NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

March 6, 2019

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

Dear Mr. Shulman:

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 2017-S-41 entitled, "Improper Medicaid Payments for Childhood Vaccines."

Please feel free to contact Estibaliz Alonso, Assistant Commissioner, Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

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

Enclosure

cc: Estibaliz Alonso

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2017-S-41 entitled, "Improper Medicaid Payments for Childhood Vaccines"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2017-S-41 entitled, "Improper Medicaid Payments for Childhood Vaccines."

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.

Response #1:

Detail of the $29.8 million in potential overpayments was received by the Department on September 12, 2018. The Department will collaborate with the Office of the Medicaid Inspector General (OMIG) to review the improper payments and identify where overpayment has occurred. Findings will be distributed to the Managed Care Organizations (MCOs) with instructions to review, recover and properly report any recoveries on their Medicaid Managed Care Operations Reports (MMCORs). The OMIG will determine if the MCOs properly account for the recoveries on their MMCORs. However, the Department is concerned that the OSC does not differentiate between potential overpayments and actual overpayments and characterizes both as improper payments.

In addition, OSC's $29.8 million in potential overpayments consists of institutional and professional encounters. The statement on page 7 of the report "…encounter claims, and the payments reported on them are built into the monthly managed care premium rates" is not accurate because the Department does not use encounter data to develop the non-pharmacy portion of the base medical component of the monthly capitation rate. That portion of the base medical component relies on data from the MMCORs.

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.

Response #2:

The Department will issue plan guidance to instruct the MCOs on the proper payment of Program vaccine administration fees for all eligible members. Instructions will 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; MCOs are not paying for the cost of Program vaccines; and administration units do not exceed the number of vaccines administered.

Recommendation #3:

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

Response #3:

The Department and the OMIG will work collaboratively to monitor the issue and ensure MCOs are properly paying providers for Program vaccines. The Department will require MCOs to develop and implement appropriate claims processing edits to prevent overpayment of claims.

Recommendation #4:

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

Response #4:

Fee-for-Service Payments: Ambulatory Patient Group (APG)

The Department has concerns with OSC's methodology of the calculation and the amount of the overpayment identified for APG clinic claims. However, despite these concerns, the Department takes seriously its obligation to prevent inappropriate payments and is reviewing ways to strengthen existing requirements and procedures.

In this particular finding, OSC's calculation of the potential overpayment assumes that all immunization claims reimbursed above $17.85 for vaccine administration billed with a vaccine administration procedure code are overpaid claims. The Department has advised OSC that the universe of claims must be re-run through the APG grouper/pricer to determine whether the claim is overpaid. To calculate the actual amount that Medicaid would have paid for the claim if billed correctly, the adjusted claims must include the immunization procedure code appended with only an "-SL" modifier and no vaccine administration code. The calculated amount then needs to be compared to the actual amount that was paid for the claim in question.

OSC acknowledged that it is necessary to re-run the claims through the APG grouper/pricer to determine whether a claim payment is improper, however, OSC is not able to re-run the claims and therefore, has identified the payments as "potential" overpayments. The Department therefore questions the extent of the overpayment, if any.

Fee-for-Service Payments: Non-APG

The Department is in the process of reviewing the claims to verify the overpayment amount.

The OMIG reviewed the identified payments and will pursue recovery of any payment determined to be inappropriate.

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.

Response #5:

The Department will evaluate the need for system changes for APG, ordered ambulatory, and pharmacy 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.

Response #6:

The Department will re-issue billing guidance for vaccines. Provider billing guidance for Vaccines for Children Program (VFC Program) vaccines will be contained in a Medicaid Update. Pharmacy billing guidance for VFC Program vaccines will be contained in a Medicaid Update article and an email notification to billing providers.

Office of the State Comptroller's Comments:

OSC Comment #1:

The Department is misrepresenting the audit work. We shared detail of the $29.8 million in actual overpayments with OMIG, which investigates and recovers improper Medicaid payments on behalf of the Department, on August 10, 2018. OMIG confirmed receipt on August 14, 2018. Nevertheless, we are pleased the Department is collaborating with OMIG to review and recover the overpayments.

Response to Comment #1:

In terms of the OSC assertion that the Department is misrepresenting the audit work, the Department respectfully disagrees with the statement.

OSC Comment #2:

The Department's assertions are misleading. Our methodology was straightforward, based on facts, and agreed to by OMIG. We used payment information reported by MCOs to the Department on encounter claims to identify actual overpayments made. Specifically, we compared the amount an MCO paid to a provider to the amount that should have been paid using the Department's and federal government's payment policies related to VFC Program vaccines. As such, we are concerned as to why Department officials believe claims that reimbursed providers an amount higher than allowed under the Medicaid State Plan may in fact be appropriate. We also note that we used a conservative approach to identify the $29.8 million in actual overpayments. Specifically, we used the maximum allowable administration fee of $25.10 to calculate the overpayments. As the Department is aware, MCOs can pay providers up to $25.10, but can also pay lower amounts – in which case, the actual overpayments would be

higher than $29.8 million. Nonetheless, officials agreed to review the $29.8 million in overpaid claims and ensure recoveries are made.

Response to Comment #2:

The Department disagrees with the assertion that the OSC's methodology was straightforward. The following issues were identified with the file the OSC provided:

- The Transaction Control Number (TCN) used to identify the encounters was improperly formatted, preventing the Department from doing any review.
- The Department has questioned the $29.8 million identified in the OSC's report as it is unable to reconcile the encounter records within the file to this amount.

The Department acknowledges that a revised file of the encounters in question was received on February 1, 2019 and the TCN issue has been addressed.

OSC Comment #3:

We are aware of the Department's methodology for setting managed care premium rates. The MCOs report their medical costs on their MMCORs. The medical costs are derived from the MCOs' claim payments to providers, which are represented on the encounter claims submitted to the Department. Regardless, we modified the language on page 7 of the report to clarify the statement.

Response to Comment #3:

The Department would like to highlight the inaccuracy made in the OSC's statement that encounters were submitted to the eMedNY claims processing system (page 5), when in fact there were distinct systems within eMedNY to process claims submitted for payment and managed care encounter data. Lastly, from page 7, the Department suggests that the term "medical expenditures" rather than "claims payments" is a more accurate description of a component used to calculate the monthly managed care premium rates.

The Department also notes that the VFC Program audit, while initially focused on the review of the Fee-For-Service claims, was later expanded to the Department's managed care program without feedback from the Division of Health Plan Contracting and Oversight, the regulatory overseer of the Department's managed care program.

Nonetheless, the Department stands by our initial response whereby we agree to review the $29.8 million in potential overpayments and will work with the OMIG to ensure that where appropriate, recoveries are made and properly reported.

OSC Comment #4:

We acknowledged the Department's concern with our calculation on page 9 of this report. We reviewed the 62,847 improperly billed claims and found 12,900 (about 20 percent) of the claims where the Department's concern existed. We remind Department officials that, while each corrected overall claim payment amount is unknown without running the claims through the APG grouper/pricer, the individual line item(s) of each claim we identified was inaccurate and overpaid. The Department acknowledged that the claims would need to be billed correctly in

order for the proper payment to be made. As we reported, the 62,847 claims were not billed correctly (i.e., in accordance with Department policy) and resulted in improper payments.

Response to Comment #4:

The Department stands by its original response and respectfully disagrees with OSC's methodology of the calculation and the amount of the overpayment identified.

OSC Comment #5:

The Department's response does not address preventing improper payments on ordered ambulatory and pharmacy claims.

Response to Comment #5:

The comment was addressed with changes to the Department's response above.

OSC Comment #6:

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.

Response to Comment #6:

The Department is currently in the final stage of updating the APG manual. The Department will ensure that the provider billing instructions are reflected in the APG manual.