



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

Division of State Government Accountability

Reducing Medicaid Costs for Recipients With End Stage Renal Disease

Medicaid Program Department of Health



Report 2015-S-14

March 2017

Executive Summary

Purpose

To determine whether the Department of Health took sufficient steps to control the Medicaid costs of recipients diagnosed with end stage renal disease who were eligible for, but not enrolled in, Medicare. The audit covered the period January 1, 2010 through December 31, 2015.

Background

End stage renal disease (ESRD) is a medical condition in which a person has permanent kidney failure and requires dialysis or a kidney transplant to stay alive. For the six-year period ended December 31, 2015, Medicaid paid \$909 million for medical services (including inpatient, clinic, physician/professional, referred ambulatory, transportation, durable medical equipment, and laboratory services) on behalf of 10,906 Medicaid recipients who were diagnosed with ESRD.

Medicaid recipients with ESRD are eligible for Medicare coverage if they receive regular dialysis treatments or a kidney transplant, and meet one of the following requirements: (1) have worked the required amount of time under Social Security, the Railroad Retirement Board, or as a government employee; (2) are already receiving or are eligible for Social Security or Railroad Retirement Board benefits; or (3) are the spouse or dependent child of a person who meets either of the aforementioned requirements.

When Medicaid recipients with ESRD are also enrolled in Medicare, Medicare becomes the primary insurer (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.

Key Findings

- For decades – since July 1973 – Medicaid recipients diagnosed with ESRD have been eligible for Medicare benefits. This allows state Medicaid programs to transfer some of the medical costs of these individuals to the federal Medicare program. We determined the Department of Health (Department) has not taken steps to effectively control the Medicaid costs of recipients diagnosed with ESRD. In particular, the Department does not identify Medicaid recipients with ESRD, notify ESRD recipients of their entitlement to Medicare, or take actions to help (or encourage) them to apply and enroll in Medicare. As a result, we identified 3,015 Medicaid recipients with ESRD who met the Medicare eligibility criteria, but who were not enrolled in Medicare at the time their medical services were provided. Had the Department informed the recipients about their entitlement to Medicare and taken proactive steps to help get them enrolled, the Medicaid program could have saved as much as \$146 million over the six-year audit period. For example, we identified a child who was diagnosed with ESRD, was receiving continuous dialysis treatments, and qualified for Medicare based on his parent's work credits. Had the child been enrolled in Medicare, the Medicaid program would have saved about \$1.5 million over a four-year period.
- Based on our analysis of the \$146 million, we estimated the Medicaid program could save as much as \$69 million from 2016 through 2018 if the Department took immediate steps to

identify Medicaid recipients with ESRD and helped guide them on how to apply for and enroll in Medicare. In response to our audit, the Department initiated a project to identify Medicaid recipients diagnosed with ESRD. According to Department officials, this process will produce an outreach letter that notifies ESRD recipients that they may be eligible for Medicare, explains the benefits of Medicare enrollment, and tells them how and where to apply for Medicare. Going forward, the Department can obtain recoveries from Medicare (up to 12 months of an individual's medical costs) by tracking when ESRD recipients are retroactively enrolled in Medicare.

- In addition to the 3,015 recipients who met the Medicare eligibility criteria based on their or a qualifying family member's work credits, we identified 4,381 ESRD Medicaid recipients who did not qualify for Medicare based on their time worked and for whom we could not identify a spouse or parent to establish Medicare eligibility. These 4,381 ESRD recipients included 4,240 adults and 141 children whose Medicaid case information did not note a spouse or parent. Medicaid payments for these recipients totaled about \$553 million for services that Medicare would have covered. If even a small percentage of these patients were eligible for Medicare, there could be material savings for the Medicaid program.
- Sometimes a Medicaid recipient who is eligible for Medicare does not take steps to obtain Medicare coverage. To address this, the federal Social Security Administration (SSA) has a policy that allows Medicaid recipients who are age 65 and older and who are eligible for regular Medicare benefits to be enrolled in Medicare without a recipient's consent. However, this policy does not address Medicaid recipients under age 65 who meet ESRD Medicare eligibility requirements who do not apply for Medicare. We requested that SSA issue a formal ruling as to whether Medicaid recipients diagnosed with ESRD could be similarly enrolled, without a recipient's consent, as long as they met ESRD Medicare requirements.

Key Recommendations

- Implement a process to identify and notify Medicaid recipients with an ESRD diagnosis to apply for Medicare coverage and instruct them on how and where to apply for Medicare.
- Develop an outreach program that encourages ESRD-related providers and other stakeholders to inform ESRD recipients about Medicare benefits and Medicaid's payment of Medicare out-of-pocket costs, and to actively assist recipients apply for Medicare.
- Follow up with recipients who do not apply for Medicare by implementing a process that:
 - Ascertains the Medicare eligibility of recipients diagnosed with ESRD (by identifying recipients' qualifying relations [spouse, parent] and obtaining recipients' qualifying work credits ["quarters of coverage," or QCs] from SSA); and
 - Notifies the recipients of their apparent Medicare eligibility.
- If SSA clarifies or amends rules to allow the enrollment of ESRD recipients who do not apply for Medicare, then for recipients with the necessary QCs, collect and submit documentation required for SSA to make an ESRD Medicare eligibility determination.
- Recover Medicaid claims paid for any retroactive Medicare enrollments of ESRD recipients.

Other Related Audits/Reports of Interest

[Department of Health: Unnecessary Managed Care Payments for Medicaid Recipients With Medicare \(2010-S-75\)](#)

[Department of Health: Improper Payments Related to the Medicare Buy-In Program \(2010-S-76\)](#)

State of New York
Office of the State Comptroller

Division of State Government Accountability

March 1, 2017

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 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 Medicaid program entitled *Reducing Medicaid Costs for Recipients With End Stage Renal Disease*. 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.

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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State Government Accountability Contact Information:

Audit Director: Andrea Inman

Phone: (518) 474-3271

Email: StateGovernmentAccountability@osc.state.ny.us

Address:

Office of the State Comptroller
 Division of State Government Accountability
 110 State Street, 11th Floor
 Albany, NY 12236

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

Background

The New York State Medicaid program 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. The Medicaid program is administered by the State's Department of Health (Department). For the fiscal year ended March 31, 2016, New York's Medicaid program had approximately 7.4 million enrollees and Medicaid claim costs totaled about \$56 billion. The federal government funded about 53.2 percent of New York's Medicaid claim costs; the State funded about 30.6 percent; and the localities (the City of New York and counties) funded the remaining 16.2 percent.

Many of the State's Medicaid recipients are also eligible for Medicare. Medicare is the federal health insurance program for people who are age 65 or older, people under 65 who have certain disabilities, and people with end stage renal disease (ESRD). Different parts of Medicare help cover different services. For instance, Medicare Part A covers inpatient hospital stays (such as for kidney transplants), care in skilled nursing facilities, hospice care, and some home care services. Medicare Part B covers outpatient care (including dialysis services), certain doctor's services, medical supplies, and preventive care.

ESRD is the last stage of chronic kidney disease. A person with ESRD has permanent kidney failure, in which the kidneys function at less than 15 percent of their normal capacity and can no longer support a person's day-to-day life. Individuals with ESRD must either receive kidney transplants or undergo regular dialysis, a method of filtering blood through an external machine.

Qualifying for ESRD-Based Medicare Benefits

Most people are eligible for Medicare when they reach age 65. However, people younger than 65 who have ESRD may be eligible for Medicare coverage if they receive regular dialysis treatments or a kidney transplant and have met one of the following requirements:

- Have worked the required amount of time under Social Security, the Railroad Retirement Board, or as a government employee, or
- Are already receiving or are eligible for Social Security or Railroad Retirement Board benefits, or
- Are the spouse or dependent child of a person who meets either of the aforementioned requirements.

The required amount of time worked under Social Security, the Railroad Retirement Board, or as a government employee is measured in "quarters of coverage" (QCs). QCs are credits that workers earn through the payment of federal payroll taxes under the Federal Insurance Contributions Act (FICA). Individuals can earn up to four QCs per year. For example, in 2016 a person would have received one QC for each \$1,260 of wages earned, and would have had to earn \$5,040 ($\$1,260 \times 4$) to receive the maximum four QCs for that year. Generally, the amount of earnings needed for one QC goes up each year.

The number of QCs required for ESRD-based Medicare eligibility depends upon several factors, such as the individual's age and when the individual was diagnosed with ESRD. For example, a 46-year-old person who was diagnosed with ESRD would need 24 QCs to qualify for Medicare benefits. Generally, the younger a person is, fewer QCs are needed to qualify for ESRD-based Medicare benefits. In addition, certain individuals with ESRD may be eligible for Medicare based on the earnings of a qualified family member. For instance, a person diagnosed with ESRD could also qualify for Medicare based on their spouse or parent earning enough QCs to qualify for Medicare. For example, a 20-year-old child diagnosed with ESRD would need a parent to have earned at least six QCs just before the child's ESRD onset to qualify the child.

Generally, a person would apply for Medicare after their ESRD condition was diagnosed and dialysis services were needed. Either the individual who was diagnosed with ESRD, his/her legal representative, or someone responsible for the individual (such as the spouse or a relative) must file an application form with the Social Security Administration (SSA) to determine eligibility to receive ESRD Medicare benefits. Another federal agency, the Centers for Medicare & Medicaid Services (CMS), provides SSA with guidance and policies related to ESRD-based Medicare issues.

Once a person with ESRD is enrolled in Medicare, Medicare covers the cost of lifetime dialysis treatments. ESRD-based Medicare enrollees are covered not only for kidney failure-related services, but for all Medicare-covered services, including services not related to ESRD. For example, Medicare would cover the cost of a kidney transplant and follow-up care, including other hospital inpatient services, physician visits, and laboratory tests as well as non-ESRD preventive care. If a person has Medicare only because of ESRD (for instance, they have not reached the age of 65), their Medicare coverage would end one year after the month the person stops dialysis treatments or three years after a kidney transplant surgery (if the new kidney functions and the patient no longer needs dialysis).

Out-of-Pocket Costs for the Medicare Program

Medicare requires enrollees to pay certain out-of-pocket costs, such as monthly premiums, and 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. Additionally, individuals diagnosed with ESRD are not required to pay a Medicare Part A premium. People enrolled in Medicare Part B, however, typically pay monthly premiums (in 2015, the Part B premium was \$104.90 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 insurer (payer) and Medicaid the secondary. This cost-sharing arrangement transfers some of the 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 recipients' Medicare premiums under the State Buy-In Agreement and the Medicare Savings Program.

Under the State Buy-In Agreement,¹ individuals who receive Supplemental Security Income (SSI) benefits, and who are correspondingly enrolled in Medicare, are automatically enrolled in Medicaid and the Medicaid program will "buy-in" (pay) for the recipients' Medicare premiums.

Under the Medicare Savings Program (MSP), individuals with Medicare submit an MSP application to the Department and the Department applies an income test to determine if Medicaid will pay an individual's Medicare premiums. The State's local Departments of Social Services and the Human Resources Administration in New York City (collectively referred to as local districts) administer the MSP determination process.

Medicaid Costs for Individuals With ESRD

For the six-year period ended December 31, 2015, Medicaid paid about \$2.4 billion for medical services on behalf of 10,906 Medicaid recipients diagnosed with ESRD. The scope of our audit included certain services that are covered by Medicare: inpatient, clinic, professional (e.g., physician services), referred ambulatory, transportation, supply/durable medical equipment, and laboratory services. These Medicare-covered services totaled \$909 million in Medicaid payments.

¹SSA POMS HI 00815.006 The State Buy-In Agreement.

Audit Findings and Recommendations

We identified 3,015 Medicaid recipients diagnosed with ESRD who were not enrolled in Medicare at the time their medical services were provided. We determined these recipients would have been entitled to Medicare based on their ESRD condition, continuous dialysis treatments or kidney transplant, and their (or a qualifying family member's) earned QCs. For the six-year period ended December 31, 2015, Medicaid payments on behalf of these recipients totaled over \$184 million for medical services that could have been covered by Medicare as the primary insurer. We determined Medicaid could have avoided total net payments of up to \$146 million (after deducting Medicare out-of-pocket costs) had the 3,015 recipients been enrolled in Medicare when they first became eligible. Going forward, we estimated Medicaid could save up to \$69 million over the next three years if the Department implemented a process to identify and notify recipients with ESRD of their potential Medicare eligibility, and took proactive steps to help those recipients apply for Medicare.

Also, Medicaid recipients sometimes do not apply for Medicare coverage, although they meet ESRD Medicare eligibility requirements. Depending on the outcome of an anticipated SSA ruling pertaining to the enrollment of such recipients into Medicare without a recipient's consent, the Department should incorporate any corresponding new rules into the State's Medicaid program, as warranted.

Identification of Medicaid Recipients Diagnosed With End Stage Renal Disease

ESRD Medicaid Recipients Who Met Medicare Eligibility Requirements

Congress² has stressed that "Medicaid is intended to be the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." Thus, the Department is required to take all reasonable measures to determine what other health insurers are responsible for the payment of health services.

The Department takes proactive steps to identify and notify Medicaid recipients who are nearing the Medicare eligible age of 65 to apply for Medicare at their local SSA office because they may be entitled to these benefits. However, the Department does not proactively identify Medicaid recipients diagnosed with ESRD, of any age, to notify them that they may be entitled to Medicare and to apply for these benefits. Consequently, for the six years ended December 31, 2015, we identified Medicaid payments totaling about \$184 million for 3,015 Medicaid recipients with ESRD who were not enrolled in Medicare at the time their medical services were provided, but who would have been entitled to Medicare based on their ESRD condition, continuous dialysis treatments or kidney transplant, and earned QCs. (The Exhibit at the end of this report presents the location of the 3,015 cases across New York State.)

² Senate Report Number 146, 99th Congress, Second Session. 1, 312, reprinted in 1986 U.S. Code Cong. & Admin. News 42, 279.

In order to determine the total net Medicaid payments that could have been avoided, we offset the \$184 million with the Medicare out-of-pocket expenses that Medicaid would have paid for the medical services (such as Medicare premiums,³ deductibles, and coinsurance). We determined Medicaid could have avoided net payments of up to \$146 million for health care services that Medicare would have covered (\$95 million for Medicare Part A services and \$51 million for Medicare Part B services). Using the savings we computed for 2014 and 2015 as an average, we estimate the State could save up to \$69 million over the next three years (from 2016 through 2018) if the Department implemented processes to identify recipients with ESRD and took actions to get these recipients to apply for and enroll in Medicare.

The determination of cost savings was based on whether Medicaid recipients who were diagnosed with ESRD would qualify for Medicare based on their own self-earned QCs or on the QCs earned by a qualifying family member (i.e., spouse or parent). We determined that 2,505 of the 3,015 recipients diagnosed with ESRD would have qualified for Medicare based on self-earned QCs. Medicaid payments over the six-year audit period for these recipients totaled about \$139 million for services that Medicare covered. We determined the net Medicaid savings (after consideration of Medicaid's payment of Medicare out-of-pocket expenses) would have totaled about \$109 million (\$70 million for Part A services and \$39 million for Part B services) if the recipients had been enrolled in Medicare as the primary insurer.

For example, a 44-year-old Medicaid recipient was diagnosed with ESRD in September 2008 and began continuous dialysis treatments. At that time, the recipient had already earned enough QCs to qualify for Medicare. If this recipient applied for Medicare, we determined Medicare coverage would have begun December 1, 2008 (the fourth month of continuous dialysis treatment). Medicaid payments for this recipient for the six-year audit period totaled \$784,851 for the medical services in our audit scope. However, we determined Medicaid could have saved a net total of \$717,713 (\$550,134 for Part A services and \$167,579 for Part B services) if the recipient had applied for and been enrolled in Medicare Part A and Part B when the recipient first became eligible.

We also determined that 522 of the 3,015 recipients⁴ diagnosed with ESRD would have qualified for Medicare based on the QCs earned by a spouse or, in the case of a dependent child, a parent. Medicaid payments over the six-year audit period for these recipients totaled about \$45 million for services that Medicare covered. We determined the net Medicaid savings (after consideration of Medicaid's payment of Medicare out-of-pocket expenses) would have totaled about \$37 million (\$25 million for Part A and \$12 million for Part B) if these recipients had been enrolled in Medicare as the primary insurer.

For example, a child was diagnosed with ESRD in September 2009 and began receiving continuous dialysis treatments. Based on a parent's QCs, this child would have qualified for Medicare. If Medicare had been applied for, we determined Medicare coverage would have begun December

³ To avoid overstating cost savings, we assumed the Department would have paid the Part B premium for each Medicaid recipient with ESRD. We did not offset a Part A premium because ESRD recipients are not required to pay a Part A premium.

⁴ Twelve of the 3,015 recipients qualified based on their own self-earned QCs and on the QCs earned by a qualifying family member, but during different time periods. Total recipients of 3,015 is the total number of unique Medicaid recipients. Claim findings are not duplicated.

1, 2009 (the fourth month of continuous dialysis treatment). Medicaid payments for this recipient for the six-year audit period totaled \$1.7 million for the medical services in our audit scope. We determined Medicaid could have saved a net total of about \$1.5 million (over \$1.1 million for Part A services and \$321,441 for Part B services) had the recipient been enrolled in Medicare Part A and Part B.

ESRD Medicaid Recipients Who May Potentially Meet Medicare Eligibility Requirements

In addition to the 3,015 recipients diagnosed with ESRD who would have qualified for Medicare based on the QCs earned by themselves or a qualifying family member, we identified a large portion of Medicaid recipients diagnosed with ESRD who might also be eligible for Medicare, but for whom we lacked certain information to make an eligibility determination.

We determined these recipients did not qualify for Medicare based on their own QC earnings, and we could not identify a spouse or parent whose QCs the recipient might use to qualify for Medicare. In total, we identified 4,381 recipients (4,240 adults and 141 children) who were diagnosed with ESRD, but their Medicaid case information did not identify a spouse or parent. Medicaid payments for these 4,381 recipients totaled about \$553 million for services that Medicare would have covered. For example, one child for whom we could not identify a parent had \$297,509 in Medicaid payments since 2014 for medical services that would be covered by Medicare. We determined that if a qualifying relative could be found whose work credits qualified the child for ESRD Medicare, then Medicaid could have saved a net total of \$288,300 (\$273,405 for Part A services and \$14,895 for Part B services) if the recipient had been enrolled in Medicare as the primary insurer.

If the Department took steps to identify these recipients and encouraged them to apply for Medicare, there could be material savings to the Medicaid program, if even a small percentage of these recipients became eligible for Medicare.

Steps to Controlling Medicaid Costs

We found that the Department has no formal mechanism to identify specific recipients with ESRD and proactively inform them of their potential Medicare eligibility. For example, the Department does not collect or analyze data to identify recipients with ESRD who do not have Medicare. If it did, it could take steps to inform these recipients of their potential Medicare eligibility and request the recipients to apply for Medicare through their local SSA office (by phone or in person) or to contact other resources for assistance. For example, the Department could instruct recipients to call the New York State Office for the Aging's Health Insurance Information Counseling and Assistance Program (HIICAP), which provides free counseling and assistance on Medicare. The Department could also instruct recipients to call their local Department of Social Services to inquire if the Medicaid program would pay their Medicare premiums.

As a result of our audit, the Department took steps to initiate the development of an automated process to identify Medicaid recipients diagnosed with ESRD. Department officials stated this process will produce an outreach letter to notify these recipients that they may be eligible for Medicare benefits, explain the benefits of Medicare enrollment, and tell them how and where to apply for Medicare.

Additionally, with a little more effort, the Department has the potential to further lower Medicaid expenditures by enlisting the community of dialysis-related providers and resources to educate and actively assist ESRD recipients apply for Medicare benefits. For example, other useful community-level resources we identified are: dialysis center social workers and case/care managers; State-certified insurance navigators who assist people seeking health insurance; and staff from the State's Office for the Aging.

To illustrate, we contacted four dialysis centers to determine if they help Medicaid recipients with ESRD apply for Medicare. We also asked if there are reasons why some recipients do not apply for Medicare. We found that one of the four centers did not have a formal system to inform and help patients apply for Medicare. Also, three out of four centers said that some patients do not apply for Medicare because they do not want to pay the Medicare premium for Part B coverage. (Note: ESRD recipients are not required to pay a Medicare Part A premium.)

If the Department educated and encouraged dialysis-related providers and community-level resources to help ESRD Medicaid recipients apply for Medicare and inform recipients about Medicare Savings Program (MSP) opportunities in which Medicaid pays Medicare Part B premiums, it could induce more recipients to enroll in Medicare. While the Department cannot require them to take on this role, it could create educational materials to ensure that facts are presented accurately and to highlight the MSP opportunities available to recipients. Because Medicare reimbursements are generally comparable to or exceed Medicaid's rates, there would be little or no financial risk to ESRD service providers, and material Medicaid savings would likely be realized at the same time if the Department took such actions.

Recommendations

1. Implement a process to identify and notify recipients with an ESRD diagnosis to apply for Medicare coverage. Instruct the recipients on how and where to apply for Medicare.
2. Develop an outreach program that educates and encourages ESRD-related providers and other stakeholders to proactively inform Medicaid recipients with ESRD about Medicare benefits, inform recipients about State MSP opportunities, and actively assist recipients apply for Medicare.

Monitoring and Follow-Up of Eligible Recipients Who Do Not Apply for Medicare

Department Follow-Up on ESRD Medicaid Recipients Who Meet Medicare Eligibility Requirements

To address Medicaid recipients who do not apply for Medicare requires a bit more work by the Department. The Department and local districts should monitor and follow up with ESRD Medicaid recipients who appear likely eligible for Medicare, but who do not apply for Medicare. This would entail identifying recipients' qualifying family members and obtaining QC data from SSA to ascertain whether ESRD recipients are likely to be eligible for Medicare. A mechanism to obtain QC data exists within the Department's health exchange system (the New York State of Health, or NYSOH).

However, the Department did not have a formal process to obtain QC data from SSA to identify ESRD Medicaid recipients who appeared to be eligible for Medicare. Further, Department officials stated that while "the Medicaid program is obligated to advise people to apply for benefits they may be eligible for...it does not have an obligation to perform an informal Medicare eligibility determination." Given the significant amounts of potential Medicaid cost savings that could be realized, we urge the Department to reconsider this position. In particular, the Department should take steps to ascertain a recipient's Medicare eligibility and send follow-up notifications to ESRD recipients if they appear to be Medicare eligible. Such notifications should inform recipients about the zero cost of Medicare Part A premiums and programs (such as MSP) that pay Medicare Part B premiums. If such steps are taken, the Department can better ensure that an optimal amount of ESRD Medicaid recipients apply for Medicare.

SSA Policies That Address Cost-Sharing

SSA administers policies regarding Medicare eligibility and enrollment. For Medicare and Medicaid cost-sharing purposes, SSA should consider examining its current policies with regard to ESRD recipients who do not apply for Medicare. Generally, an SSA policy will specify if it applies to the ESRD eligibility group. However, some SSA policies that address cost-sharing for people who do not apply for Medicare do not specifically address the ESRD eligibility group. This creates a risk that cost-sharing cannot occur for this ESRD eligibility group (i.e., those who do not apply for Medicare) until SSA clarifies its policies.

For example, one SSA policy⁵ addresses when SSA determines a Medicaid recipient is over age 65 and is eligible for regular Medicare benefits, but the person refuses to apply for Medicare. This policy allows SSA and the corresponding state to share data on the person, and enroll the person in Medicare Part B without the person's consent. This policy clearly applies to uncooperative recipients over age 65 who meet Medicare eligibility requirements and who have little or no income. However, there are no SSA policies that address an "uncooperative" Medicaid recipient under the age of 65 with ESRD who qualifies for ESRD Medicare, but refuses to submit a Medicare application.

⁵ SSA POMS HI 00815.045 Establishing Buy-in Eligibility for Persons Who Refuse to Cooperate—State Accretions.

Under SSA's policies regarding persons who refuse to apply for Medicare, Part B enrollments occur without a person's consent. A state is permitted to refer an uncooperative recipient, without the recipient's consent, for Medicare Part B enrollment as long as: (1) SSA receives evidence to show that the recipient was requested to apply for Medicare, but refused to do so; and (2) the state can submit documentation to SSA that demonstrates the uncooperative recipient meets Medicare eligibility criteria. Once the individual is enrolled in Medicare Part B, Medicaid will buy-in (pay for) the Medicare Part B premiums on behalf of the uncooperative individual.

However, this SSA policy does not specifically address the ESRD eligibility group. Given that Medicaid is intended to be the payer of last resort and other available resources must be used before Medicaid pays for the care of an individual, the Department needs a process to cost-share, or buy-in, for Medicaid recipients with ESRD who are eligible for, but do not apply for, Medicare. Therefore, our Office formally requested that SSA issue an official ruling regarding the Department's authority to request the enrollment of a recipient diagnosed with ESRD (regardless of age) who does not apply for Medicare, as long as they met ESRD Medicare requirements. At the time our audit fieldwork was completed, SSA officials were working with CMS on our request.

If SSA clarifies or amends its policies regarding persons who refuse to apply for Medicare to include Medicaid recipients with ESRD, regardless of age, the Department would need a process to collect and submit documentation required for SSA to make a determination on a recipient's ESRD Medicare eligibility. Also, the Department may need to develop a new process with SSA to effectuate the recipients' Medicare enrollment and buy-in.

Recommendations

3. Monitor and follow up with recipients who do not apply for Medicare and facilitate their enrollment by developing and implementing processes that include, but are not limited to:
 - Identifying recipients' qualifying relations (spouse, parent),
 - Obtaining recipients' qualifying credits (QCs) data from SSA,
 - Ascertaining whether Medicaid recipients diagnosed with ESRD are potentially eligible for Medicare, and
 - Sending follow-up notifications to recipients informing them of their apparent Medicare eligibility.
4. If SSA clarifies or amends its rules for uncooperative individuals to include ESRD recipients:
 - Collect and submit the documentation required for SSA to make an ESRD Medicare eligibility determination for recipients with the necessary QCs who do not apply for Medicare, and
 - Design and implement new processes to effectuate Department requests for Medicare enrollment and buy-in for eligible ESRD recipients who do not apply for Medicare.

Obtaining Claim Recoveries

Going forward, the Department can obtain claim recoveries by tracking when the identified Medicaid recipients diagnosed with ESRD are retroactively enrolled in Medicare. SSA policies allow for retroactive ESRD Medicare enrollment for up to 12 months to cover medical services already provided. If a recipient is retroactively enrolled into Medicare, the total Part B premiums must be paid immediately upon enrollment. Therefore, the Department should track and pursue Medicaid claim recoveries for recipients who become retroactively enrolled in ESRD Medicare.

Recommendation

5. Recover claims paid for any retroactive Medicare enrollments of Medicaid recipients diagnosed with ESRD.

Audit Scope and Methodology

The objective of our audit was to determine whether the Department took sufficient steps to control the Medicaid costs of recipients diagnosed with ESRD who were eligible for, but not enrolled in, Medicare. The audit covered the period January 1, 2010 through December 31, 2015.

To accomplish our audit objective and assess internal controls related to our objective, we interviewed officials from the Department and examined the Department's relevant Medicaid policies and procedures. We also reviewed applicable federal and State laws, rules, and regulations. Additionally, we interviewed officials from SSA, several local districts including the Human Resources Administration in New York City, as well as four dialysis centers and a private medical practice that treats people with kidney disease. We shared our methodology with and provided data and findings to Department and Office of the Medicaid Inspector General officials during the audit for their review. We acknowledge NYSOH officials for their cooperation and technical assistance in obtaining the qualifying credit (QC) data for our audit.

In addition, we used the Medicaid Data Warehouse and the Medicaid claims processing system (eMedNY) to identify Medicaid recipients who were diagnosed with ESRD and received continuous dialysis treatments or kidney transplants, but did not have Medicare coverage at the time the service was provided. We also used the Medicaid Data Warehouse to identify the spouse and parent(s) of ESRD Medicaid recipients. With cooperation from NYSOH officials, we obtained QC data from SSA for all of these individuals. We applied SSA rules to compute whether ESRD Medicaid recipients would have qualified for Medicare either on their own QCs ("self-qualified") or using qualified family members' (spouse/parent) QCs, had they applied for Medicare, and calculated their Medicare qualifying date for each period of dialysis-related treatments.

Also, we extracted paid Medicaid claims for qualified ESRD recipients only for medical services that Medicare would have covered after their Medicare qualifying dates. These medical services were for inpatient, clinic, professional, referred ambulatory, transportation, supply/durable medical equipment, and lab claims. We used these paid claims to calculate Medicaid cost savings.

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.

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.

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 the audit recommendations and indicated that certain actions have been and will be taken to address them. Of particular note, officials indicated that the Department is taking steps to acquire contractor assistance to conduct outreach to all Medicaid recipients with an ESRD diagnosis who are not enrolled in Medicare. Officials added that the contractor will provide Medicare education, including information about benefits, how and where to apply, and the potential for Medicaid to pay the cost of Medicare premiums through the Medicare Savings Program.

Within 90 days of the 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

Andrea Inman, Audit Director
Warren Fitzgerald, Audit Manager
Gail Gorski, Audit Supervisor
Paul Alois, Audit Supervisor
Mark Breunig, Examiner-in-Charge
Earl Vincent, Examiner-in-Charge
Suzanne Loudis, Supervising Medical Care Representative
Yanfei Chen, Senior Examiner
Lisa Rooney, Senior Examiner

Division of State Government Accountability

Andrew A. SanFilippo, Executive Deputy Comptroller
518-474-4593, asanfilippo@osc.state.ny.us

Tina Kim, Deputy Comptroller
518-473-3596, tkim@osc.state.ny.us

Brian Mason, Assistant Comptroller
518-473-0334, bmason@osc.state.ny.us

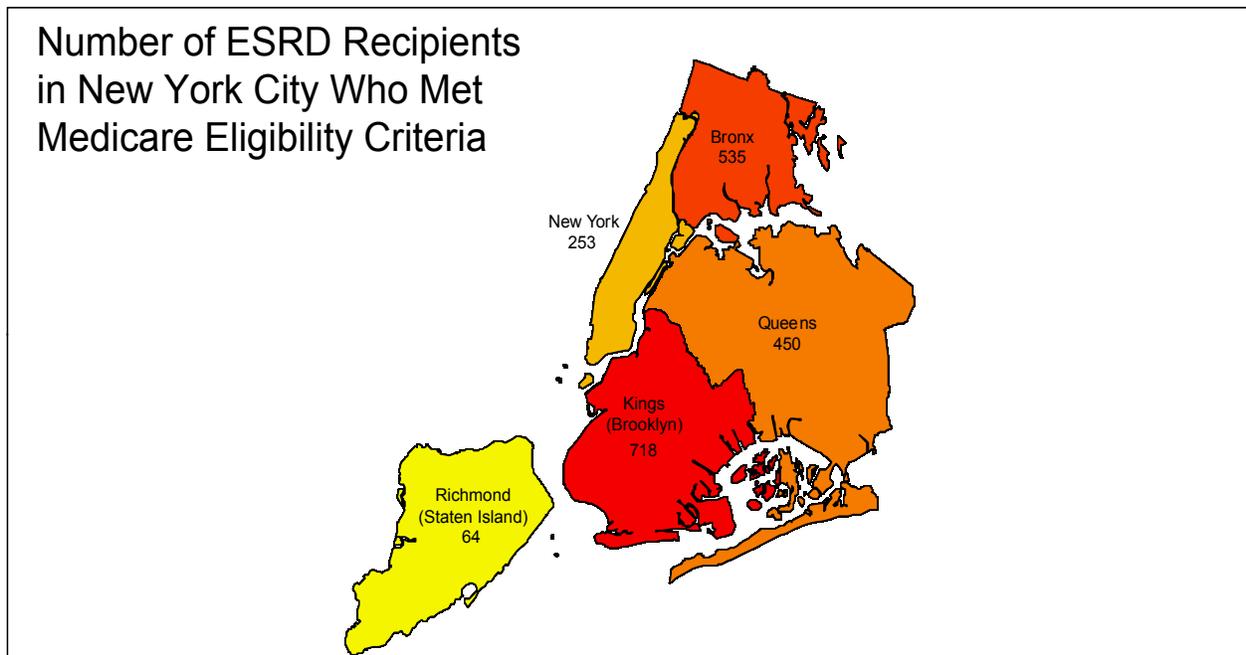
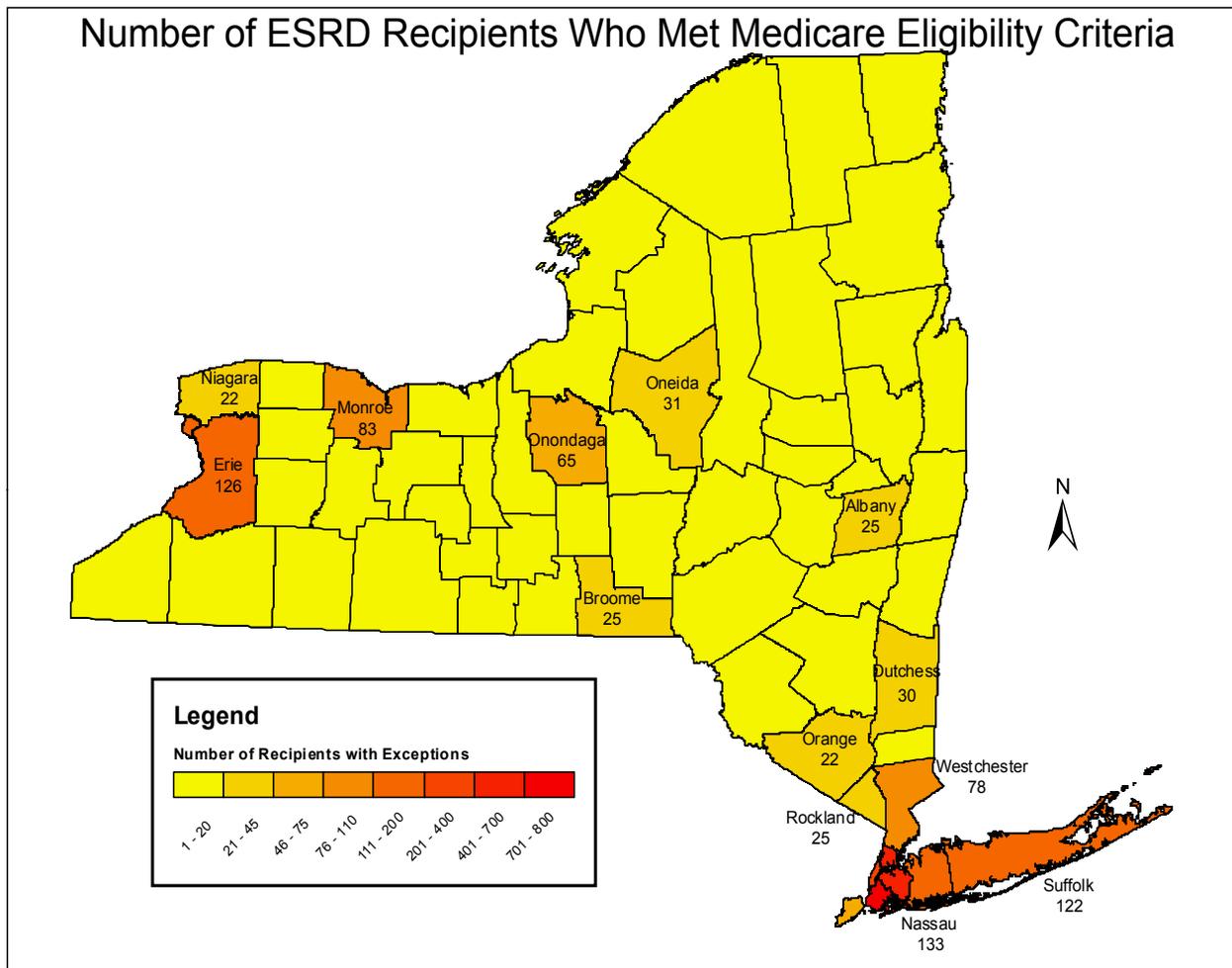
Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

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

Exhibit



Agency Comments



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 2, 2016

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 2015-S-14 entitled, "Reducing Medicaid Costs for Recipients with End Stage Renal Disease."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
Jason A. Helgeson
Dennis Rosen
James Dematteo
James Cataldo
Brian Kiernan
JoAnn Veith
Elizabeth Misa
Geza Hrazdina
Jeffrey Hammond
Jill Montag
Diane Christensen
Lori Conway
OHIP Audit SM

**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2015-S-14 entitled,
Reducing Medicaid Costs for Recipients with End Stage Renal
Disease**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2015-S-14 entitled, "Reducing Medicaid Costs for Recipients with End Stage Renal Disease."

Background

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to \$8,305 in 2015, consistent with levels from a decade ago.

Recommendation #1

Implement a process to identify and notify recipients with an ESRD diagnosis to apply for Medicare coverage. Instruct the recipients on how and where to apply for Medicare.

Response #1

The Department has initiated a project that will identify recipients with an End Stage Renal Disease (ESRD) diagnosis. It will provide them with information on how and where to apply for Medicare, as well as notifying them that Medicaid may pay for their Medicare Part B premiums.

Recommendation #2

Develop an outreach program that educates and encourages ESRD-related providers and other stakeholders to proactively inform Medicaid recipients with ESRD about Medicare benefits, inform recipients about State MSP opportunities, and actively assist recipients apply for Medicare.

Response #2

The Department will take steps to evaluate and implement an efficient and cost effective means of making educational information available to other stakeholders. These stakeholders may have the opportunity to inform and assist Medicaid recipients with ESRD in applying for Medicare.

Recommendation #3

Monitor and follow up with recipients who do not apply for Medicare and facilitate their enrollment by developing and implementing processes that include, but are not limited to:

- Identifying recipients' qualifying relations (spouse, parent),
- Obtaining recipients' qualifying credits (QCs) data from SSA,
- Ascertaining whether Medicaid recipients diagnosed with ESRD are potentially eligible for Medicare, and
- Sending follow-up notifications to recipients informing them of their apparent Medicare eligibility.

Response #3

The Department is taking steps to acquire contractor assistance to conduct outreach to all Medicaid recipients with an ESRD diagnosis who are not enrolled in Medicare. The contractor will provide Medicare education; including information about benefits, how and where to apply, and the potential for Medicaid to pay the cost of the Medicare premiums through the Medicare Savings Program. Additionally, the contractor will provide customer service assistance, including Medicare application assistance and scheduling appointments with the Social Security Administration (SSA). The contractor will be required to monitor and track this process to assess Medicare eligibility outcomes for the Department.

Recommendation #4

If SSA clarifies or amends its rules for uncooperative individuals to include ESRD recipients:

- Collect and submit the documentation required for SSA to make an ESRD Medicare eligibility determination for recipients with the necessary QCs who do not apply for Medicare, and
- Design and implement new processes to effectuate Department requests for Medicare enrollment and buy-in for eligible ESRD recipients who do not apply for Medicare.

Response #4

Current SSA policy only allows states to submit proof of Part B eligibility for a Medicaid recipient that meets all four of the factors listed below:

- Uncooperative in applying for Medicare;
- Over age 65;
- Resident of the United States (US); and
- US citizen or meets the necessary alien requirements.

Like any rule and/or policy change, if SSA modifies its rule and allows states to prove Part B eligibility in the future for uncooperative Medicaid recipients with ESRD regardless of age, the Department will assess the implications of the rule change and take appropriate actions at that time.

Recommendation #5

Recover claims paid for any retroactive Medicare enrollments of Medicaid recipients diagnosed with ESRD.

Response #5

OMIG will review claims paid for any retroactive Medicare enrollments of Medicaid recipients, and pursue recoveries of overpayments where appropriate.