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Executive Deputy Commissioner

January 22, 2019

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 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 2018-F-28 entitled, "Improper Medicaid Payments to Eye Care Providers" (Report 2015-S-6).

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
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Department of Health
Comments on the
Office of the State Comptroller's
Follow-Up Audit Report 2018-F-28 entitled,
Improper Medicaid Payments to Eye Care Providers (Report 2015-S-6)

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2018-F-28 entitled, "Improper Medicaid Payments to Eye Care Providers."

Recommendation #1

Review the Providers' applications/revalidations to determine if their ownership and control interest disclosures were complete and accurate, and in compliance with regulations. Where necessary, consider remedial actions to ensure compliance, impose sanctions, or remove Providers from the Medicaid program.

Status – Partially Implemented

Agency Action – In our initial audit, we determined the Department's application and revalidation processes did not ensure optical establishments listed the names of individuals with an ownership or control interest. Therefore, the Department did not always have knowledge of who controlled or was liable for the establishment's conduct or whether these individuals were excluded or sanctioned by Medicaid or other health insurance programs, such as Medicare. Nine of the 16 optical establishments we reviewed did not list an individual as an owner. For example, one optical establishment was allowed to enroll without identifying any owners or parties with controlling interest. This establishment only listed two compliance officers. Since the initial audit, the Department has established ownership in eMedNY for four of the nine optical establishments. The Department is in the process of obtaining ownership information for another four optical establishments. The remaining optical establishment was terminated from the Medicaid program during the initial audit.

Response #1

The Department disagrees that recommendation #1 was partially implemented. The actions below demonstrate the recommendation is fully implemented.

The Department has taken action to obtain the nine updated optical establishment applications. Since the initial audit request, four of the nine identified establishments did revalidate with Medicaid, which includes providing updated ownership information. These applications are currently at the Office of the Medicaid Inspector General (OMIG) for review.

The Department sent revalidation letters to another four optical establishments identified in the audit on October 11, 2018; however, updated applications have not been returned. The providers will be notified of this requirement again in January 2019. This letter will notify the providers that they have 45 days to revalidate or they will receive a termination notice. Upon receipt of the termination notice the provider has 30 days to respond. Participation in Medicaid will be terminated if the provider does not revalidate.

As noted in the report, the Department terminated one provider from the Medicaid program during the initial audit.

Since the initial audit the Department has updated its forms requiring businesses to identify the individual owners, the officers of a corporation and affiliations with other businesses. In August 2018, the provider community was also notified of this change.

Recommendation #2

Revise the Optical Establishment Enrollment Application and Revalidation form to capture all required affiliation data, and establish procedures to verify the accuracy and completeness of ownership, control interest, and affiliation data.

Status – Implemented

Agency Action – The Department revised the Optical Establishment Enrollment Application and Revalidation form in August 2018. The form now specifies that all other business addresses of the owners of optical establishments must be listed. A hyperlink to the regulations that define agents, managing employees, and those with a control interest has also been added to the form to clarify which individuals affiliated with the optical establishment must be identified. Additionally, the Department created a new form, Disclosure of Other Businesses at Same Location, which is required to be completed by all optical establishments upon enrollment and revalidation. Eye care providers were notified of this new form on October 31, 2018.

The Department established new procedures to be completed for all optical establishment enrollment applications and revalidations. The Department now performs an eMedNY search for other optical establishments located within the same zip code to determine if other optical establishments are operating out of the same location. The Department also uses Google street views to help confirm business name, phone number, and the number of optical establishments at the business address. Furthermore, the Department now searches eMedNY using key fields from the enrollment applications and revalidations, such as name, Social Security number, federal employer identification number, national provider identifier, and/or license number, to help verify the completeness of ownership, control interest, and affiliation information.

Response #2

The Department confirms agreement with this report.

Recommendation #3

Consider using other technical tools and resources to verify information reported by providers on applications and revalidations.

Status – Implemented

Agency Action – As mentioned in the Agency Action section of Recommendation 2, during all reviews of optical establishment enrollment applications and revalidations, the Department now searches eMedNY using zip codes and other key fields to identify provider affiliations, including other optical establishments located at the same address, and uses Google street views to help verify the information reported on applications and revalidation forms.

Response #3

The Department confirms agreement with this report.

Recommendation #4

Coordinate operational procedures between the Department's provider enrollment staff and the OMIG to ensure identification of providers with elevated enrollment or revalidation risk and to conduct additional integrity steps as appropriate.

Status – Implemented

Agency Action – The Department and OMIG have agreed on specific language to be used in order to improve communication between the agencies and prompt OMIG to conduct additional review steps for providers with elevated enrollment or revalidation risk. The Department will now specify the reasons for referring an application or revalidation to OMIG as well as the expectations of OMIG as it relates to the matter.

Response #4

The Department confirms agreement with this report.

Recommendation #5

Review the Medicaid overpayments totaling $34,625 for the 1,177 improper procedures and recover payments as appropriate.

Status – Partially Implemented

Agency Action – The initial audit determined the Providers improperly reported, and the Department paid, $16,542 in excessive Medicare coinsurance claims and an additional $18,083 in improper claims for services not supported by proper medical records. OMIG investigates and recovers improper Medicaid payments on behalf of the Department. In December 2017, as a result of our initial audit, OMIG opened investigations for the providers with identified overpayments.

Response #5

The OMIG has an open active investigation of these providers. The OMIG will review the claims as part of the investigation and determine an appropriate course of action.

Recommendation #6

Instruct the Providers that, in submitting claims, they must use the Medicaid identification number of the entity that rendered the services.

Status – Implemented

Agency Action – In the initial audit, we determined that at least one of the Providers billed for services under another Provider's Medicaid identification number. In September 2017, the Department mailed letters to all the Medicaid providers listed under the 34 provider identification numbers reviewed in the initial audit to remind them that optical establishments must bill with the Medicaid provider identification number of the entity that rendered the services. A reminder was also sent to all Medicaid vision care providers in September 2017.

Response #6

The Department confirms agreement with this report.

Recommendation #7

Monitor the Providers' claims to prevent improper payments, including excessive coinsurance payments.

Status – Partially Implemented

Agency Action – The initial audit determined the Providers improperly reported, and the Department paid, $16,542 in excessive Medicare coinsurance claims. In response to our audit, the Department implemented pre-payment reviews for 8 of the 34 provider identification numbers. As a result, documentation for certain claims with potentially inaccurate Medicare coinsurance amounts can be reviewed by the Department to determine whether a Medicaid payment should be made.

Our initial audit also found that the Providers billed for services with missing, inadequate, or altered supporting documentation, resulting in improper payments of $15,967 for 640 procedures. Additionally, our initial audit found they billed for services rendered by other providers owned or managed by the same individual(s), resulting in improper payments of $2,116 for 63 procedures. For example, services were billed by one optical establishment, but the services were actually provided by another optical establishment located at the same address. Therefore, the providers under review could circumvent the Department's pre-payment review by billing under another Provider's Medicaid identification number. Likewise, the current pre-payment reviews do not assess whether improper payments continue to be made as a result of inadequate supporting documentation.

Response #7

The Department placed the remaining 26 providers on Edit 1142 (Provider on Review) for all crossover claims. All 34 identified providers will remain on 1142.

The Department will develop and implement controls to ensure payments are only made for medically appropriate services that are consistent with the Medicaid Fee for Service policy.