NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

January 27, 2021

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-Up Audit Report, 2020-F-3 entitled, "Improper Medicaid Payments for Childhood Vaccines" (Follow Up to Report 2017-S-41)."

Thank you for the opportunity to comment.

Sincerely,

Lisa J. Pino, M.A., J.D.
Executive Deputy Commissioner

Enclosure

cc: Diane Christensen
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Department of Health Comments on the Office of the State Comptroller's Follow-Up Audit Report 2020-F-3 entitled, "Improper Medicaid Payments for Childhood Vaccines" (Report 2017-S-41)

The following are the responses from New York State Department of Health (Department) to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2020-F-3 entitled, "Improper Medicaid Payments for Childhood Vaccines (Report 2017-S-41)."

Recommendation #1:

Review the $29.8 million in improper MCO payments that we identified and instruct the MCOs to recover overpayments where appropriate. Ensure the MCOs recover the improper payments and account for the recoveries on their MMCORs.

Status – Partially Implemented

Agency Action - MCOs annually report their recoveries to the Department in Medicaid Managed Care Operating Reports (MMCORs). In January 2019, the Department began its review of the improper MCO payments. The Department reached out to MCOs in February 2019, directing them to review all the identified overpayments. The MCOs initiated the recoupment and void process with the intent to finalize by December 31, 2020. However, the process will take longer because, according to the Department, the MCOs disputed the overpayments related to the vaccine administration fee.

Federal regulations require the Department to identify the amount that the State will pay providers for the administration of a Vaccine for Children (VFC) Program vaccine to a Medicaid-eligible child. The regulations further state that this amount cannot exceed the State's regional maximum administration fee that is established by the Secretary of the Department of Health and Human Services. The MCOs' dispute is based on training provided by the Department in October 2017. In the training, the Department informed the MCOs that under Medicaid managed care, the regional maximum reimbursement for vaccine administration fees is established through contractual agreement between an MCO and its providers. As a result of the MCOs' dispute, the Department put its recovery efforts on hold while it waits for clarification from the Centers for Medicare & Medicaid Services (CMS). In August 2019, the Department contacted CMS for its opinion regarding the regional maximum fee as it relates to Medicaid managed care. According to Department officials, as of November 2020, they are still waiting for final guidance from CMS.

We note that we contacted CMS in May 2019, specifically asking if the state Medicaid program or Medicaid managed care plan can ever pay more than the regional maximum fee. CMS officials responded that the vaccine administration fee should never exceed the regional maximum fee and that the regional maximum fee applies to all children in Medicaid, regardless of the delivery system (managed care or fee-for-service).

Response #1:

On 11/25/2020, the Department contacted CMS to inform them the Department is still awaiting final guidance from CMS that will inform implementation of this recommendation. Specifically, the Department contacted CMS for its position regarding the regional maximum fee as it relates to Medicaid managed care. Dependent upon official final guidance from CMS, the Office of the

Medicaid Inspector General (OMIG) will independently extract data, which may include the OSC-identified overpayments and pursue recovery of any payment it determines to be inappropriate as a result of that analysis (within the allowable six-year lookback period, as outlined in State regulations). Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to due process. Given the importance of CMS's official final guidance to full implementation of this recommendation, the Department continues to follow-up with CMS for a pertinent response.

Recommendation #2:

Formally instruct MCOs on the proper payment of VFC Program claims in order to comply with Medicaid standards. This includes ensuring:

- Administration fees do not exceed the regional maximum administration fee (and ensuring providers are instructed on the proper submission of claims with VFC Program modifiers);
- Administered units do not exceed the number of vaccines reported;
- VFC Program vaccine lists are complete and up-to-date; and
- Claims for Medicaid recipients younger than 19 years old are processed using VFC Program payment rules.

Status – Partially Implemented

Agency Action - In its 90-day response, the Department stated it would issue plan guidance to instruct the MCOs on the proper payment of VFC Program vaccine administration fees for all eligible members. Instructions would provide guidance and recommendations for MCOs to implement front end measures on their claim payment systems to ensure payments for vaccine administrations do not exceed the regional maximum fee, administration units do not exceed the number of vaccines administered, and MCOs do not pay for the cost of VFC Program vaccines. As noted in Recommendation 1, however, Department officials contacted CMS regarding the regional maximum fee and are still awaiting final guidance from CMS regarding the regional maximum fee before issuing their own guidance to the MCOs.

Response #2:

On 11/25/2020, the Department contacted CMS to inform them the Department is still awaiting final guidance from CMS on the regional maximum fee. Given the importance of CMS's guidance to full implementation of this recommendation, the Department continues to follow-up with CMS for a pertinent response.

Recommendation #3:

Monitor encounter claims to ensure MCOs are not overpaying providers for VFC Program vaccines and administration fees.

Status – Partially Implemented

Agency Action - To monitor encounter claims and ensure MCOs are not overpaying providers for VFC Program vaccines and administration fees, the Department designed an automated query to identify potential overpayments made after our initial audit period, and will share the results with the Office of the Medicaid Inspector General. The Department is completing its quality assurance process on the query. Once testing is complete, the Department plans to periodically use the query as a monitoring tool.

Response #3:

The Department designed an automated query to identify potential overpayments made after the initial audit period. Once testing is complete and the query is approved, the Department will share the results with OMIG. OMIG will perform analysis of the data provided and pursue recovery of any payments it determines to be inappropriate as a result of that analysis (within the allowable six-year lookback period, as outlined in State regulations). Pursuant to State regulations, any identified overpayments OMIG pursues for recovery are subject to the provider's right to dueprocess.

The Department remains committed to running this query routinely and sharing the results with OMIG to assist in recoveries. However, as with prior responses, the quality assurance process cannot be completed until final guidance is received from CMS on whether MCOs are to be held to the regional maximum administration fee. Given the importance of CMS's guidance to full implementation of this recommendation, the Department continues to follow-up with CMS for a pertinent response.

Additionally, in August 2020, the Department requested a copy of the data extraction code OSC used for its findings. The Department requested this code to ensure we are following the same methodology that OSC used in the audit. OSC did not provide the SQL code until January 6, 2021, such that additional time is needed to complete this verification process.

State Comptroller's Comment 1 – The Department's comment is misleading. After receipt of the Department's August 2020 request, we responded to the Department in September 2020, indicating that this information was already provided during the initial audit. In fact, our auditors provided the SQL data extraction code we used for our audit findings to the OMIG (the Department's recovery agency) on July 5, 2018. We did not hear back from the Department regarding our September 2020 communication until December 2020, upon which we provided the SQL data extraction code again in January 2021.

Recommendation #4:

Review the $2.9 million in improper fee-for-service payments that we identified and recover overpayments where appropriate.

Status – Partially Implemented

Agency Action - The improper payments occurred because providers did not properly bill Medicaid for the vaccines or administration fees and eMedNY, the Department's claims processing and payment system, lacked controls to prevent the overpayments. The Department recovered $39,923 of the $78,064 related to ordered ambulatory and pharmacy claims. However, the remaining $2.8 million in payments related to Ambulatory Patient Groups (APG) claims have not been recovered.

Throughout the initial audit and in its 90-day response, the Department expressed concerns with the audit methodology for calculating overpayments related to APG claims. Specifically, the Department noted that all the claims needed to be rebilled correctly, but then re-run through its APG grouper/pricer software to determine whether the corrected claims actually resulted in overpayments. Our report and OSC's comment acknowledged the Department's concerns and concluded the improper claims represented actual and potential overpayments. We further noted that, while the exact overpayment amount cannot be determined without running the claims through the APG grouper/pricer, the individual line item(s) of each claim we identified were billed inaccurately (i.e., not in accordance with Department policy). Furthermore, the Department in its response acknowledged that the claims were not billed correctly and resulted in improper payments.

The Department stated it would have to rerun each claim (62,847 claims) individually through the grouper/pricer software because it is not able to batch process a large volume of claims through the software. We encourage the Department to have providers rebill their claims in accordance with Department policies to ensure proper payment.

Response #4:

The Department published a *Medicaid Update* article in July 2020 reminding providers to bill childhood vaccinations in accordance with Department policy to ensure proper payment. However, the Department continues to dispute the OSC finding that alleges incorrectly that there were $2.8 million dollars in potential overpayments for childhood vaccines. The Department reviewed a sample of claims provided by OSC and determined that no overpayment had occurred for the reviewed claims. The Department advised OSC of this error with appropriate supporting documentation, but OSC did not adjust their audit finding nor did they explain the rationale for failing to accept the Department's initial response. Therefore, the actual amount of a potential overpayment, if any beyond the amounts already recovered, cannot be validated and completed using the OSC methodology.

To date, OMIG has recovered $34,702 and verified additional provider-initiated voids totaling $5,220. The Department will reissue instructions for providers to rebill their Ambulatory Patient Groups (APG) claims. The rebilling of APG claims by providers will generate adjustments to the claims that will result in overpayments being returned to the Medicaid program administratively through the claims processing system. OMIG will independently extract data, which may include the OSC-identified overpayments and verify that the required adjustments have been made.

It is important to note that at the time OSC issued its Final Report, more than 11,000 claims were included in its recommendation that were no longer recoverable, because the claims were beyond the six-year lookback period permitted by State regulations. Additionally, 845 out of the 62,847 impacted claims identified are not reviewable in response to this audit because they are already included in audit universes for other OMIG audit projects.

State Comptroller's Comment 2 – As we reported multiple times in our initial audit and follow-up review, the 62,847 claims totaling $2.8 million were not billed correctly (i.e., in accordance with Department policy), and the improper claims represented "actual and potential" overpayments. We reported that, while each corrected overall claim payment amount is unknown without running the claims through the Department's pricing software, the individual line item(s) of each claim we

identified was inaccurate and overpaid. The Department's response acknowledged that the claims would need to be re-billed correctly in order for the proper payments to be made. Despite this, the Department disputes all $2.8 million in findings based on a very small sample of the 62,847 claims it reviewed. Further, the Department's response to our follow-up report contradicts itself because the Department disagrees with all $2.8 million in findings yet acknowledges OMIG already recovered $34,702 related to the finding and states additional recoveries will be made.

Further, the Department's statement that it "advised OSC of this error with appropriate supporting documentation, but OSC did not adjust their audit finding nor did they explain the rationale for failing to accept the Department's initial response" is false. Based on the results of the Department's sample review and its response to our preliminary audit report and the audit closing conference, we included the Department's position in the draft audit report, the final audit report (page 9 and in our comments to the Department's response to the final audit report), as well as in our follow-up report. In fact, we reviewed the 62,847 claims to determine the potential impact the Department's concern had on our population and, based on that, we included the corresponding claim count and improper payment amount (12,900 claims and $597,402) in our draft audit report and final audit report. In addition, we acknowledged that "improper billings may have caused other portions of the APG claims to be underpaid," and that the Department "should review all the improperly billed claims to ensure that all providers are paid appropriately" regardless of an over- or underpayment.

Lastly, the Department notes that some of the claims from the audit findings are no longer recoverable. However, the Department has no excuse for failing to review these improper payments and correcting payments timely because we provided SQL extraction code and the claim findings file back on July 5, 2018 – over 2.5 years ago. We encourage the Department to review the improper claims and recover overpayments promptly.

Recommendation #5:

Design and implement eMedNY edits to prevent improper payments of VFC Program vaccines and administration fees on APG, ordered ambulatory, and pharmacy claims.

Status – Partially Implemented

Agency Action - The Department implemented a pharmacy claims edit in May 2019 that prevents payments for vaccines available for free through the VFC Program. In addition, in July 2020, the Department updated its grouper/pricer logic to help prevent improper payments on APG claims. The Department is still researching and evaluating its current system edits, as well as possible system changes for ordered ambulatory claims.

Response #5:

The Department has implemented systems edits that are currently in place for APG, ordered ambulatory, practitioner and pharmacy VFC Program vaccine claims.

Recommendation #6:

Ensure all VFC Program policies and guidance are up-to-date and formally advise providers on how to properly bill Medicaid for VFC Program vaccines and administration fees.

Status – Partially Implemented

Agency Action - In July 2020, the Department issued a Medicaid Update (the Department's official publication for Medicaid providers) that formally advised providers on Medicaid fee-for-service's vaccine coverage policy and instructed providers on how to properly bill Medicaid for VFC Program vaccines and administration fees.

Our initial report noted that the billing guidance in the APG Provider Manual was contrary to instructions in the September 2012 Medicaid Update and that, in addition to re-issuing billing guidance in a Medicaid Update, the Department should update its APG Provider Manual to reflect the instructions in the Medicaid Update. The Department has still not updated the contradictory billing guidance in the APG Provider Manual. Specifically, the manual directs providers to bill VFC Program vaccines as ordered ambulatory claims.

Response #6:

The Department is currently in the final stages of updating the APG Provider Manual in its entirety and is incorporating the policies published in the July 2020 Medicaid Update article in order to recommunicate the Department's guidance on the proper billing of vaccinations.