



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

Division of State Government Accountability

Improper Fee-for-Service Payments for Pharmacy Services Covered by Managed Care

**Medicaid Program
Department of Health**



Executive Summary

Purpose

To determine whether Medicaid made improper fee-for-service claim payments for pharmacy services covered by recipients' managed care plans. The audit covered the period October 1, 2011 through December 31, 2013.

Background

Medicaid provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. In general, the Medicaid program pays medical providers through either the fee-for-service method or the managed care plan method. Under the fee-for-service method, Medicaid pays providers directly for Medicaid-eligible services rendered to Medicaid recipients. Under the managed care plan method, Medicaid pays managed care organizations (MCOs) a monthly premium for every Medicaid recipient enrolled in the MCO, and the MCO arranges for the provision of services its members require. MCOs typically have networks of participating providers that they reimburse directly for services provided to their enrollees.

Prior to October 2011, pharmacy benefits were reimbursed through the fee-for-service method because they were excluded from managed care coverage. However, beginning October 1, 2011, most pharmacy benefits were covered by managed care plans, and fee-for-service reimbursement was no longer appropriate for recipients enrolled in managed care. As of December 2013, approximately 4 million Medicaid recipients were enrolled in managed care plans. During the 27-month period, October 1, 2011 through December 31, 2013, Medicaid paid approximately \$46.5 billion in premiums to 92 MCO plans.

Key Findings

- Medicaid inappropriately paid 29,289 fee-for-service pharmacy claims totaling \$978,251 on behalf of 18,010 recipients whose pharmacy benefits were already covered by managed care plans.
- For example, from August 2012 through April 2013, Medicaid paid 51 fee-for-service pharmacy claims totaling \$1,736 on behalf of a recipient who was enrolled in a managed care plan during the entire period.
- Overpayments occurred because the Department of Health did not update its Medicaid eligibility files with MCO enrollment information in a timely manner, in some cases taking more than six months to enter new enrollee eligibility data.

Key Recommendations

- Review the \$978,251 in improper fee-for-service claim payments we identified and recover funds as appropriate.
- Take corrective action to ensure enrollment information is entered and updated in a timely manner.

Other Related Audit/Report of Interest

[Department of Health: Medicaid Fee for Service Payments for Managed Care Recipients \(2007-S-100\)](#)

State of New York
Office of the State Comptroller

Division of State Government Accountability

January 5, 2015

Howard A. Zucker, M.D., J.D.
Acting Commissioner
Department of Health
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Empire State Plaza
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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 *Improper Fee-for-Service Payments for Pharmacy Services Covered by Managed Care*. 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

Medicaid is a federal, state, and local government program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the year ended March 31, 2014, New York's Medicaid program had approximately 6.5 million enrollees and Medicaid claim costs totaled about \$50.5 billion. The federal government funded about 49.25 percent of New York's Medicaid claim costs, the State funded about 33.25 percent, and the localities (City of New York and counties) funded the remaining 17.5 percent.

The New York State Medicaid program is administered by the Department of Health (Department). In general, the Department uses two methods to pay Medicaid providers: the fee-for-service method or the managed care plan method. Under the fee-for-service method, Medicaid pays providers directly for each Medicaid-eligible service rendered to Medicaid recipients. Under the managed care plan method, Medicaid pays each managed care organization (MCO) a monthly premium for every Medicaid recipient enrolled in the plan, and the MCO arranges for the provision of services its members require. MCOs typically have networks of participating providers that they reimburse directly for services provided to their enrollees.

Generally, the costs of all services that MCO enrollees require are covered by Medicaid monthly premiums. However, certain services are specifically excluded from managed care coverage and are reimbursed on a fee-for-service basis. Prior to October 2011, pharmacy benefits were reimbursed using the fee-for-service method because they were not included under managed care coverage.¹ Effective October 1, 2011, however, most pharmacy benefits were covered by MCOs, and fee-for-service reimbursement was no longer appropriate for recipients enrolled in managed care. As of December 2013, approximately 4 million Medicaid recipients were enrolled in managed care plans. During the 27-month period, October 1, 2011 through December 31, 2013, Medicaid paid approximately \$46.5 billion for premiums to 92 MCO plans.

During our audit, 58 local social services districts (representing 57 counties and the five boroughs of New York City) were responsible for enrolling individuals in Medicaid. The local districts were also responsible for enrolling Medicaid recipients in managed care plans, and ensuring that enrollment information was kept up to date. Recipient eligibility and enrollment information was transmitted to, and maintained by, the State's eligibility system, referred to as the Welfare Management System (WMS).

On October 1, 2013, in accordance with the Affordable Care Act, the Department implemented the automated New York State of Health system (NYSoH). The NYSoH is an organized marketplace designed to help individuals shop for and obtain health insurance coverage. The NYSoH also allows people to check their eligibility for, and enroll in, Medicaid. With the implementation of the NYSoH, Medicaid enrollments through the local districts have decreased. However, certain Medicaid eligibility determinations are still made at the local districts, such as those for individuals with Supplemental Security Income, individuals in nursing homes, children in foster care, and people applying for the Medicare Savings Program.

¹ Prior to August 1, 1998, prescription drugs were a covered Medicaid managed care plan benefit.

Ultimately, information concerning recipient eligibility and MCO enrollment is communicated to the Department's Medicaid claims payment system, eMedNY. The Department uses eMedNY to make Medicaid payments to participating medical service providers and managed care plans. For payment control purposes, claims processed by eMedNY are subject to various automated system edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement. For example, an edit is in place to deny fee-for-service claims for recipients enrolled in an MCO if the service is covered by managed care.

Audit Findings and Recommendations

For the 27-month period, October 1, 2011 through December 31, 2013, we found Medicaid inappropriately paid 29,289 fee-for-service pharmacy claims totaling \$978,251 on behalf of 18,010 Medicaid recipients whose pharmacy benefits were covered by managed care. The inappropriate payments occurred primarily because Medicaid eligibility files were not updated with MCO enrollment information in a timely manner, in some cases taking more than 180 days to do so. As a result, eMedNY system edits did not deny the improper fee-for-service pharmacy payments. During this 27-month period, Medicaid also paid more than \$126 million in premiums to MCOs for health services, including pharmacy benefits, for these Medicaid recipients.

Delays in Entering New Managed Care Organization Enrollment Information

Medicaid improperly paid 22,378 fee-for-service pharmacy claims totaling \$571,125 on behalf of 14,369 MCO enrollees – 13,463 of whom were newborns – because, at the time the service was provided, the eMedNY system lacked the MCO enrollment information for these individuals. Lacking this data, Medicaid paid the fee-for-service claims although the services were already covered by Medicaid monthly MCO premiums. Enrollment data entry was delayed more than one month for 61 percent of the new enrollees, more than three months for 24 percent of the new enrollees, and longer than six months for nearly 10 percent of the new enrollees, during which time Medicaid was making redundant payments (a premium payment and fee-for-service payment) for claims submitted. Table 1 presents a breakdown of the improper payments for fee-for-service claims based on the recipients' MCO enrollment dates.

Table 1

| Number of Days Data Entry of MCO Enrollment Was Delayed | Number of New MCO Enrollees | Number of Pharmacy Claims Processed as Fee for-Service | Total Fee-for-Service Amount Paid by Medicaid |
|--|--|---|--|
| 1 – 30 | 5,588 | 13,412 | \$207,530 |
| 31 – 60 | 4,545 | 5,347 | \$107,352 |
| 61 – 90 | 770 | 1,720 | \$62,558 |
| 91 – 180 | 2,073 | 1,351 | \$105,766 |
| > 180 | 1,393 | 548 | \$87,919 |
| Totals | 14,369 | 22,378 | \$571,125 |

As an example, from August 2012 through April 2013, Medicaid paid 51 fee-for-service pharmacy claims totaling \$1,736 on behalf of one recipient who was enrolled in a managed care plan during the entire period. However, enrollment information for this individual was not updated to the eMedNY system until December 16, 2013.

Notably, 13,463 of the 14,369 new MCO enrollees (94 percent) were newborns whose mothers were enrolled in managed care plans at the time of the births. According to Department guidelines, if the mother of a newborn is enrolled in a managed care plan, the newborn child should also be enrolled in the plan, and the managed care plan assumes medical risk for the newborn on the actual date of birth. As demonstrated in Table 2, neonatal care (particularly in the first two months of life) accounted for a significant portion of the fee-for-service pharmacy claims that were improperly paid.

Table 2

| Enrollee Age on Date of Service | Number of Enrollees | Number of Fee-for-Service Claims |
|--|----------------------------|---|
| Younger than two months | 12,915 | 17,731 |
| Two – six months | 1,054 | 2,221 |
| Older than six months | 872 | 2,426 |
| Totals | 14,841* | 22,378 |

*Number reflects 14,369 unique recipients, 472 of whom had claims in more than one age category.

In a prior audit (Report 2007-S-100, issued May 2008), we identified that delays in entering enrollment information for newborns was a critical issue, and it continues to be a significant concern. The Department agreed with our earlier findings – that such delays resulted in inappropriate payments – and at the time established a work group to identify opportunities for ensuring the timely updating of managed care plan information. However, our current audit shows that improvements are still needed as the Department continues to pay fee-for-service claims for recipients enrolled in managed care.

Delays in Updating Changes in Managed Care Organization Enrollment Information

Medicaid improperly paid 4,345 fee-for-service pharmacy claims totaling \$245,775 because the managed care enrollment information – in particular, revised MCO enrollment expiration dates – was not updated timely to the Medicaid eligibility files used to process Medicaid claims. As a result, when fee-for-service claims were paid, the eMedNY system indicated the recipients' MCO enrollment had expired when, in fact, it had not.

For example, a fee-for-service pharmacy claim for \$249 (with a service date of April 16, 2013) was paid on April 22, 2013 for a recipient whose MCO enrollment, according to system data at the time, ended on March 31, 2013. However, on July 10, 2013, the recipient's MCO enrollment information was updated in the system to extend that enrollment through April 30, 2013. Thus, the April 22, 2013 fee-for-service claim was inappropriately paid because the recipient was, in fact, enrolled in managed care at the time of the service. If the recipient's MCO enrollment data had been updated more timely, the claim would likely have been rejected by an existing eMedNY edit designed to deny payment of fee-for-service claims when the recipient is enrolled in managed care.

Edit to Prevent Improper Payments

Medicaid improperly paid 2,566 fee-for-service pharmacy claims totaling \$161,351 for services that were provided during October 2011, the first month that pharmacy benefits were covered under managed care. Department officials initially told us these payments were made because the eMedNY system edit designed to prevent the payments had not yet been activated. However, further analysis shows that the edit was activated as some claims were denied even on October 1, 2011. Department officials could not explain why certain fee-for-service claims were paid. As such, the Department should determine why the claims were improperly paid and take any necessary corrective actions.

Recommendations

1. Review the \$978,251 in improper fee-for-service claim payments we identified and recover overpayments as appropriate.
2. Take corrective action to help ensure managed care enrollment information, particularly for newborns, is entered and updated timely.
3. Determine why fee-for-service pharmacy claims were inappropriately paid during October 2011 and take any necessary corrective actions.

Audit Scope and Methodology

Our audit objective was to determine whether Medicaid made improper fee-for-service claim payments for pharmacy services covered by recipients' managed care plans. The audit covered the period October 1, 2011 through December 31, 2013.

To accomplish our objective, and assess internal controls related to our objective, we obtained enrollment information for managed care enrollees during the period and identified those members who had fee-for-service pharmacy claims. We excluded claims for carved-out drugs and members enrolled in managed care plans which did not include pharmacy benefits. We then identified fee-for-service claims that occurred during months for which premium payments were made to managed care plans for these members. We compared these results with enrollment information and considered payments to be improper when the service dates of the fee-for-service claims fell during members' managed care enrollment periods.

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 (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

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 it. In their response, Department officials concurred with our recommendations and indicated that certain actions have been and will be taken to address them.

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

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Vision

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Agency Comments

NEW YORK

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HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

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

December 5, 2014

Mr. Dennis Buckley, Audit Manager
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Dear Mr. Buckley:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2014-S-5 entitled, "Improper Fee-For-Service Payments for Pharmacy Services Covered by Managed Care."

Thank you for the opportunity to comment.

Sincerely,



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

Enclosure

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**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2014-S-5 entitled,
"Improper Fee-For-Service Payments for Pharmacy Services
Covered by Managed Care"**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2014-S-5 entitled, "Improper Fee-For-Service Payments for Pharmacy Services Covered by Managed Care."

Background:

New York State is a national leader in its oversight of the Medicaid Program. Through the efforts of the Department and the Office of the Medicaid Inspector General (OMIG), over the last five years, New York State alone accounted for 54.9 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement. Over the last three calendar years, the administration's Medicaid enforcement efforts have recovered over \$1.73 billion, a 34 percent increase over the prior three-year period.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality 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 840,000 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to \$7,929 in 2013, consistent with levels from a decade ago.

Recommendation #1

Review the \$978,251 in improper fee-for-service claim payments we identified and recover overpayments as appropriate.

Response #1

The OMIG has reviewed the file of claims which make up the \$978,251 in fee-for-service (FFS) claim overpayments that OSC identified. The OMIG agrees that an overpayment exists since these recipients show managed care coverage for the same period. However, in many cases, the FFS payment was made prior to the retroactive enrollment of the recipients into managed care. The OMIG will proceed with recovery with guidance from the Department.

Recommendation #2

Take corrective action to help ensure managed care enrollment information, particularly for newborns, is entered and updated timely.

Response #2

Enrollment information to plans, for consumers who exist in the Welfare Management System (WMS) environment, is posted in a roster that appears twice monthly. WMS generates an enrollment report for the plans the third weekend of each month. A subsequent second roster is

run after the first of each month to inform plans of enrollees who have gained eligibility/enrollment after the first roster, but before the first of the roster month. Population of the roster is driven by Local Department of Social Services (LDSS) eligibility actions, combined with enrollment activity. The enrollment portion is done by either the LDSS or the Enrollment Broker.

There is a plan to move from the WMS roster system to an 834 file process, which the New York State of Health (NYSOH) currently uses. The 834s are files that transmit daily eligibility/enrollment changes to directed parties. The evolution project (EP) for this action is slated to be implemented during the first quarter of 2016.

Recommendation #3

Determine why fee-for-service pharmacy claims were inappropriately paid during October 2011 and take any necessary corrective actions.

Response #3

Of the data sampled by the Department, it appeared there was often retroactive actions that give a revisionist history to claims processing, meaning that today's eligibility/enrollment portrayal does not appear as the verification did on the date of service. Currently edit #01172 rejects FFS claims for benefits that are covered under the managed care plan's scope of benefits to prevent FFS payment when the consumer's record shows managed care enrollment. This edit should be sufficient to govern claim payment.

Medicaid's policy for provider authorization directs providers to deliver service based on eligibility response from NYSOH, on the date of service. Providers treat consumers as Medicaid eligible if that is the returned response from eMedNY's ePACES system. Managed care plans are given rosters that direct them to service consumers for the upcoming month. The roster directs the plan to apply benefits as per the coding appearing on that month's roster, i.e., for Supplemental Security Income individuals, much of behavioral health is carved out to FFS.

If there are changes to the eligibility/enrollment, post service/eligibility verification date due to audit, these retroactive changes can give the appearance that a provider should not have been allowed to bill FFS. Providers and plans must work from timely authorizations. Subsequent changes to the consumer's eligibility/enrollment can make it appear that the claim was incorrectly paid, when at the time of service, the provider had authorization from ePACES or the roster.

Some claims failed to hit edit #01172 with no obvious reason, causing them to pay. Claims staff at eMedNY were asked to research the claims to see why they paid. The paid claims given to eMedNY for review are compound claims billed with the generic National Drug Code and were processed during the transition phase of EP#1312 (Implementation of Version 5010 and D.0 Transactions). EP#1312 created a new translation list 0016 (COMPOUND EDIT BYPASSES) to bypass edits for compound claims and edit #01172 was one of those edits on the list to bypass. This allowed the claims to pay inappropriately.

On October 17, 2011, edit #01172 was removed from translation list 0016. This allowed the claims to fail edit #01172 and claims were appropriately denied from that point forward. No further corrective action is necessary.