



Department of Health

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Governor

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

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

June 17, 2016

Mr. Brian Mason
Assistant Comptroller
Division of State Government Accountability
NYS 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 2013-S-1 entitled, "Eye Care Provider and Family Inappropriately Enroll as Recipients and Overcharge for Vision Services."

Please feel free to contact me at (518) 474-2011 with any questions.

Sincerely,

A handwritten signature in black ink that reads "Howard Zucker M.D." in a cursive, slightly stylized script.

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

Enclosure

**Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2013-S-1 entitled,
Eye Care Provider and Family Inappropriately Enroll as Recipients
and Overcharge for Vision Services**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2013-S-1 entitled, "Eye Care Provider and Family Inappropriately Enroll as Recipients and Overcharge for Vision Services."

Background

New York State (NYS) is a national leader in its oversight of the Medicaid Program. With the transition to care management, the Office of the Medicaid Inspector General (OMIG) continues to improve upon our processes and direct our resources to match this changing direction in the Medicaid program. In conjunction with the Department, NYS will continue its focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse wherever it exists.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of 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 1,405,500 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to \$7,868 in 2014, consistent with levels from a decade ago.

Recommendation #1

Coordinate with Human Resources Administration (HRA) officials to investigate the five identified recipients who had not yet been investigated. Such coordination should include an assessment of the recipients' Medicaid eligibility, deactivation of the Medicaid identification numbers of those determined to be ineligible for benefits, and the recovery of any improper payments identified.

Response #1

OMIG will continue to coordinate with HRA officials to investigate the five identified recipients who had not yet been investigated to determine if they were eligible for benefits, and take appropriate actions based on the findings.

Recommendation #2

Review and recover the improper Medicaid payments made to the Provider including 69 services totaling \$2,050 in overpayments that the Provider did not void and \$4,443 in Medicaid payments that did not have supporting documentation.

Response #2

OMIG is currently investigating the overpayments that the Provider did not void or did not have supporting documentation for.

Recommendation #3

Review the remainder of the Provider's Medicaid claims (not tested as part of the audit) to determine the extent to which the Provider submitted other improper claims, and recover improper payments, as warranted.

Response #3

OMIG is currently investigating the Provider to determine if there are other improper claims.

Recommendation #4

Assess the appropriateness of the Provider's future participation in the Medicaid program, and take the necessary steps to remove the Provider from the program if warranted.

Response #4

OMIG will assess the appropriateness of the Provider's future participation in the Medicaid program, based on the findings of the investigation, and take appropriate action at that time.

Recommendation #5

Assess whether the eMedNY system edit noted in this report should be set to deny inappropriate and/or excessive claims.

Response #5

Claim Edit Code 02015 was activated April 1, 2015, with a Pend disposition for all media types of Eye Care claims. Department staff performing adjudication reviews of the pended eye care claims have identified a consistently high rate of denials, indicating the edit is effectively identifying and suspending these claims from payment. Therefore, the Department requested Computer Sciences Corporation change the disposition for all media types of eye care claims that hit edit 02015 be changed to Deny.

Recommendation #6

Formally advise the providers noted in this report of the Department's requirements for updating changes to business ownership, address, and/or affiliations.

Response #6

The Department formally notified the Providers identified in this audit report of the requirements for updating changes to business ownership, address, and/or affiliations.

Recommendation #7

Deactivate the two ETINs that the owner of the billing company established.

Response #7

The New York State Attorney General's (AG) office investigated the potential forgery and declined to prosecute. The Department will review internal documents for irregularities or suspicions of waste, fraud or abuse and refer its findings to the OMIG for their review.

Deactivation of Electronic Transmitter Identification Numbers (ETINs) has not been used by the Department for program integrity purposes. This would only prevent the provider from submitting all claims electronically. The Department already has the providers in question on review. If there is a suspected case of fraud, waste or abuse, the Department and OMIG consult with the AG to determine the appropriate course of action regarding their continued enrollment in the Medicaid program.

Recommendation #8

Using a risk-based approach, assess the propriety of claims billed through the two ETINs that the owner of the billing company established.

Response #8

Department staff completed their review and identified 13 claims (20 claim lines) from the OSC supplied spreadsheet entitled "Corrected OVP for Missing Doc" that were still available in the eMedNY claims inquiry system. Staff conducted a 100% review of available claims/claim lines. In response to OSC's finding that the provider used a non-Medicaid-enrolled billing service company to submit claims: eMedNY system enhancements, known as Ordering/Prescribing/Referring/Attending (OPRA) edits, were initiated on January 1, 2014 to identify and deny claims submitted by non-enrolled providers and billing services. The review found that all claims were submitted prior to the January 1, 2014 implementation of these edits. Additionally, all claims reviewed were Medicare crossover claims which do not contain an originating New York State ETIN of the provider's billing service. The OPRA edits require a billing service's or provider's ETIN to search the file for enrollment dates. Medicare crossover claims are first submitted by a provider or billing service to Medicare, according to Medicare claim submission guidelines (which do not require the state assigned ETIN). Once Medicare processes the claim, it forwards (or "crosses over") the claim information directly to the state. Therefore, even if the OPRA edits were in place at the time of claim submission, the system would not have been able to detect whether the billing service was currently enrolled. Based on these review findings, the eMedNY system correctly processed submitted claims with the functionalities present and with claim information supplied at the time of submission.

State Comptroller's Comments:

OSC Comment #1:

We were aware of policy 08 OHIP/ADM-4, which requires districts to verify the accuracy of the income reported by recipients to re-determine Medicaid eligibility. In particular, the policy states, "In lieu of income documentation, local social services districts must verify the accuracy of the income information provided by the recipient by comparing it to information to which they have access, such as RFI (Resource File Integration) ..." data. As detailed on page 8 of our report, the family we identified provided a check as proof of

income upon recertification. Given the documentation provided, we questioned HRA officials why the recipients continued receiving benefits despite their RFI, which showed income above the eligibility limits. HRA officials responded that HRA processed over 70,000 re-certifications each month, and therefore, a thorough review of each case was not possible. Also, based on the Department's comments, we modified the pertinent statements on page 8 of the report, as appropriate.

Response to Comment #1:

The Department agrees with the changes to the pertinent statements on page 8 of the report as a result of the Department's comments.

OSC Comment #2:

On July 16, 2014, we provided written preliminary audit observations to the Department which identified the edit in question as "edit 02015," the same edit identified in the Department's response. Moreover, we are pleased the Department activated edit 02015 in April 2015 and has requested the claims administrator to deny claims which hit that edit.

Response to Comment #2:

The Department's response to OSC's comment #2 is included in the revised response for recommendation #5.