



New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Improper Payments Related to the Medicare Buy-In Program

Medicaid Program Department of Health



Report 2010-S-76

October 2012

Executive Summary

Purpose

To determine if Medicaid properly paid Medicare premiums and medical claims for people in the Medicare buy-in program. The audit covered the period March 1, 2006 through February 28, 2011.

Background

The federal government established the Medicare buy-in program to assist certain low-income people pay out-of-pocket Medicare expenses. Under the buy-in program, Medicaid pays the Medicare premiums and sometimes the deductibles and coinsurance of people who meet various eligibility requirements. Determinations of Medicare buy-in program eligibility are made by the New York City Human Resources Administration and the 57 other county departments of social services outside of New York City (local districts). Medicaid payments for the Medicare buy-in program total about \$1 billion annually.

Key Findings

- From March 2006 through February 2011, Medicaid made nearly 260,000 improper payments (totaling about \$26.8 million) for people enrolled in the Medicare buy-in program.
- The improper payments included 187,050 Medicare premiums (totaling about \$21.1 million) for 16,219 people who were ineligible for the buy-in program. This included improper payments (totaling \$1.9 million) for 532 people who were deceased. In one instance, Medicaid made payments totaling \$10,700 for a person who had not lived in the United States for nearly two years.
- The improper payments also included 71,355 medical claim reimbursements (totaling about \$5.5 million) for people who were eligible for the buy-in program. In one instance, Medicaid overpaid a claim by \$34,000 because the Medicaid claims processing system did not properly reflect buy-in program rules.
- The improper payments resulted from insufficient Department of Health oversight, poor local district practices, and weaknesses in certain Medicaid claims processing controls. In recent years, Department actions have reduced the amount of improper buy-in program payments. However, weaknesses still exist in local district practices and in certain Medicaid claims processing controls, and improper payments likely continue to occur.

Key Recommendations

- Increase oversight of local districts to help ensure they assess persons' buy-in program eligibility and end premium payments for ineligible people timely.
- Recover inappropriate Medicare buy-in payments.
- Develop and implement changes in the Medicaid claims processing system to ensure accurate payment of medical claims for individuals eligible for the buy-in program.

Other Related Audits/Reports of Interest

Department of Health: [Medicaid Payments for Medicare Part A Beneficiaries \(2009-S-36\)](#)

**State of New York
Office of the State Comptroller**

Division of State Government Accountability

October 26, 2012

Nirav R. Shah, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Dear Dr. Shah:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for 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 New York State Medicaid Program entitled *Improper Payments Related to the Medicare Buy-In Program*. 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,

*Office of the State Comptroller
Division of State Government Accountability*

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This report is also available on our website at: www.osc.state.ny.us

Background

The New York State Department of Health (Department) is responsible for administering the State's Medicaid program. Medicaid is a federal, state and locally 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 fiscal year ended March 31, 2011, New York's Medicaid program had more than five million enrollees and costs totaled about \$53 billion. The federal government funds about 49 percent of Medicaid costs; the State funds about 34.4 percent; and the localities (the City of New York and counties) fund the remaining 16.6 percent.

The Department's Office of Health Insurance Programs (OHIP) administers Medicaid and various other medical assistance programs offered to New Yorkers. To receive benefits, residents apply for programs through their local Department of Social Services district office (local district). Outside of New York City, the local districts include the county offices of social services. Within New York City, the five counties (boroughs) comprise one local district administered by the New York City Human Resources Administration (HRA). The OHIP establishes eligibility and other program guidance for the 57 local districts and HRA to follow to administer Medicaid programs. Local districts and HRA are responsible for enrolling people in Medicaid (including the Medicare buy-in program) and for ensuring that recipients meet all program eligibility requirements.

Many of the State's Medicaid beneficiaries are also enrolled in Medicare, the federal healthcare program for people 65 years of age and older and people under 65 years old with certain disabilities. These recipients are known as "dual eligible." Medicare has several "parts" for different medical services. For instance, Medicare Part A (hospital insurance) covers inpatient care, and Medicare Part B (medical insurance) covers doctors' services and outpatient care. Medicare often requires recipients to pay certain out-of-pocket costs, such as monthly premiums, annual deductibles and coinsurance on claims. For dual eligible people, Medicaid typically pays out-of-pocket Medicare costs, such as deductibles and coinsurance.

The federal government established the Medicare buy-in program to assist certain low-income people pay their out-of-pocket Medicare expenses. Under the buy-in program, Medicaid pays the Medicare premiums of most dual eligibles. Further, for certain non-dual eligibles who only have Medicare coverage, Medicaid is required to pay their out-of-pocket Medicare expenses, including premiums, deductibles and coinsurance if they meet various buy-in program eligibility requirements.

Between March 1, 2007 and February 28, 2011, New York's Medicaid program paid about \$4.5 billion in Medicare premiums for individuals enrolled in the buy-in program. Additionally, during the period from March 1, 2006 through February 28, 2011, Medicaid paid approximately \$26.5 million in medical claims payments, including deductibles and coinsurance for individuals who were eligible only for the buy-in program.

Audit Findings and Recommendations

During our audit period, Medicaid made nearly 260,000 improper payments (totaling about \$26.8 million) for people enrolled in the Medicare buy-in program. Most of the improper payments were for Medicare premiums for people who were ineligible for the buy-in program. The improper payments occurred because OHIP did not take sufficient steps to ensure local districts performed the required eligibility determinations for many recipients. In addition, weaknesses in the Department's Medicaid claims processing system (eMedNY) led to significant overpayments of certain medical claims for persons who were program eligible.

Premium Payments for Recipients Without Eligibility Determinations

From March 1, 2007 through February 28, 2011, HRA and the local districts did not perform eligibility determinations for 85,760 people in the Medicare buy-in program. Medicaid made about 837,000 Medicare premium payments (totaling \$85.9 million) for these recipients. Moreover, based on our review, we determined that at least \$21.1 million (of the \$85.9 million) in Medicaid payments were for 16,219 people who were ineligible for the buy-in program. Additionally, Medicaid made \$163,000 in duplicate Medicare premium payments.

When a recipient is no longer eligible for their standard Medicaid benefit (which covers a wide range of services such as hospital inpatient care, doctors visits, nursing home care, mental health services, home care, etc. - herein referred to as 'basic Medicaid coverage'), local district workers must still determine if the person is eligible for the Medicare buy-in program. A person can lose his or her buy-in eligibility for many reasons, including: no longer a State resident; no longer meeting the income test; or death. If someone is no longer eligible for the buy-in program, local district workers must take a separate eMedNY action to end the person's eligibility and stop the payment of premiums. Thus, if a local district closes a recipient's eligibility for their basic Medicaid coverage, but does not assess (or re-assess) that person's buy-in program eligibility, Medicaid would improperly pay Medicare premiums if the person was ineligible for the program. This error occurred frequently.

Using eMedNY data, we determined the reasons why certain people lost their basic Medicaid benefit. From this analysis, we identified 16,219 people who received Medicare buy-in coverage after their eligibility for that program ended. Moreover, we determined that Medicaid made 187,050 improper premium payments (totaling \$21.1 million) for these recipients. This included 13,170 improper payments (totaling \$1.9 million) for 532 people who were deceased. (Note: The propriety of the remaining \$64.8 million [\$85.9 million - \$21.1 million] in questionable buy-in premium payments would require more detailed eligibility determinations by HRA and the local districts. Based on our audit work, we believe there is significant risk that material amounts of these payments also were improper.)

The following are three examples of persons for whom Medicaid made improper buy-in program premium payments.

- A person's eligibility for their basic Medicaid coverage ended in February of 1996. However, Medicaid continued to pay monthly Medicare buy-in premiums (we estimate to be \$75,800) for the ensuing 15 years. This included more than \$25,000 in improper buy-in payments for this person made during our audit period (March 2007 through February 2011). We brought this case to the local district's attention, and officials took prompt action to stop further improper premium payments for the recipient.
- A person's eligibility for their basic Medicaid coverage ended in August 2009. However, Medicaid continued to pay Medicare buy-in premiums (totaling \$10,700) for this person through March 2011 (a period of 19 months). We advised local officials of the issue, and they determined the person moved out of the country in August 2009. However, local district workers never followed through to stop the improper buy-in payments during the 19-month period. As a result of our inquiry, the local district stopped the buy-in payments for this recipient.
- A buy-in recipient died on August 3, 2004, and the local district ended the decedent's eligibility for their basic Medicaid coverage effective October 1, 2004. However, Medicaid continued to pay Medicare buy-in premiums for this person for the next six and a half years. During our audit period, the improper buy-in payments for this person totaled \$25,729. Local district officials stopped the buy-in payments in February 2011, after we brought this matter to their attention.

In addition, the buy-in program allows for recoveries of improper Medicare premium payments dating back to the month of a recipient's death. Thus, the Department has instructed local districts that such recoveries can (and should) be made when payments for deceased recipients are identified. Some local officials, however, were unaware that premium payments for deceased beneficiaries could be recovered. Consequently, the aforementioned payments (totaling \$25,729) for one particular recipient were not recovered. Further, there is material risk that premium payments for other deceased recipients were not recovered as well. Moreover, localities cannot recover non-death related improper premium payments beyond two months. Therefore, it is very important to end buy-in coverage periods for ineligible people in eMedNY in a timely manner.

Although the Department has taken certain steps to address some of the problems that caused overpayments, further enhancements are needed. For several years, Department officials were aware that local districts had not performed eligibility determinations for many Medicaid recipients who were enrolled in the Medicare buy-in program. Thus, to reduce the amount of improper Medicaid payments for buy-in premiums, the Department developed a monthly report to identify persons whose Medicaid coverage expired - but for whom Medicaid continued to make buy-in premium payments. The Department instructed local districts to review the report and make formal determinations of the buy-in program eligibility of the recipients listed. Further, if the recipients listed were not eligible, the local districts were expected to stop any future buy-in payments for them.

In April 2007, the Department formally advised the local districts of improper buy-in program premium payments and of the monthly report to help prevent them. At that time, the Department

instructed the local districts to review the report on an ongoing basis and take the actions necessary to stop further improper premium payments. Additionally, from 2007 through 2009, the Department provided training and issued guidance to the districts on the importance of using the reports to promptly identify and stop improper buy-in payments. Also, to further reduce improper payments, the Department developed a system to automatically end (“auto-close”) buy-in coverage and stop premium payments when someone lost eligibility for basic Medicaid coverage for certain reasons (such as no longer a State resident). This feature took effect in April 2009 for all districts outside of New York City, and, in March 2011, it took effect in New York City.

Although the automatic closure of certain buy-in cases has reduced the number of improper buy-in payments, it has not eliminated the problem. For instance, if someone’s Medicaid case was closed because the person exceeded the income limit, the local district must still determine if the person qualified for the buy-in program. If the person no longer qualified, the local district would have to manually enter data into eMedNY to end that person’s buy-in coverage. Because this scenario is not subject to the auto-close process, it requires manual intervention (including a review of the monthly report). However, district officials’ knowledge and use of the monthly report varied considerably. At one district we contacted, officials were unaware of the report and, consequently, they did not use it.

Although the number of improper buy-in payments decreased significantly after the distribution of the monthly reports (in April 2007), problems have persisted. As such, there was considerable risk that material amounts of improper buy-in payments continued. In December 2010, there were about 13,500 cases (exceptions) on the monthly report. At that time, the monthly buy-in premium for Medicare (Part B) was \$110.50. Thus, the total amount of improper buy-in payments could have been as much as \$1,491,750 (13,500 x \$110.50) per month. Moreover, during 2010 and 2011, the Department did little to ensure the local districts used the monthly reports to remove ineligible recipients from the buy-in program in a timely manner.

We brought this matter to the attention of officials in five local districts (HRA and Albany, Monroe, Nassau and Suffolk Counties). Officials at the five local districts promptly reviewed the monthly buy-in reports, and as a result, they closed nearly 7,500 additional buy-in cases and stopped the related premium payments. As of September 30, 2011, the number of exceptions on the report had been reduced from nearly 13,000 cases to about 5,300 cases. Moreover, as a result of our audit, the Department has expanded the auto-close process by adding certain “reason codes” to eMedNY system controls designed to end inappropriate buy-in coverage and, thereby, prevent improper premium payments. Further, the Department plans to contact local districts if the number of cases on the monthly report exceeds specific thresholds.

Our review also identified 1,167 duplicate Medicare premium payments (totaling \$163,000) that were made on behalf of 50 people. The duplicate payments occurred because Medicare had two different identification numbers for each of these people, and eMedNY paid premiums for both identification numbers. For one person, for example, Medicaid paid Medicare buy-in premiums totaling \$4,805 over a period of four years. However, Medicaid made duplicate premium payments (also totaling \$4,805) to Medicare over the same period for the same person under a different identification number. We advised Department officials of this problem, and officials indicated

they will initiate reviews to identify and resolve issues regarding duplicate premium payments on a routine basis.

Recommendations

1. Formally and periodically remind HRA and the local districts to:
 - ensure that eligibility determinations are made for all people enrolled in the Medicare buy-in program; and
 - re-assess the eligibility of buy-in program recipients who lose their basic Medicaid program benefits. Remove ineligible people from the buy-in program timely.
2. Recover the inappropriate premiums (totaling \$1.9 million) paid after individuals in the buy-in program died and the duplicate premium payments (totaling \$163,000).
3. Formally determine the reasons for duplicate premium payments and take steps as needed to prevent them in the future.

Excessive Claim Payments for Eligible Buy-in Program Recipients

Some people qualify for the Medicare buy-in program, although they do not qualify for basic Medicaid coverage. Medicaid pays the Medicare premiums for these recipients. In addition, Medicaid will also pay the Medicare deductibles and coinsurance of these recipients, if their income levels are low enough and they meet other program eligibility standards. Between March 1, 2006 and February 28, 2011, Medicaid made about \$26.5 million in claim payments for individuals who were eligible for the buy-in program only (and not for basic Medicaid coverage).

As a result of our audit, we identified 71,355 excessive payments (totaling nearly \$5.5 million) that eMedNY made for 6,413 recipients. In general, the excessive payments resulted from eMedNY system weaknesses. The following are two examples of persons (eligible for the buy-in program) for whom excessive payments were made.

- A person was admitted to a hospital and was eligible for Medicaid payment of his Medicare deductibles and coinsurance as well as his monthly premium. Medicare, however, paid only a small portion of the resulting hospital claim. Therefore, the hospital submitted the claim to eMedNY requesting payment of the hospital's regular Medicaid rate less the amount received from Medicare. Nonetheless, according to buy-in program rules, Medicaid was only responsible for the claim's deductibles and coinsurance. However, because an eMedNY system edit did not reflect buy-in program rules, Medicaid overpaid this claim by \$34,000.
- A person's income was too high to qualify for Medicaid payment of Medicare deductibles and coinsurance. The person was hospitalized, and Medicare paid most of the resulting claim, except for the coinsurance of \$6,600. The hospital submitted a claim to eMedNY requesting payment for the coinsurance (\$6,600). However, because the person's income

exceeded the prescribed limit, the person was entitled only to Medicaid payment of his Medicare premiums. Nonetheless, because of flaws in an eMedNY edit, Medicaid incorrectly paid the hospital the \$6,600 it had claimed.

The eMedNY system identifies individuals in the buy-in program and indicates their income level and whether their benefits are limited to the buy-in program only. eMedNY system edits use this information to ensure that buy-in medical claim payments are paid appropriately. However, the edits did not work properly during our audit period. The Department identified similar deficiencies, and in August 2010, the Department adjusted the edits to conform more closely with buy-in program requirements. The adjustments addressed some, but not all of the inappropriate payments we identified.

In response to the audit, Department officials stated they will evaluate the feasibility of developing eMedNY edits to strengthen the processing of Medicare buy-in related claims. Further, officials will review the claims we identified and seek recoveries where appropriate.

Recommendations

4. Develop and implement changes to the eMedNY system to ensure accurate payment of claims for individuals who are eligible for buy-in coverage only.
5. Review the \$5.5 million in improper claim payments we identified and recover funds where appropriate.

Audit Scope and Methodology

Our audit had two objectives. Our first objective was to determine whether the Department only paid Medicare premiums for individuals who were authorized to be in the Medicare buy-in program. The audit period for this objective was March 1, 2007 through February 28, 2011. Our second objective was to determine whether the Department properly paid medical claims for individuals who were only eligible for the buy-in program. The audit period for this objective was March 1, 2006 through February 28, 2011.

To accomplish our objectives, we met with officials from the Department and local districts. We reviewed applicable laws and regulations for the buy-in program. We obtained and reviewed buy-in premium payment data and compared that data with eMedNY eligibility data. We also reviewed the monthly buy-in reports the Department makes available to the local districts. We judgmentally selected five local districts (HRA and Albany, Monroe, Nassau and Suffolk Counties) for review based on their size and geographic location. We also analyzed the buy-in data to detect multiple payments for the same individual for the same month. In addition, we obtained and reviewed Medicaid claims from eMedNY for individuals in the buy-in program who were classified with buy-in only coverage. We also obtained and reviewed eMedNY system documentation relating to claim edits for buy-in participants.

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 objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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 (some of whom have minority voting rights) to certain boards, commissions and public authorities. 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.

Authority

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.

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 generally concurred with our recommendations and indicated that certain actions have been and will be taken to address them.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner 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.

Contributors to This Report

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Vision

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To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

Nirav R. Shah, M.D., M.P.H.
Commissioner

NEW YORK
state department of
HEALTH

Sue Kelly
Executive Deputy Commissioner

September 21, 2012

Mr. Brian E. Mason, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street - 11th Floor
Albany, New York 12236-0001

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2010-S-76 on "Improper Payments Related to the Medicare Buy-In Program"

Thank you for the opportunity to comment.

Sincerely,



Sue E. Kelly
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
James C. Cox
Jason A. Helgeson
Diane Christensen
Stephen Abbott
Dennis Wendell
Stephen LaCasse
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**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2010-S-76 on
Improper Payments Related to the Medicare Buy-In Program**

The following are the Department of Health's (Department) comments in response to Office of the State Comptroller's (OSC) Draft Audit Report 2010-S-76 on "Improper Payments Related to the Medicare Buy-In Program."

Recommendation #1:

Formally and periodically remind HRA and the local districts to ensure that eligibility determinations are made for all people enrolled in the Medicare Buy-In program, and also to re-assess the eligibility of Buy-In program recipients who lose their basic Medicaid program benefits. Remove ineligible people from the Buy-In program timely.

Response #1:

The Department expanded the automated Buy-In closing process during 2012 by including an additional 27 Medicaid reason codes in the selection process. This expansion is expected to significantly reduce the number of cases which are not selected for auto-closing as well as the number of cases requiring manual review and deletion, and should result in removing these cases from the Buy-In program in a timely manner. Further, cases requiring manual review and deletion will appear on the monthly Buy-In deletion report (listing the individuals who do not have an active Medicaid case to support the Buy-in span) whenever the local district does not act in a timely manner. The Department will issue formal guidance before the end of the year reminding all local districts to take timely actions in performing manual reviews and deleting cases listed on the monthly Buy-In deletion report.

Recommendation #2:

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

Response #2:

A death certificate is required to recover from the Social Security Administration (SSA) more than two months of premiums paid after the individual's death. Department program staff is following-up on the possibility of obtaining death certificates internally from the Bureau of Biometrics, and will also contact SSA regarding the possibility of meeting this requirement by submitting a copy of the file containing the death data as an alternative to the death certificate. In addition, in April 2011, the Department submitted a refund request relative to the 50 cases identified by OSC with duplicate payments totaling \$163,000.

Recommendation #3:

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

Response #3:

The Department will immediately begin routinely analyzing the TRMP0061 Report as a means of identifying duplicate premium payments. Whenever a duplicate is identified, the cause will be determined and steps implemented to prevent a reoccurrence where viable.

Recommendation #4:

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

Response #4:

The Department will evaluate the feasibility of developing and implementing eMedNY edits to strengthen systematic processing of Buy-In related claims.

Recommendation #5:

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

Response #5:

The Department will review the claims identified by OSC and seek recoveries as warranted.