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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

December 24, 2002

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Maintenance of the Medicaid Prescription Drug File
Report 2001-S-58

Dear Dr. Novello:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we audited the Department of Health's policies and procedures for maintaining the information used to reimburse pharmacies for prescription drugs dispensed to Medicaid recipients for the two-year period January 1, 2000 through December 31, 2001.

A. Background

The New York State Department of Health (Health) administers the State's Medical Assistance program (Medicaid), which was established under Title XIX of the federal Social Security Act to provide medical assistance to needy people. Health uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system that is operated by a fiscal agent (Computer Sciences Corporation), to process Medicaid claims and make payments to health care providers for services rendered.

MMIS receives claims from pharmacy providers seeking reimbursement for prescription drugs dispensed to Medicaid recipients. Medicaid paid approximately $5.3 billion for prescription drugs for the two-year period January 1, 2000 through December 31, 2001. In New York State, the federal, State and county governments share in these costs.

Article V, Title 11 of the New York State Social Services Law requires Health to base payments for prescription drugs on monthly drug pricing information provided by an independent drug pricing clearinghouse. MMIS compares the pricing information provided by the clearinghouse

with the amount charged on the pharmacy claim, and reimburses the pharmacy the lesser of the two amounts. The clearinghouse also provides Health with information designating a drug's classification as brand or generic. MMIS uses a drug's classification to determine the amount of co-payment (the Medicaid recipient's share of the cost of a prescription drug) and dispensing fee (the amount paid to pharmacies to fill a prescription) for each prescription drug. Health maintains the pricing and drug classification information on the MMIS in a Medicaid prescription drug file.

B. Audit Scope, Objective and Methodology

We audited Health's policies and procedures for maintaining the information used to reimburse pharmacies for prescription drugs dispensed to Medicaid recipients for the two-year period January 1, 2000 through December 31, 2001. The objective of our performance audit was to determine whether Health maintains accurate information to pay pharmacies and maximizes reimbursement from the federal government.

To accomplish our audit objective, we interviewed Health officials, examined relevant Health records, and reviewed applicable payment policies and procedures. In addition, we developed computer programs to verify the accuracy of the prescription drug file. From a population of more than 22,000 drugs, we judgmentally selected 100 drugs because of their high Medicaid expenditures, to compare MMIS pharmacy payments with drug pricing information provided by the clearinghouse. These 100 drugs accounted for over $2 billion in Medicaid drug expenditures, or about 39 percent of the total Medicaid prescription drug expenditures for the period January 1, 2000 through December 31, 2001.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations of Health included in our audit scope. Further, these standards require that we understand Health's internal control structure and compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations that have been identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, finite audit resources are used to identify where and how improvements can be made. Thus, little audit effort is devoted to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

C. Results of Audit

Health is responsible for maintaining the MMIS to enable accurate payment of Medicaid claims submitted by health care providers, such as pharmacies. MMIS uses the prescription drug file to pay pharmacies for dispensing prescription drugs to Medicaid recipients. To ensure that pharmacies are paid correctly and that the federal government is accurately billed for its share of Medicaid costs, it is imperative that data on the prescription drug file be accurate. This requires that Health have procedures to maintain and monitor the accuracy of the prescription drug file, as well as formal policies to process retroactive drug price changes.

We identified weaknesses in Health's procedures for maintaining the prescription drug file. As a result, Medicaid did not collect $1.3 million in available federal reimbursement during our audit period and made incorrect payments totaling $600,000 to pharmacies. In addition, Health did not have formal policies for processing retroactive drug price changes. For a sample of 100 drugs, retroactive drug price increases and decreases totaled $12 million during our audit period.

1. Inaccurate Information on the Prescription Drug File

Using computer-assisted audit techniques, we evaluated the entire prescription drug file and determined that the drug file contained inaccurate information. We identified a variety of inaccuracies on the file affecting the cost sharing, co-payment and dispensing fee information. In total, we identified 535 drugs for which the file contained inaccurate information. These errors occurred because Health does not have formal procedures for maintaining and periodically reviewing the accuracy of information on the file.

In New York State, the federal, State and county governments share in the cost of Medicaid prescription drugs, as follows: federal government – 50 percent; New York State – 25 percent; county governments – 25 percent. However, the cost of family planning drugs for recipients between the ages of 10 and 55 is shared in the following proportions: federal government – 90 percent; New York State – 5 percent; county governments – 5 percent. Each month, Health officials update the file with information relating to drug pricing, drug classification and family planning designation. However, we found that 92 family planning drugs were not classified as such on the file during the monthly file update process. Consequently, when Health billed the federal government for its share of the cost of these drugs, it billed at the 50 percent reimbursement rate, instead of at the higher rate of 90 percent for family planning drugs. As a result, we determined that Health did not collect about $1.3 million in federal funding to which the State was entitled.

MMIS deducts the co-payment amount from a pharmacy's reimbursement, because it is the recipient's responsibility to pay pharmacies this amount. Typically, generic drugs have a co-payment of 50 cents, while brand name drugs have a $2 co-payment. In addition to reimbursing pharmacies for the cost of the prescription drugs, Medicaid pays a dispensing fee of $3.50 for brand name drugs and $4.50 for generic drugs to cover the pharmacy's cost of filling the prescription.

We identified 443 drugs for which the file contained incorrect co-payment or dispensing information. For example, for 222 of the drugs, we found the co-payment on the file indicated the drug was generic, while the dispensing fee on the file indicated the drug was brand. Since both the

co-payment and dispensing fee are determined by the drug's classification as generic or brand, the drug's classification should be consistent on the file. Generally, such inconsistencies occur as a result of the manufacturers changing the classification of certain drugs, without Health making appropriate updates to the file. Health does not perform reviews to identify such inconsistencies. We determined that Medicaid incorrectly paid pharmacies a total of $600,000 because of inaccurate drug classification information. We believe it may not be feasible to adjust these past payments because of the numerous pharmacies involved. In addition, the co-payment portion is the responsibility of the recipient, and at the time of service, the pharmacies were not aware of the correct co-payment amount. However, it is important for the file to be accurate to ensure proper payments in the future.

2. Retroactive Adjustments in Drug Prices

Monthly, Health receives updated drug pricing information from the clearinghouse, and some of the pricing information relates to prior periods (i.e., retroactive price changes). Retroactive price changes can result in either an increase or decrease in the prior drug price and therefore have an effect on the amount of Medicaid reimbursement due pharmacies. Because pharmacies have already submitted claims to MMIS and have received reimbursement, these claims payments did not reflect the most current MMIS pricing. However, Health is responsible for ensuring accurate Medicaid payments, and therefore should have a formal policy to address retroactive price changes. We found that Health does not have a formal policy. Instead, for retroactive price increases, Health officials maintain that pharmacy operators may submit adjusted claims to obtain additional reimbursement. For retroactive price decreases, Health does not seek recovery of the Medicaid overpayments, such as by offsetting current payments to pharmacies.

To assess the effect of retroactive drug price changes, we sampled 100 drugs, and compared the prices used to originally pay pharmacy claims with the current pricing information on the file. We found that for 91 of the 100 drugs, the file contained retroactive price changes. As a result of retroactive price changes for these drugs, Health incorrectly paid pharmacies $12 million. This amount consists of $10.2 million due to retroactive drug price increases and $1.8 million due to retroactive price decreases. Since our analysis was limited to our sample of 100 drugs, we believe there are significantly more incorrect payments than those identified in this report.

Recommendations

1. *Develop formal procedures to maintain the accuracy of the prescription drug file and periodically review and evaluate the information on the file to determine whether the file is accurate.*

2. *Seek recovery of the $1.3 million from the federal government for family planning claims, as well as for all family planning claims before and after the audit period.*

3. *Develop a policy to address retroactive drug price changes.*

We provided Department officials with a draft copy of this report for their review and comment. Their comments have been considered in the preparation of this report and are included as Appendix A. Department officials generally agreed with the report's recommendations. With respect to Recommendation 1, officials stated that eMedNY, the replacement Medicaid system, uses a more comprehensive file directly from the Department's drug service, thus eliminating the need for reference file adjustments and related procedures. Officials stated they would continue to investigate and address errors in pricing information. Regarding Recommendation 2, officials stated their initial review indicated the majority of claims do not appear to be eligible for federal funding, but that they would continue to investigate potential recoveries on claims when they are confirmed to be subject to federal guidelines. To Recommendation 3, Department officials stated they will develop a formal policy to address retroactive drug pricing changes.

In addition to the findings discussed in this report, we identified other matters that needed improvement. Although these matters are of lesser significance, Health officials should take the necessary corrective actions to address these issues. Any follow-up review or ensuing audit will include review of the extent to which Health officials have addressed the matters of lesser significance.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Major contributors to this report were Ken Shulman, William Clynes, Don Paupini, Paul Alois, Claudia Christodoulou, Julie DeRubertis, Tina Santiago and Paul Bachman.

We wish to thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this audit.

Very truly yours,

Kevin M. McClune
Audit Director

cc: Deirdre A. Taylor

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

December 5, 2002

Kevin M. McClune
Audit Director
Office of the State Comptroller
110 State Street
Albany, New York 12236

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 2001-S-58, entitled "Maintenance of the Medicaid Prescription Drug File".

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix A

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
2001-S-58 Entitled
"Maintenance of the Medicaid
Prescription Drug File"

The following are the Department of Health's (DOH) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2001-S-58 entitled "Maintenance of the Medicaid Prescription Drug File".

Recommendation #1:

Develop formal procedures to maintain the accuracy of the prescription drug file and periodically review and evaluate the information in the file to determine whether the file is accurate.

Response #1:

The pricing system, used under Phase I of eMedNY and implemented in November 2002, uses a more comprehensive file directly from the Department's drug service, thus eliminating the need for reference file adjustments and related procedures. Formal procedures for these functions will no longer be required. The Department will continue to investigate and address errors in information for individual pricing issues.

Recommendation #2:

Seek recovery of the $1.3 million from the federal government for family planning claims, as well as for all family planning claims before and after the audit period.

Response #2:

The Department's initial review of data provided by the OSC indicates that the majority of these claims do not appear to be eligible for federal funding. However, the Department will continue to investigate potential recoveries on claims when they are confirmed to be subject to federal guidelines.

Recommendation #3:

Develop a policy to address retroactive drug price changes.

Response #3:

The Department will develop a formal written policy to address retroactive drug pricing changes, reflecting the current position that providers may submit adjusted claims to obtain additional reimbursement.