



Department of Health

ANDREW M. CUOMO
Governor

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

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

March 26, 2015

Mr. Brian Mason
Assistant Comptroller
New York State Office of the State Comptroller
110 State Street, 10th Floor
Albany, New York 12236

Dear Mr. Mason:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2014-S-5 entitled, "Improper Fee-for-Service Payments for Pharmacy Services Covered by Managed Care."

Please feel free to contact Amy Nickson, Office of Governmental and External Affairs at (518) 474-2011 with any questions.

Sincerely,

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

Enclosure

**Department of Health
Comments on the
Office of the State Comptroller's
Final 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) Final Audit Report 2014-S-5 entitled, "Improper Fee-for-Service (FFS) 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 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 is in the process of recovering overpayments as appropriate.

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 for the following month. The second roster is run the Saturday after the first of the month to catch anyone who enrolled after the first roster but before the first of the 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. Evolution project (EP) #1843 was established precisely for this action and 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.