THOMAS P. DiNAPOLI
COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

December 27, 2018

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Improper Medicaid Payments to Eye Care Providers
Report 2018-F-28

Dear Dr. Zucker:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we have followed up on the actions taken by officials of the Department of Health to implement the recommendations contained in our audit report, *Improper Medicaid Payments to Eye Care Providers* (Report 2015-S-6).

Background, Scope, and Objectives

The Department of Health (Department) administers the State's Medicaid program, which provides a wide range of health care services to individuals who are economically disadvantaged and/or have special health care needs. Under federal and State regulations, providers must apply for enrollment into the Medicaid program and meet certain requirements in order to provide services to Medicaid recipients. In addition, Medicaid providers must revalidate their enrollment every five years. The enrollment and revalidating processes are intended to prevent improper payments for services rendered by providers who do not meet federal and State requirements for participation in the Medicaid program and to protect Medicaid recipients from receiving care or services from providers who are not qualified (e.g., individuals or entities who may be excluded from Medicare or Medicaid).

Provider enrollment and revalidation serve as first-line defenses in the prevention of Medicaid fraud and abuse and are required in order to obtain a Medicaid provider identification number. Medicaid providers use these numbers to submit claims for services to eMedNY, the Department's Medicaid claims processing and payment system. Providers are prohibited from billing Medicaid for services rendered by other providers.

During the enrollment and revalidation processes, providers are required to disclose complete and accurate ownership, control interest, and managing employee information. The Department reviews enrollment applications and revalidations to ensure that only qualified providers participate in the Medicaid program. The Department coordinates with the Office of the Medicaid Inspector General (OMIG) to conduct site visits and additional screening steps, when necessary, before providers are enrolled or revalidated. When the Department identifies questionable Medicaid claims, the Department may place providers on prepayment review and providers may be required to submit documentation to support their claims prior to payment. Providers who commit fraud, waste, or abuse may face further sanctions, such as denied enrollment, suspension, or termination from the Medicaid program.

We issued our initial audit report on October 6, 2017. The objective was to determine whether certain eye care providers, who appeared to be affiliated, complied with Medicaid provider enrollment rules and if Medicaid paid for improper claims billed by the eye care providers. The audit covered the period from January 1, 2010 through December 31, 2015. We identified vulnerabilities in the Department's provider enrollment and revalidating processes that undermine the Department's ability to (1) ensure that only qualified providers participate in the Medicaid program and (2) prevent improper payments for services rendered by providers who do not meet federal and State requirements. As a result of these weaknesses, six eye care professionals, who jointly owned or operated 16 optical establishments and who did not comply with the Department's Medicaid policies for enrollment and revalidation, were able to obtain Medicaid eligibility under 34 different provider identification numbers without disclosing all of their apparent affiliations (hereafter referred to as Providers). During the six-year audit period, Medicaid reimbursed these Providers about $13 million under the 34 Medicaid provider identification numbers. Additionally, based on tests of samples of claims, we identified 1,177 improperly billed eye care services totaling $34,625. The improper payments involved claims for excessive Medicare coinsurance and services not supported by proper medical records. We made seven recommendations to the Department to review the appropriateness of the Providers' enrollment, enhance controls over the Department's enrollment process, monitor the appropriateness of the Providers' Medicaid claims, and recover improper payments.

The objective of our follow-up was to assess the extent of implementation, as of December 11, 2018, of the seven recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials have made progress addressing the problems identified in the initial audit. For instance, the Department has improved enrollment and revalidation procedures to verify the accuracy and completeness of ownership, control interest, and affiliation data. The Department has also established pre-payment reviews of claims for 8 of the 34 provider identification numbers, and OMIG has opened investigations into the providers we identified as having received improper payments. Of the initial report's seven audit recommendations, four were implemented and three were partially implemented at the time of our follow-up.

Follow-Up Observations

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.

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.

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.

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.

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.

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.

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.

Major contributors to this report were Mark Breunig, Wendy Matson, and Adil Siddique.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Warren Fitzgerald
Audit Manager

cc: Mr. Daniel Duffy, Department of Health
Mr. Dennis Rosen, Medicaid Inspector General