosing information to third parties (i.e., the Department). Specifically, we question why SSA would have to provide the Department recipient information when SSA could review the list of recipients from the Department and make the necessary Medicare eligibility determinations. If this approach was taken, obtaining recipients'

consent and paying associated record fees could be avoided. Nevertheless, if obtaining consent and paying fees was unavoidable, we encourage the Department to weigh the costs incurred by obtaining the necessary information from SSA with the potential for greater savings to the Medicaid program. We also note that the Department took 4 months to solicit a response from SSA and, furthermore, did not share the sample with SSA. Department officials indicated they were unsure of who to contact at SSA and attributed the delay to trying to find the appropriate contact person.

The Department lacks effective processes to ensure that recipients with SSI are given necessary assistance to allow them to obtain the Medicare coverage they may be entitled to. The Department has also failed to take sufficient steps to control the Medicaid costs for SSI recipients who appear to be eligible for, but were not enrolled in, Medicare.

Recommendations

1. Follow up with the identified recipients who appeared eligible for Medicare, including those with SSI, and ensure they apply for Medicare, as appropriate.
2. Work with Local Districts to develop and implement procedures to ensure that information on file is correct and all recipients, including those with SSI, are asked to apply for Medicare when they appear eligible.
3. Evaluate the cost–benefit of developing and implementing processes to periodically identify recipients with SSI who appear eligible for Medicare and refer them to SSA for Medicare eligibility determinations.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether the Department took sufficient steps to control the Medicaid costs of recipients who were eligible for Medicare based on age but were not enrolled in Medicare. The audit covered the period from July 2016 through June 2021.

To accomplish our objective and assess relevant internal controls, we interviewed officials from the Department, Local Districts, and SSA. We examined the Department's relevant Medicaid policies and procedures. We also reviewed applicable federal laws and State rules and regulations. To identify the population, we used the Medicaid Data Warehouse and eMedNY, the Department's Medicaid claims processing and payment system, to identify and analyze Medicaid recipients who were at least age 65 at some point during the audit scope, were citizens or permanent residents with sufficient work history, and were never enrolled in Medicare as of July 2022 (some recipients may have received Medicare after July 2022). We also analyzed facilitated enroller reports for August 2018 through December 2022. We extracted FFS and encounter clinic, inpatient, and practitioner claims paid on behalf of the Medicaid recipients and removed any claims that would not be sufficiently covered by Medicare. To calculate Medicaid cost savings, we reduced the potential savings by removing costs that Medicaid could be responsible for, including coinsurance, deductibles, and Medicare premiums that could be paid through the Medicare Buy-In program. We reviewed Medicare application information on file at six Local Districts (Erie, HRA, Monroe, Nassau, Suffolk, and Westchester) for 181 Medicaid recipients without SSI. We judgmentally selected the six Local Districts and 181 Medicaid recipients from these Local Districts based on high total claim paid amounts to determine if the recipients applied for Medicare. Additionally, we selected a judgmental sample of 47[1] recipients with SSI based on high potential cost savings and requested that the Department send the sample to SSA for a Medicare eligibility review. Because the samples were judgmentally selected, the results cannot be projected to the population as a whole.

Based on our audit work, we believe the data used was sufficiently reliable for the purpose of this audit. We shared our methodology and findings with Department officials during the audit for their review.

1 The original sample contained 50 recipients but, upon further discussion with Department officials, only 47 had Medicaid case types consistent with receiving SSI payments.

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. These duties could be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our professional judgment, these duties do not affect our ability to conduct this independent performance audit of the Department's oversight and administration of Medicaid payments for recipients who are eligible for, but not enrolled in, Medicare.

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 it. In their response, Department officials agreed with the audit recommendations and indicated that certain actions have been and will be taken to address them. We address certain Department remarks in our State Comptroller's Comments, which are embedded within 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

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

MEGAN E. BALDWIN
Acting Executive Deputy Commissioner

August 9, 2023

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 Andrea Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2021-S-16 entitled, "Medicaid Program: Reducing Medicaid Costs for Recipients Who are Eligible for Medicare."

Thank you for the opportunity to comment.

Sincerely,

Megan E. Baldwin
Acting Executive Deputy Commissioner

Enclosure

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Department of Health Comments to Draft Audit Report 2021-S-16 entitled, "Medicaid Program: Reducing Medicaid Costs for Recipients Who are Eligible for Medicare" by the Office of the State Comptroller

The following are the responses from the New York State Department of Health (the Department) to Draft Audit Report 2021-S-16 entitled, "Medicaid Program: Reducing Medicaid Costs for Recipients Who are Eligible for Medicare" by the Office of the State Comptroller (OSC).

General Comments:

As stated in the report, the $294.4 million identified by the OSC is potential cost savings. It must be characterized as potential because not all people aged 65 or older are eligible for Medicare and OSC used this age threshold as a principal premise of its cost savings analysis.

State Comptroller's Comment – The Department's comment is misleading. Most Medicaid recipients age 65 and older are eligible for Medicare.

The potential cost savings amount also includes an amount for recipients who were not required to apply for Medicare as a condition of their Medicaid eligibility, as a result of the public health emergency (PHE).

Furthermore, the total potential cost savings amount identified by OSC (including the federal share) for the five-year audit period amounts to less than a tenth of one percent (< .1%) of total Medicaid claim costs for the same period.

The Department does not agree with OSC's assessment that the Department failed to take sufficient steps to control Medicaid costs for Supplemental Security Income (SSI) recipients because they were not enrolled in Medicare. All Medicaid recipients, including SSI recipients, receive a letter from the state three months prior to their 65th birthday telling them to apply for Medicare. The agreement between Social Security Administration (SSA) and New York State pursuant to section 1634 of the Social Security Act controls the treatment of SSI individuals. It requires SSA to determine eligibility for Medicare and auto-accrete all eligible individuals into the State Buy-In program. Since the Department does not have authority over Medicare determinations, its leveraging power to compel Medicaid recipients to complete the Medicare application process is limited.

State Comptroller's Comment – We commend Department officials for indicating they will take steps to implement the audit's Recommendation 3, which addresses improvement steps for the SSI population. In our report, we identified areas where the Department could make improvements. For instance, as discussed on pages 11–13 of the report, facilitated enrollers work with, but failed to establish contact with a high percentage of, these Medicaid recipients. Medicaid recipients may not provide sufficient information to SSA in order to receive Medicare. Consequently, assistance from facilitated enrollers is important to ensure that submitted Medicare applications are complete, thereby reducing the risk of recipients not receiving Medicare due to incomplete applications or insufficient information. In addition, as stated in the report, the Department could also refer recipients with SSI who appear eligible for Medicare to SSA for Medicare eligibility determinations.

Background (page 8, last paragraph):

Additionally, Medicaid can pay certain recipients' Medicare premiums through the Medicare Savings Program (MSP).

Response:

The last sentence of the last paragraph on page 8 is incorrect. Rather than "Medicare Savings Program", it should state the following:

> "Additionally, Medicaid can pay certain recipients' Medicare premiums through the federal Medicare Buy-In program."

State Comptroller's Comment – Our report used the term "Medicare Savings Program" as a broader reference that included the Medicare Buy-In program, as "Medicare Savings Program" is the term generally used by CMS in its publications. Regardless, we changed the term in the report to reference the Medicare Buy-In program.

Audit Recommendation Responses:

Recommendation #1:

Follow up with the identified recipients who appeared eligible for Medicare, including those with SSI, and ensure they apply for Medicare, as appropriate.

Response #1:

With the end of the PHE and the beginning of the unwinding process, the Department issued GIS 23 MA-03 to the Local Departments of Social Services (LDSS) providing guidance to resume the requirement that individuals over 65 years old need to apply for Medicare.

Recommendation #2:

Work with Local Districts to develop and implement procedures to ensure that information on file is correct and all recipients, including those with SSI, are asked to apply for Medicare when they appear eligible.

Response #2:

The Department issued 17 ADM-01 instructing LDSS offices that individuals over 65 years old must apply for Medicare. The Department also issued GIS 23 MA-03 notifying LDSS offices that the requirement was reinstated due to the end of the PHE.

Recommendation #3:

Evaluate the cost–benefit of developing and implementing processes to periodically identify recipients with SSI who appear eligible for Medicare and refer them to SSA for Medicare eligibility determinations.

Response #3:

The Department will evaluate if existing processes can be leveraged to accomplish the goals of getting additional SSI beneficiaries to apply for Medicare.

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