STATE OF NEW YORK
DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION
THE HARRIMAN STATE CAMPUS – BUILDING 2
1220 WASHINGTON AVENUE
ALBANY, N.Y. 12226-2050

ANDREW M. CUOMO
GOVERNOR

BRIAN FISCHER
COMMISSIONER

February 19, 2013

Ms. Carmen Maldonado
Audit Director
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

Dear Ms. Maldonado:

The Department of Corrections and Community Supervision (DOCCS) has reviewed the Office of the State Comptroller's Final Audit Report 2010-S-4, *Payments for Inmate Health Care Services.* In accordance with Section 170 of the Executive Law, DOCCS's ninety day reply to the audit is attached.

We are complying with the provisions of the Budget Policy and Reporting Manual, Item B-140, by simultaneously forwarding two copies of this response to the Division of the Budget.

DOCCS would like to acknowledge the time and effort of all employees that were involved with this audit and their desire to improve the Department's operation.

Sincerely,

Brian Fischer
Commissioner

Attachment

cc: Governor Andrew M. Cuomo
Lieutenant Governor Robert J. Duffy
Senator Dean G. Skelos
Senator Jeffrey Klein
Senator Liz Krueger
Senator Andrea Stewart-Cousins
Senator John A. DeFrancisco
Senator Patrick Gallivan
Assemblyman Sheldon Silver
Assemblyman Joseph D. Morelle
Assemblyman Herman D. Farrell
Assemblyman Brian M. Kolb
Assemblyman Jim Hayes
Division of the Budget

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BRIAN FISCHER
COMMISSIONER

CARL J. KOENIGSMANN, M.D.
DEPUTY COMMISSIONER/
CHIEF MEDICAL OFFICER

February 14, 2013

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

Re: Final Report 2010-S-41, Department of Corrections and Community Supervision *Payments for Inmate Health Care Services.*

Dear Ms. Maldonado:

The Department of Corrections and Community Supervision (DOCCS) has reviewed Report 2010-S-41 *Payments for Inmate Health Care Services*, and, as required by Section 170 of the Executive Law, this letter serves as the DOCCS' official ninety day response to your report dated December 5, 2012. We have included our original comments from October 25, 2012 and have added additional comments in italic bold print.

The Report states that the State could save an estimated $20 million annually if DOCCS billed Medicaid for eligible offender inpatient care. While DOCCS has been doing this, we want to note that estimated savings is speculative, since we do not know the percentage of offenders who are eligible for Medicaid. It was also noted that medical costs for offenders has increased at DOCCS from April 1, 2008 to March 31, 2010 while the offender population has decreased. While medical costs have gone up, so have other Agency expenses. It should be noted that the total cost of health expenditures as a percentage of total DOCCS expenditures has decreased from 14.84% during fiscal year 2008-09 to 13.09% during fiscal year 2009-10 to 12.01% during fiscal year 2010-11. DOCCS notes that the 62% increase in health spending between FY 1999-2000 and FY 2010-2011 which OSC cites can be attributed to three significant changes: the NYS employee union negotiated salaries

increased by 34.75% during this time period, the BLS Consumer Price Index for Medical Services increased by 54.70% during this time period and most DOCCS health care contracts allot CPI increases year to year to keep up with inflation, and DOCCS opened up two new Regional Medical Units, two new maximum security facilities with high levels of medical care, and a 30 bed Unit for the Cognitively Impaired (UCI) all with the intent of reducing medical costs in the long term.

Additionally, new AIDS and Hepatitis C treatments came into existence during this time period which resulted in an increase in drug and lab expenditures as more offenders were put onto these multi-drug therapies. DOCCS continues to explore avenues to reduce medical costs while maintaining or improving health care quality.

Another concern for DOCCS were changes in the data and overcharges presented in the draft report from the four preliminary findings presented to DOCCS in November and December of 2010. The more specific discrepancies are indicated below:

- Hourly Clinics: Final draft report indicates five providers were overpaid $84,483.00. The Preliminary Finding indicated five providers were overpaid $83,635.22. However, DOCCS discovered additional overpayments and to date DOCCS has collected $78,966.27 in overcharges and is in the process of collecting $46,132.85 over the next year.

DOCCS notes that OSC subsequently amended the report based on the information in the report.

- Double Billing: The two claims overcharged in the amount of $4,134.99 cannot be identified. Please provide the detail on these two claims.

OSC did subsequently provide this information.

- The final draft report indicates OSC identified 424 instances where the Department overpaid $32,708.00 in separate fees that were already included in the payments for the primary procedures. DOCCS had discussed this with OSC at the time of this audit and the issue concerning modifiers for professional and technical components and the claims that we reviewed did not result in overpayments.

DOCCS agrees that the codes identified should not have been billed with modifiers. However, the inclusion of these modifiers by these providers would not result in any incorrect or duplicate payments. Some current procedural terminology (cpt) codes include 3 different reimbursement rates – the global rate which is the full payment, and the professional component (modifier 26), and the technical component (modifier TC) which are both reductions of the global rate. These modifiers are used to indicate a reduction from the global payment rate when appropriate. These modifiers are not used to indicate an additional charge or service. The codes identified by OSC are only paid at the global rate and do not include a professional or technical rate. For this reason we would disregard the modifier and pay at the proper global amount. The fact that the providers erroneously included modifiers on these claims would not result in incorrect or

duplicate payments. The first 10 claims on the list provided by OSC were reviewed. Corresponding claims tied to these 10 claims were pulled and reviewed to determine if any duplicate payments were made as a result of providers billing the modifier code. It was determined that no duplicate payments were made. Copies of these claims are available.

Since OSC's recommendation and DOCCS' interest are to recover these overcharges, DOCCS requests that OSC provide the supporting documentation to these discrepancies.

DOCCS' responses to the eight OSC recommendations are as follows:

Recommendation #1: Collect overpayments made to providers cited in this audit.

DOCCS Response: DOCCS agrees in part. DOCCS has recovered and is still seeking reimbursement for the overcharges cited in OSC's preliminary findings. Currently, DOCCS has collected $78,966.27 in overcharges and is in the process of receiving $46,132.85 over the next year. DOCCS is requesting the supporting documentation from OSC for the overcharges cited in this report, but not disclosed in the preliminary findings.

DOCCS agrees in part. DOCCS has recovered overcharges cited in OSC's preliminary findings in the amount of $62,927.05. Overcharges cited by OSC still to be collected total $1,158.85. DOCCS disagrees with overcharges cited by OSC totaling $44,154.98 and will not be seeking reimbursement. Attached is a list identifying the providers and the reasons DOCCS will not be seeking reimbursement. Overcharges cited by OSC totaling $20,909.08 are pending review. DOCCS payment reviews identified an additional $61,730.60 in overpayments. To date, $32,036.50 has been collected and $29,694.10 remains to be collected.

Recommendation #2: Test samples of future payments to service providers to determine if recovery for overcharges is necessary.

DOCCS Response: DOCCS disagrees. DOCCS has developed a *Clinic Hours Tracking Form* in triplicate to be used by the health care provider and verified by the facility medical staff to document the hours that the health care provider was at the facility. It is signed by a facility medical supervisor with a copy issued to the health care provider and the DOCCS Medical Bill Payment Unit where it is reconciled with the medical bill from the provider. This recommendation is not necessary due to this new process which was developed after the OSC audit.

In response to OSC's subsequent comment that the Clinic Hours Tracking Form is a good control, however, some periodic testing of payments besides clinic claims should be done, DOCCS agrees. DOCCS uses an outside vendor, APS Healthcare Bethesda Inc. (APS), to review health care referrals to determine if the health care referral is medically necessary. APS also reviews a percentage of inpatient and outpatient billings for appropriateness and receives a commission for any overpayments they discover. Since APS began their review of outpatient billing in December 2010 to present, APS has recovered $48,221.00 in overpayments for

DOCCS. During this same time frame, APS has recovered $1,074,128.22 for DOCCS in overpayments from inpatient claims.

Recommendation #3: Review claims to determine if procedure codes are being inappropriately separated resulting in overcharges.

DOCCS Response: DOCCS agrees. DOCCS uses an outside vendor, APS Healthcare Bethesda Inc (APS), to review health care referrals to determine if the health care referral is medically necessary. APS also reviews a percentage of inpatient and outpatient billings for appropriateness and receives a commission for any overpayments they discover. Since APS began their review of outpatient billing in December 2010 to present, APS has recovered $48,221.00 in overpayments for DOCCS. During this same timeframe, APS has recovered $1,059,325.00 for DOCCS in overpayments from inpatient claims.

DOCCS agrees. APS Healthcare Bethesda Inc. reviews a portion of outpatient billings for appropriateness as cited in DOCCS response #2 above.

Recommendation #4: Verify that the actual hours worked in connection with clinic services agree with the hours billed and paid for.

DOCCS Response: DOCCS agrees. As cited in recommendation #2, DOCCS uses the *Clinic Hours Tracking Form* to be used by the health care provider and verified by the facility medical staff and forwarded to the DOCCS Medical Bill Payment Unit to document the hours that the health care provider was at the facility.

DOCCS agrees. DOCCS has developed a Clinic Hours Tracking Form in triplicate to document the hours that the health care provider was at the facility. The health care provider completes the form and submits to a facility medical supervisor who in turn verifies that the hours reported are correct. A copy is returned to the health care provider to submit to the Medical Bill Payment Unit with their claim. The medical supervisor then sends an original directly to the Medical Bill Payment Unit so it can be matched with the copy received from the health care provider to confirm there are no discrepancies.

Recommendation #5: Research alternatives to electronically capture all procedure codes and modifiers on paid claims for analysis of billing accuracy and appropriateness.

DOCCS Response: DOCCS agrees. DOCCS agrees to investigate the need and possibility of expanding the parameters currently used by APS for review. Currently APS utilizes several triggers to target claims for audit such as dollar amount thresholds, evaluation codes combined with procedure codes and inpatient versus outpatient evaluation codes. DOCCS is currently in the process of purchasing Ambulatory Patient Groups (APG) software from 3M Corporation to be used by the Medical Bill Payment Unit to calculate Medicaid rate based outpatient payments, and All Patient Refined Diagnosis Related Groups (APR DRG) software also from 3M Corporation to Calculate Medicaid rate based inpatient payments. While this will not aid in capturing procedure codes and modifiers on the FHS-1 system, we believe that the use of this software, that is the same used by Medicaid as well as

hospitals to calculate Medicaid payments, will increase the accuracy of payments over the current process in which payment amounts are manually calculated. It should be noted that the FSH-1 system was developed for the purpose of scheduling offender medical visits and not for auditing bills. DOCCS' Management Information Services (MIS) unit indicated that to program such edits into the current FSH-1 system would be costly and time consuming.

DOCCS agrees. DOCCS has subsequently purchased the APG software which is being installed by the Management Information Services (MIS). Appropriate staff will need to be trained on this software.

Recommendation #6: Establish and use billing standards for periodic analysis of historical paid claims data to identify indications of inaccurate bills, incompatible services and unusually high levels of a service for an inmate. Follow-up on such instances to access their appropriateness.

DOCCS Response: DOCCS agrees in part. DOCCS uses APS to identify inaccurate bills. APS is focusing on unbundling of procedures. DOCCS does not agree with OSC's assumption that we model our healthcare program after Medicaid's program. These are two distinct and separate programs. Medicaid establishes frequency limitations on medical procedures but does not require patients to demonstrate medical necessity of the procedure until the frequency limitation is exceeded. DOCCS, however, will not refer an offender for any medical procedure until DOCCS' primary care medical doctors have examined the offender and deemed the medical procedure as being necessary. The medical referral is then reviewed with APS, to see if it is medically appropriate and meets community standards of healthcare based upon Milliman Care Guidelines which is an industry gold standard used by Blue Cross/Blue Shield organizations, traditional health insurers, managed care organizations, and third party administrators. DOCCS asserts our process provides better healthcare outcomes, is more cost effective and more efficient than the Medicaid model. DOCCS Medical Bill Payment Unit would not benefit from a review of unusually high levels of service for an offender as an internal control procedure since DOCCS Health Service staff and APS have deemed the procedure necessary. The DOCCS Medical Bill Payment Unit needs to only verify if the procedure was done, not if it was necessary.

DOCCS agrees in part. DOCCS contracts with APS to identify inaccurate claims as cited in #2 above. In response to OSC's subsequent comment, DOCCS believes the Medical Bill Payment Unit's role is to verify if medical procedures were done as prescribed and not question if the number of procedures were necessary.

Recommendation #7: Amend the current provider agreements to require the Department to pay for successful procedures.

DOCCS Response: DOCCS agrees in part. The industry standard for paying for unsuccessful procedures includes the use of modifiers to CPT codes. Currently, providers bill for services and use modifier codes when appropriate to bill for unsuccessful procedure attempts. DOCCS agrees that appropriate future provider agreements will include a requirement to use a modifier code to the CPT code for

billing for unsuccessful procedure attempts. Likewise, existing provider agreements will include this same language if the provider agreement is updated. This is commensurate with current industry standards. DOCCS asserts that to change over 1,000 provider agreements is prohibitive. Further, DOCCS asserts the current billing practice of using modifier codes is acceptable industry standard and will continue. This is how this information is captured.

DOCCS' response remains the same.

Recommendation #8: Evaluate the feasibility and cost benefit to seek reimbursement from Medicaid or other third party insurance for medical services from outside providers when appropriate.

DOCCS Response: DOCCS agrees in part. DOCCS, in conjunction with the Division of the Budget (DOB) and the Department of Health (DOH), has been seeking retroactive reimbursement from the Federal Government for inpatient services provide to Medicaid eligible inmates. The Federal Government has provided reimbursements in the amount of $4,589,822.00 to date. DOH is currently receiving the monetary benefit of the Department's effort. DOCCS, DOB, and DOH are also currently working on developing a process in which Inpatient related hospital services provided to Medicaid eligible inmates will be billed directly to Medicaid by the Hospital providing the service. DOCCS Counsel has researched the suggestion on third party insurance coverage payment by offenders and is of the opinion that DOCCS could not unilaterally bill a third party insurance carrier for the medical treatment that we provide to an offender, except for the limited circumstances as provided for in Correction Law §611. DOCCS is legally responsible to provide medical care to offenders, a legal mandate that has been litigated and determined by the highest court in the nation. DOCCS Counsel believes that absent a statute that authorized reimbursement of all medical expenses, DOCCS cannot pursue this option.

Concerning work release offenders, the average cost for a work release offender is from 3% (Rochester Correctional Facility) to 44% (Lincoln Correctional Facility) in comparison to what the average offender's medical cost was in general population during fiscal year 2008 – 2009. Since there are so few work release offenders and their health care costs are already significantly lower, there is little opportunity to reduce costs any further in this area. DOCCS is open to the possibility of reimbursement of health care costs through workers' compensation, however, this rarely occurs to work release offenders. Further, DOCCS would not know if a work release inmate has employer health insurance until the offender is hired. Finally, an offender's spouse can offer to pay for an offender's consultation in accordance with HSPM, Number 7.02, *Inmate Provider of Choice.*

DOCCS agrees in part. DOCCS, in conjunction with the Division of the Budget (DOB) and the Department of Health (DOH), has been seeking retroactive reimbursement from the Federal Government for inpatient services provided to Medicaid eligible inmates. The Federal Government has provided reimbursements in the amount of $5,691,348.00 to date. DOH is currently receiving the monetary benefit of the Department's effort. DOCCS, DOB, and DOH are also currently working on developing a process in which inpatient related hospital services

provided to Medicaid eligible inmates will be billed directly to Medicaid by the hospital providing the service. In response to OSC's subsequent comment that DOCCS should pursue legislation which would allow DOCCS to seek payments from offenders with third party insurance, DOCCS does not agree. In addition to DOCCS Counsel's opinion that there is no legal basis to pursue third party payment, there is no basis to OSC's assumption that there is alternative health care insurance coverage available to offenders and to develop a monitoring system would not be cost effective or practical. DOCCS has consistently noted to OSC that this was not a cost effective or practical suggestion when OSC first made the recommendation in its preliminary finding. DOCCS had not only questioned the legality of OSC's recommendation, but also indicated it was a bad idea. First, most offenders do not have third party health insurance. If they did, the offenders would need to self-disclose that they had it and, raises the question, would they maintain it. The merit of this OSC recommendation is based upon what resources most offenders maintain. Medical complaints are one of the top issues filed with the Inmate Grievance Program. Many of these medical grievances seek a second medical opinion or a different doctor to examine them. Offenders are able to receive medical examinations from their own qualified medical provider if the offender is willing and able to pay for it. Out of approximately 55,000 incarcerated offenders, only a handful of offenders do so. DOCCS asserts that pursuing legislation, developing a monitoring system for offenders with third party insurance, litigating any third party insurance legal actions, and trying to provide medical care through an offender's medical care network would not save the taxpayers any money and could cost more in administrative expenses since the significant majority of the offender population has very limited resources.

DOCCS would like to acknowledge the time and effort of all employees that were involved with this audit and their desire to improve DOCCS' Health Care Program.

Sincerely,

Carl Koenigsmann MD

Carl J. Koenigsmann, M.D.
Deputy Commissioner/Chief Medical Officer

CJK/pb

OSC IDENTIFIED OVERCHARGES NOT COLLECTED

PROVIDER	OSC CALCULATED OVERCHARGES	REASON NOT COLLECTED
Jonathan Holder	$5,960.00	Based on contract language it was reasonable that the doctor would expect this to be his correct reimbursement. Contract language has been revised to clarify and avoid this issue in the future.
Hudson Infectious Disease (Metro Region)	$1,097.82	FHS1 system supports the fact that provider was present at facility for all 3 claims in question. Two clinics were correctly reimbursed at the guaranteed one hour minimum rate. The FHS1 system indicates that 4 inmates were seen in the third clinic which is consistent with the time billed by the provider.
NaphCare	$659.28	The dietician does much of his prep work off site which cannot be verified. Working off site avoids the 6-7 hour drive required to work on site reducing costs that would be charged to DOCCS for travel.
Sundaram Ravikumar	$35,895.65	These claims were identified as containing unsuccessful procedures by OSC. DOCCS pays for unsuccessful procedures.
University at Buffalo Surgeons	$522.23	This claim was identified as containing unsuccessful procedures by OSC. DOCCS pays for unsuccessful procedures.
Richard Wurzel	$20.00	Code 92341 reimbursed at correct rate.
Total	$44,154.98	