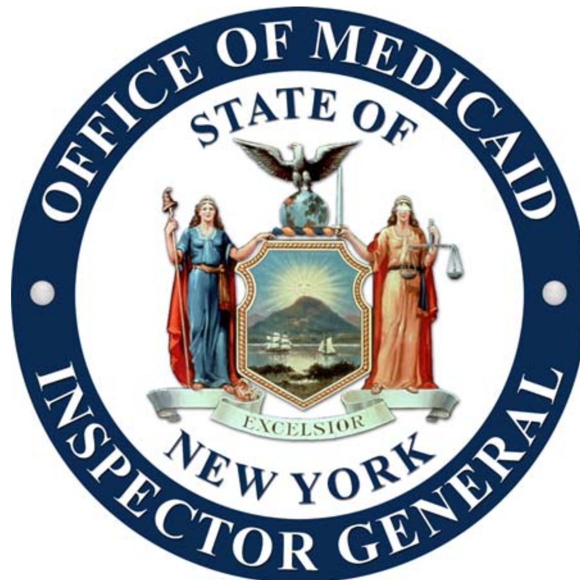
New York State
Office of the Medicaid Inspector General



2009 Annual Report

David A. Paterson
Governor

James G. Sheehan
Medicaid Inspector General

STATE OF NEW YORK

OFFICE OF THE MEDICAID INSPECTOR GENERAL

800 North Pearl Street
Albany, NY 12204

It is my pleasure to submit the Office of the Medicaid Inspector General's 2009 Annual Report.

Public Health Law §35 requires the Medicaid Inspector General to submit an annual report, by October 1, to the Governor, the Temporary President of the Senate, the Speaker of the Assembly, the Comptroller and the Attorney General on activities undertaken by the Office over the course of the preceding calendar year. As required by the Public Health Law, the attached report provides information about the audits, investigations, administrative actions, referrals and civil actions initiated and completed by the Office of the Medicaid Inspector General (OMIG). Additionally, the report includes details about activities initiated and completed covering the outcome, region, and source of complaints and total dollar amounts identified and collected.

With your support, and the cooperation of our agency partners, we expect that New York will continue to lead the nation in identifying and preventing fraud, waste and abuse in the Medicaid program, and promoting program integrity on the front end through cost avoidance, data mining and provider education.

OMIG will continue to improve and preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste and abuse control activities for all State agencies responsible for services funded by Medicaid. We look forward to continuing our work and partnering with you and other state agencies in the future. We welcome any questions you may have concerning items contained in this report or Medicaid fraud, waste and abuse in general.

Sincerely,

James G. Sheehan
Medicaid Inspector General

Executive Summary

As State governments across the nation seek to save taxpayer dollars, policymakers have found Medicaid fraud, waste and abuse to be on the top of their agendas for the past several years. Each state has a greater responsibility to stop abuses and fraud in the Medicaid system.

New York State is no exception. At the end of 2006, the State established the Office of the Medicaid Inspector General as an independent entity to tackle the issues of fraud, waste and abuse within New York State's Medicaid program.

After three years of operation, OMIG has substantially improved New York State's efforts at identifying and preventing Medicaid fraud, waste and abuse. New York has led—and continues to lead—the nation in identifying and recovering improper Medicaid payments.

In 2009, OMIG stressed to Medicaid providers the importance of compliance in health care by introducing and passing a regulation (Part 521 of NYCRR) that took effect on October 1, 2009. This regulation required all Medicaid providers who either bill or receive more than $500,000 in Medicaid payments annually to have an effective compliance program in place, containing eight specific elements outlined in the regulation. Providers then had to certify compliance with this regulation annually by December 31, 2009 through an on-line process. Strong corporate compliance programs at the facility or program level led to awareness and prevention of problems in the Medicaid program, helping the state to avoid making improper payments to providers.

As part of OMIG's corporate compliance efforts, the agency issued its first four corporate integrity agreements (CIAs) in 2009. These are proscriptive management contracts aimed at providers who fail to meet their obligations, but whose removal from the Medicaid program would negatively impact beneficiaries' access to necessary services. Under a CIA, a provider consents to implement specific compliance structures, processes and activities aimed at building integrity on the front end of providing and billing for care, services or supplies. Providers who breach their CIA obligations will face sanctions in the form of stipulated penalties and/or exclusion from the Medicaid program.

Another major initiative in 2009 was OMIG's deceased beneficiary project. OMIG worked with the Department of Health's Office of Health Insurance Programs to create a process for matching death certificate data from vital statistics records to Medicaid provider and recipient information. As this information is updated to the claims system, edits ensure that Medicaid will not pay claims for deceased providers and recipients. This initiative was implemented in May, 2009. Although these changes improved OMIG's ability to match critical data elements, inherent delays in the receipt of death data to the Medicaid program remain, and a certain amount of claims continue to be paid after the date of death. In order to better understand the circumstances behind these claims, OMIG staff started a mailout project beginning with claims that were paid in October, 2009. Providers were asked for proof that the patient had been alive when services were delivered. OMIG posted the names of those providers who failed to respond to the mailout on the agency's website.

In 2009, OMIG achieved success in its audits, investigations and cost avoidance activities. Complete statistics are included as Appendix A in this document; however, the main highlights include:

- OMIG succeeded in saving the state **$1.61 billion** through cost-savings activities (including nearly **$133 million** in recipient restrictions) during 2009.
- During federal fiscal year 2009-10 (October 1, 2008-September 30, 2009), OMIG met and exceeded federal identification and recovery requirements under the Federal-State Healthcare Reform Partnership (F-SHRP). The goal was $322 million, and, in collaboration with OMIG's state agency partners (particularly the New York State Office of the Attorney General), New York reached **$500 million**.
- OMIG initiated 3,697 investigations in 2009, and completed 2,597.
- OMIG excluded 712 providers from participating in the Medicaid program in 2009, and terminated 46.
- OMIG referred 208 cases to the New York State Attorney General for potential prosecution as criminal cases.
- OMIG referred 783 cases to other agencies; the vast majority of those (552) were referred to the New York City Human Resources Administration's Bureau of Client Fraud Investigation for investigation at the local level.
- OMIG auditors initiated 1,852 audits and completed 1,053.

New York State leads the nation in Medicaid fraud, waste and abuse prevention and detection, and serves as a role model for other states to emulate. OMIG continues to stress the importance of Medicaid program integrity at all levels of health care and add innovative approaches to protecting Medicaid integrity. OMIG plays a vital role in the preserving the integrity of the Medicaid for all New Yorkers. The future of this essential health care program for those New Yorkers in need—and for all taxpayers—depends largely on the efforts of this agency. OMIG takes this responsibility seriously and looks forward to serving New York State for many years to come.

Table of Contents

Office of the Medicaid Inspector General 1
OMIG Coordination with Medicaid Program Agencies 3
Relationship with the Attorney General's Medicaid Fraud Control Unit 4
Interagency Workgroup 5
New York State Department of Health 5
Office of Temporary and Disability Assistance 8
Office of Alcoholism and Substance Abuse Services 9
Office of Mental Health 10
Office for People With Developmental Disabilities 11
Office of Children and Family Services 12
Commission on Quality of Care and Advocacy for Persons with Disabilities 12
New York Leads the Way 13
Data Mining 13
Medicaid Program Integrity and Third Party Activities 15
Federal-State Health Reform Partnership 17
Work Plan 19
Division of Medicaid Investigation 20
Functional Description 20
Fraud Activity Comprehensive Tracking System 21
Targeting 21
DMI Units 22
Referrals to AG and Other Agencies 24
Collaborative Efforts 24
DMI Highlights 27
Summary of Fraud Financial Investigations and Referrals 29
Division of Medicaid Audit 30
Functional Description 30
Audit Process 31
Bureau of Provider Audit 34
Bureau of Rate Based Audit 40
Bureau of Managed Care and Provider Review 43
Summary of Audit Activities 48
Division of Administration 49
Bureau of Budget and Fiscal Management 49
Bureau of Collections Management 49
Bureau of Human Resources Management 50
Division of Technology and Business Automation 51
Bureau of Payment Controls and Monitoring 51
System Edits 51
Prepayment Review 51
Bureau of Third Party Liability 57
Cost Savings 58

Pre-Payment Insurance Verification ... 58
Recoveries ... 58
Medicaid Match and Recovery Contract (HMS) ... 58
Systems Match and Recovery Unit ... 59
Medicaid Fraud, Waste and Abuse County Demonstration Project ... 61
Bureau of Allegations and Complaints ... 62
Outreach and Communications Initiatives ... 63
Office of Counsel ... 65
Administrative Actions ... 65
Sanctions – Terminations & Exclusions ... 65
Monetary Penalties ... 67
False Claims Act/*Qui Tam* Activities ... 67
Agency Initiatives ... 68
Deceased Beneficiary Project ... 68
Mandatory Compliance Programs under Social Services Law §363-d ... 68
Deficit Reduction Act of 2005 ... 69
Corporate Integrity Agreements ... 70
Review of Off-Line Medicaid Expenditures ... 70
Payment Error Rate Measurement (PERM) Program ... 71
PERM Plus ... 72
Problems and Concerns ... 73
Conclusion ... 75
Appendix – Operational Statistics ... 1
2009 Investigations by Source and Region ... 1
2009 Fraud Financial Investigations by Region and Project Type ... 2
2009 Summary of Civil Recoveries ... 3
2009 Provider Audits by Type and Region ... 4
2009 Rate Audits by Type and Region ... 8
2009 Managed Care and Provider Review Audits by Type and Region ... 10
2009 Medicaid in Education Reviews by Region and Type ... 12
2009 Systems Match and Recovery by Region and Type ... 13
2009 County Demonstration Project Audits by Region and Type ... 15
Cost Savings Activities ... 16

Office of the Medicaid Inspector General

On July 26, 2006, Chapter 442 of the Laws of 2006 was signed into law, establishing the Office of the Medicaid Inspector General (OMIG) as a formal state agency. The legislation amended the Executive, Social Services, Insurance and Penal laws creating OMIG and starting the reform needed to effectively fight fraud, waste and abuse in the Medicaid system. The State separated the administrative functions and program integrity while still preserving the single state agency structure required by Federal law. Although OMIG remains a part of the New York State Department of Health, it is required by statute to be an independent office. The Medicaid Inspector General reports directly to the Governor.

OMIG's core function is to conduct and supervise activities to prevent, detect and investigate Medicaid fraud and abuse with the goal of assuring integrity in the Medicaid program. Fraud and abuse in the Medicaid program is defined by federal regulation (42 CFR 455.2). Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. Fraud focuses on the state of mind of the individual submitting the claim – that is, did they have the intention to deceive or misrepresent, with knowledge that the deception could result in an unauthorized benefit. Fraud detection and prevention activities focus on providers with bad intent; the goal is to prevent such providers from participating in Medicaid, and to deter them from fraudulent conduct by detection, investigation and prosecution.

Abuse, as defined in 18 NYCRR Part 515, is provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. The definitions of "fraud" and "abuse" are analytically distinct, although the same provider submitting the same claim may engage in both. Abuse focuses on the effect on the program, not on the state of mind of the person submitting the claim. A provider may have the best intentions, but if they fail to provide the services that meet "professionally recognized standards," or provide services that are medically unnecessary or inconsistent with sound practices, or result in unnecessary cost, OMIG has a responsibility to take action involving that provider.

Providers should not receive payments for services which are not medically necessary, are excessive in cost or inconsistent with professional standards; and funds paid to providers for services defined as abuse should be recovered. Such non-payment or monetary recovery is not a punishment; rather, it is recognition that services have failed to comply with a condition precedent to payment.

The Office of the Medicaid Inspector General is responsible for:

- coordinating fraud and abuse control activities with a number of partner agencies:
    - the Department of Health

- the Office of Mental Health, Office for Persons With Developmental Disabilities, Office of Alcoholism and Substance Abuse Services, Office of Temporary and Disability Assistance, and Office of Children and Family Services
    - the Commission on Quality of Care and Advocacy for Persons with Disabilities
    - the State Education Department
    - the fiscal agent—Computer Sciences Corporation (CSC)—employed to operate the Medicaid management information system
    - local and county governments and entities

- working in a coordinated and cooperative manner with, to the greatest extent possible,

    - the State Attorney General's Medicaid Fraud Control Unit
    - the State Comptroller
    - the Office of the Welfare Inspector General

- pursuing civil and administrative enforcement actions against those who engage in fraud, waste or abuse or other illegal or inappropriate acts perpetrated within the Medicaid program;

- keeping the Governor and the heads of agencies with responsibility for the Medicaid program apprised of efforts to prevent, detect, investigate, and prosecute fraud, waste and abuse within the Medicaid system;

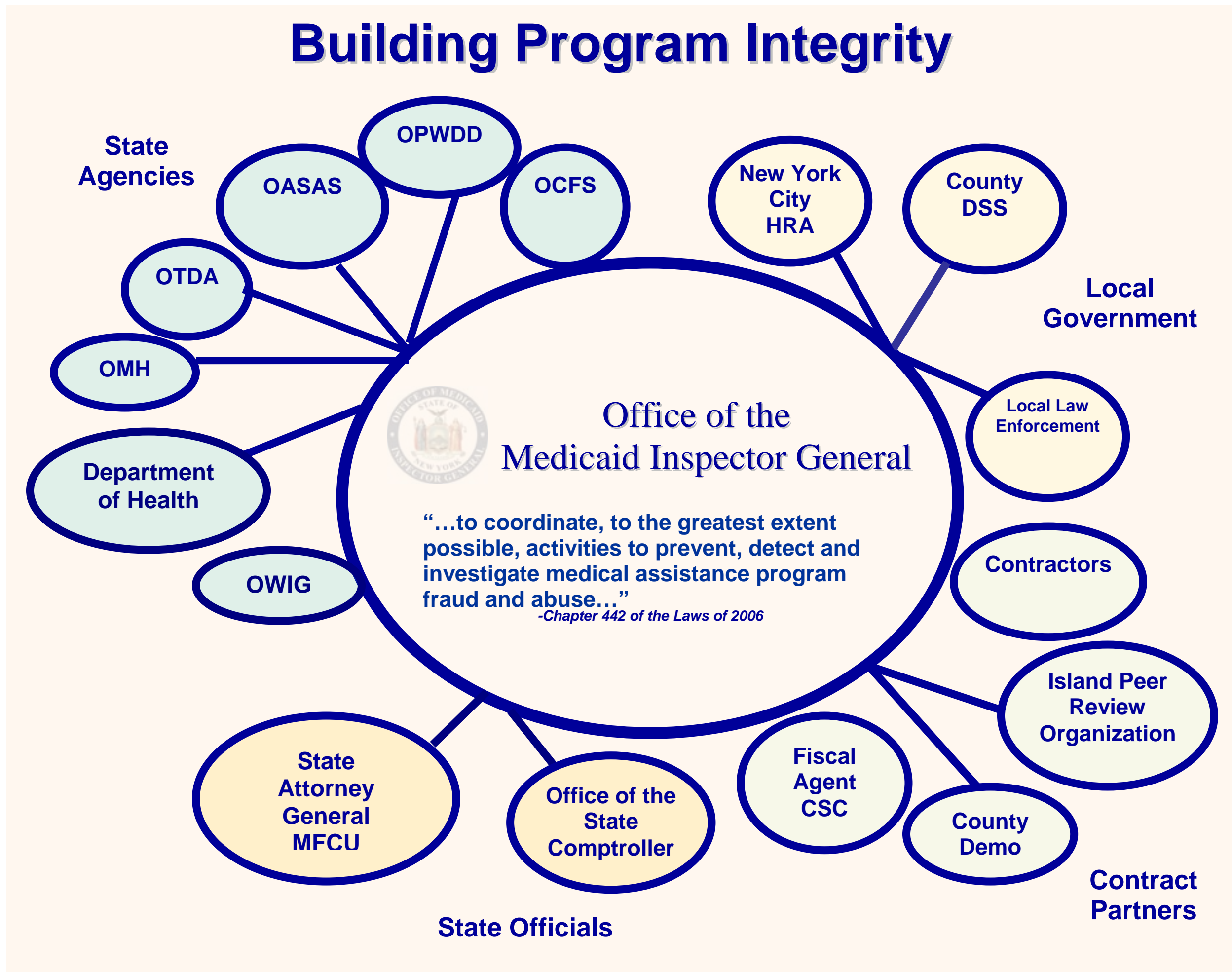
- making available to appropriate law enforcement information and evidence relating to potentially criminal acts which may be obtained in carrying out duties;

- receiving and investigating complaints of alleged failures of state and local officials to prevent, detect and prosecute fraud, waste and abuse;

- performing any other necessary or appropriate functions to fulfill the duties and responsibilities of the office;

The Medicaid Inspector General is headquartered in Albany. Certain headquarter responsibilities, as well as field office functions are based in New York City. Regional offices are located in White Plains, Hauppauge, Syracuse, Rochester, and Buffalo.

OMIG Coordination with Medicaid Program Agencies



OMIG is responsible, pursuant to New York State Public Health Law §32, for coordinating, to the greatest extent possible, activities to prevent, detect and investigate medical assistance program fraud and abuse among various state and local agencies responsible for administering Medicaid services. OMIG must also work cooperatively and in a coordinated manner with the New York State Attorney General's Medicaid Fraud Control Unit (MFCU), the New York State Comptroller, federal prosecutors, state district attorneys, the Welfare Inspector General, and the special investigative units maintained by each health insurer operating within the state.

During the first year of operation, OMIG focused primarily on establishing the agency and developing management systems to monitor activities and identify vulnerabilities. In 2008, OMIG solidified efforts to work with the agencies responsible for administering all aspects of healthcare fraud investigation and enforcement.

In 2009, OMIG continued its efforts to reach out to new and different agencies and entities who are involved in the Medicaid program, either in an administrative or oversight capacity. Through these efforts, OMIG gained valuable knowledge, learned new or advanced techniques and worked in conjunction with other partner agencies to combine resources to prevent and detect Medicaid fraud, waste and abuse. The following are examples of this coordinative effort.

Relationship with the Attorney General's Medicaid Fraud Control Unit

In order to maximize program integrity, the New York State Attorney General's Medicaid Fraud Control Unit (MFCU) and OMIG must have a high level of cooperation and coordination. In accordance with State law and Federal regulations, OMIG must refer cases of suspected provider fraud to the MFCU (Public Health Law § 32(7) and 42 CFR 455.21).

The MFCU has had continued success with Operation Home Alone this year. Since 2007, the MFCU has arrested and prosecuted dozens of people under this initiative designed to fight fraud in the home health industry. During 2009, the MFCU convicted approximately 50 individuals and entities for home health care fraud. OMIG worked with the MFCU to ensure that convicted individuals and entities were excluded from the Medicaid program.

During 2009, OMIG, MFCU, and other state and federal agencies cooperatively worked on an investigation into a major pediatric dental organization operating in New York State. The investigation resulted in a major financial recovery for New York State and led to the entity entering into a Corporate Integrity Agreement that mandates every one of their facilities in New York be visited annually by an outside entity that conducts an independent review.

OMIG continues its efforts to improve and strengthen the relationship with the MFCU. OMIG meets with the MFCU representatives on a monthly basis, and a single central coordinator from OMIG is assigned to ensure that referrals to and from the MFCU are appropriately addressed. In addition, OMIG participates in joint meetings sponsored by the MFCU with the chief investigators of the MFCU, the U.S. Department of Health and Human Services Office of Inspector General, the New York State Office of the State Comptroller, the New York State Office of the Welfare Inspector General, the New York State Bureau of Narcotics Enforcement, the FBI Federal Health Care Task Force, and the New York City Human Resources Administration. The purpose of these meetings is to discuss the investigations and trends in health care fraud that each agency has encountered, discuss potential joint investigative efforts among the group, and share expertise and knowledge.

Interagency Workgroup

In 2006, OMIG established the Interagency Workgroup to help coordinate Medicaid fraud, waste and abuse control activities of the state agencies with direct roles in administering the Medicaid program. In addition to OMIG, the workgroup is comprised of staff from the:

- Office of Alcoholism and Substance Abuse Services (OASAS)
- Office for Persons With Developmental Disabilities (OPWDD)
- Office of Mental Health (OMH)
- Office of Children and Family Services (OCFS)
- Office of Temporary and Disability Assistance (OTDA)
- DOH Office of Health Insurance Programs (OHIP)
- Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC)

Representatives from those agencies meet regularly to address issues, coordinate plans, and foster the communication necessary to monitor program integrity and administer the Medicaid program. In 2009, participants dealt with such issues as:

- CMS program review
- CMS's MIC auditor and audit process
- Contributions to and roll-out of OMIG's Work Plan
- Ambulatory Payment Groups (APGs) implementation
- System edit combinations
- Card-swipe program expansion
- OMIG's audit process survey
- Coordination of County Demonstration Project audits
- Investigations and NYS AG MFCU referrals
- Sentinel and behavioral effects and cost avoidance
- OMIG's self-disclosure program and protocols
- Mandatory provider compliance programs
- OMIG issued Corporate Integrity Agreements (CIAs)

New York State Department of Health

Office of Health Insurance Programs

Strengthening Eligibility and Enrollment Processes

Auto Close of Medicare Buy-In

Beginning April 1, 2009, a systems change was put into eMedNY to close a Medicare Buy-In payment line when a Medicaid case is closed. The Medicaid eligibility worker is no longer required to separately end date the Medicare Buy-In line in the eMedNY system every time a Medicaid case is closed. This has resulted in significant savings to the State.

Medicare Part B Enrollment

As of July 2009, staff in the Office of Health Insurance Programs' (OHIP) Third Party Liability unit reviewed active Medicaid cases where the individual had Medicare Part A coverage but had not enrolled in Medicare Part B. As a result, 2,719 individuals were enrolled in Medicare Part B and claims are, therefore, being paid by Medicare as the primary payer.

Match with CMS Files

Starting in February 2010, and on a monthly basis thereafter, the Department matches with CMS data to identify Medicaid recipients who are also enrolled in Medicare Advantage Plans. This information is now automatically posted to OHIP's Third Party Subsystem in eMedNY. Previously, this information was only received sporadically. This information is used to avoid paying claims that would otherwise be paid by Medicaid.

Tracking Disability End Date

When a Group II disability (time-limited, 1 to 7 years) is approved for an individual by the State or local Disability Review Team (DRT), an end date is established for the period of disability. Prior to the end date the local district is responsible for gathering new medical evidence to determine if the disability continues.

Prior to January 2010, upstate social services districts tracked the disability end date using either a paper file or by entering an Anticipated Future Action code and associated date in Welfare Management System. For districts using the electronic tracking method, a report was generated a few months prior to the end date to alert the district to gather and submit a disability packet for Continuing Disability Review (CDR). New York City did not have an established method to track the disability end date, resulting in a failure to review the continued disability at the appropriate time.

All local social services district commissioners were notified via a General Information System message to begin using the automated system of tracking disability end dates for all Group II disability cases, and were advised of the report that would be generated to alert the need for gathering a disability packet for CDR. These modifications streamline automated renewals and allow districts ample time to prepare a case for continuing review before the expiration of the disability period.

Improving Information About Resources

A weakness in ensuring program integrity is the lack of information about bank accounts and property at the time a potential beneficiary applies for Medicaid coverage. The Resource File Integration system, which is administered by the Office of Temporary and Disability Assistance (OTDA), verifies bank account information after enrollment rather than at the time of application. RFI does not include information on property, making it possible for

someone to be enrolled who has undisclosed property that may be generating undisclosed income.

Strengthening Claims Payment Processes

During calendar year 2009, OHIP's Division of Services engaged in significant efforts to support the prevention, detection and investigation of Medicaid fraud and abuse, including:

- A “Deceased Beneficiary” project whereby both client and provider files are matched on a monthly basis with vital statistic death records, and the resultant matches posted on the Data Warehouse for appropriate action by OMIG staff and Department designees. The processes have resulted in more timely access to data on deceased recipients and providers. These changes have strengthened the system edits, thereby reducing and preventing Medicaid payments for deceased recipients and providers.
- The Medicare Cross-over project created the capability to process Medicare Cross-over claims received from the Medicare Coordination of Benefits Contractor (COBC) rather than for providers of service.
- The Edit Control Workgroup, composed of staff from the OHIP and OMIG, was convened in 2008 to develop structured and formalized procedures and written guidelines for proposing, submitting and processing edit changes. Over the course of several months, the workgroup closely reviewed current edit control processes and procedures, as well as forms and methods used for communication. Recommendations for improvements were discussed and developed.
- A number of evolution projects, 141, were implemented during the calendar year, including 14 projects requested by OMIG. In addition to implementing DOH policies and budget initiatives, about 44 projects involved areas of potential fraud, waste or abuse, including approximately 34 which created or modified processing edits. Among these were enhancements to the Provider on Review edit, modifications to add Home Health and Private Duty Nursing claims to the edit that ensures the ordering or referring providers are identified on the claim, and creation of a new edit to deny claims for Pharmacy, DME and Dental services when the client is in a nursing facility.
- Under the direction of the Office of Health Insurance Programs, Computer Sciences Corporation (CSC) referred 23 cases of potential fraud, waste and abuse to OMIG. OHIP and CSC staff also worked with OMIG to support many fraud and abuse initiatives, including their efforts to retrieve MEVS data from eMedNY.

Ensuring Provider and Service Integrity

The OHIP Division of Provider Relations and Utilization Management (DPRUM) conducted over 871,000 pended claim reviews, resulting in over $85M in cost avoidance.

DPRUM dis-enrolled 2,172 providers due to expired licenses and 4,152 deceased providers. Another 664 providers withdrew their enrollment applications due to failure to comply with all documentation requirements.

DPRUM staff referred 26 dental and 7 medical providers to OMIG for further investigation relative to potential fraud, waste and abuse.

DPRUM staff worked with OMIG to develop a number of system edits to identify potential fraud, and prevent improper payments. Projects include NPI-Sequence Numbers, as well as Post and Clear for DME and Supplies.

Fee-for-Service Enrollment pended 620 enrollment applications to OMIG for final determination.

Coordinating with Medicaid Managed Care

For the calendar year 2009, OHIP's Bureau of Managed Certification and Surveillance received a total of 79 fraud and/or abuse cases from health plans participating in Medicaid managed care.

- 34 member fraud cases including falsifying information, improper use of script pads, improper use of Medicaid cards.

- 17 instances in which facilitated enrollers misrepresented information to beneficiaries, enrolled ineligible individuals, completed non-consensual enrollment, or falsified eligibility data.

- 28 provider related cases including falsification of credentials, billing issues, upcoding and balance billing of beneficiaries.

Office of Temporary and Disability Assistance

The Office of Temporary and Disability Assistance (OTDA) managed one project that had a direct impact on Medicaid fraud and abuse. Using the Automated Finger Imaging System, the OTDA identified instances of duplicate participation by Medicaid enrollees through a finger print match. In 2009, OTDA closed and denied 208 cases resulting in $1,460,160 in cost avoidance. This data reflects the time period of January 1, 2009 through July 1, 2009.

Office of Alcoholism and Substance Abuse Services

During 2009, the Office of Alcoholism and Substance Abuse Services (OASAS), Bureau of Quality Services Management (QSM) conducted several investigations and reviews to prevent and detect Medicaid fraud, waste and abuse.

The QSM completed 12 Quality Service Reviews (QSR) of "high-risk" Medicaid providers. OASAS initiated QSRs in 2008 as a tool for assessing the medical necessity of services being billed to Medicaid by chemical dependence outpatient programs. Providers who rank "high" or "extreme" through a Medicaid Risk Assessment are selected for QSR prior to the expiration of their Operating Certificate. QSRs focus on excessive services indicators outlined in OASAS regulations as well as other regulatory requirements that relate to the clinical necessity and quality of treatment services. With an initial determination of clinically unjustified services, providers are given the opportunity to correct deficiencies by implementing required corrective action and restructuring program operations. If continued excessive services are determined a second time, OASAS may issue a *Notice of Revocation* to the provider and a referral is made to OMIG regarding OASAS' findings.

OASAS completed and closed six additional targeted investigations and reviews that involved potential Medicaid billing issues. One investigation resulted in CG&D Alcoholism and Addiction Services, Inc. surrendering its OASAS Operating Certificate.

OASAS QSM also completed two clinical necessity reviews in 2009, at the request of OMIG's Division of Medicaid Audit, potentially contributing to OMIG's audit recoupments.

In March 2009, QSM delivered training to OMIG nursing staff regarding medical necessity determinations for outpatient services billed to Medicaid. The training focused on accepted clinical interpretation of OASAS Part 822 Chemical Dependence Outpatient Services regulations and provided an overview of the OASAS Quality Services Review process. This training enhanced OMIG's ability to make clinical necessity determinations of billed services in accordance with accepted professional standards in the chemical dependence field.

In September 2009, at the request of OMIG's Deputy Medicaid Inspector General for Audit, QSM delivered training to 25 OMIG audit staff in New York City. The training was designed to help OMIG auditors understand the basis for OASAS Quality Services and Clinical Necessity reviews, as well as key quality care elements within OASAS regulatory requirements. OASAS continues to provide consultation and assistance to OMIG on a routine basis regarding clinical necessity and regulatory interpretation.

Although it is difficult to assess the full dollar value of ongoing consultation and assistance provided by OASAS, the annual Medicaid cost savings directly associated with OASAS enforcement and administrative actions in 2009 is estimated at $1.4 million.

Office of Mental Health

In 2009, within the not-for-profit and proprietary sectors, as well as the state-operated outpatient and residential mental health system, the Office of Mental Health (OMH) conducted 989 on-site inspection visits at programs for license renewal. These reviews serve to help prevent and detect Medicaid fraud, waste and abuse. These visits assessed each licensed program's compliance with regulatory requirements pertaining to:

- appropriateness of admissions,
- treatment plans,
- case records documentation,
- evidence of active treatment,
- adequacy of staffing, and
- appropriateness of the treatment environment.

When an on-site inspection determines that a program is substantially non-compliant with regulatory requirements, or a pattern of uncorrected citations exists from previous surveys, OMH may withhold renewal of the license until submission of an acceptable plan of corrective action (POCA) and a subsequent on-site inspection is completed to confirm implementation of the POCA. Based on the findings from license renewal visits during the past year, 558 POCAs were required, 12 programs were placed in non-renewal status at some point during the year, and one program had their license revoked.

For outpatient programs and adult community residence programs, subject to OMH's Tiered Certification process, a Tier 3 status of the license indicates the most minimal level of compliance by the program, and usually results in a license being granted for not more than six months duration. A POCA is required and the program is re-visited during the next six months of the license. There were 14 programs that were issued Tier 3 status last year.

If a Comprehensive Outpatient Program Services (COPS) eligible outpatient program (i.e. – a program which receives supplemental medical assistance reimbursement) is notified of non-renewal, the COPS supplement is forfeited until the program receives at least a six month renewal license after submission of the POCA and subsequent on-site inspection. In 2009, six programs had COPS payments withheld in this manner.

Several of these licensing visits uncovered Medicaid billing issues which ultimately resulted in self-disclosure of potential overpayments and documentation issues by the providers to OMIG. In other cases, providers identified billing issues themselves and made self-disclosures. The self-disclosures were made after providers reviewed guidance posted on OMH's website, including a link to OMIG's instructions regarding self-disclosures. OMH's website has also been updated to include a Medicaid Fraud and Abuse Notification, a notification to contractors with information regarding the federal and New York State False Claims Acts, as well as other federal and state laws that aid in preventing fraud, waste and abuse.

During 2009, OMH undertook several actions to ensure that effective controls were in place for billing and receipt of Medicaid funds at OMH inpatient and outpatient mental health programs. OMH continued to review its billing systems as part of a routine internal compliance function, and engaged in several training sessions on services recording and timeliness of claims. Services recording guidance for clinicians and frequently asked questions were published on the OMH internet website. Each month, actual revenue collections are compared with projections, and variations are investigated. A review of the OMH Reimbursing Receipts Account bank reconciliation process was performed to verify adequate controls. The review resulted in no major internal control issues.

Office for People With Developmental Disabilities

The Office for People With Developmental Disabilities (OPWDD), formerly the Office of Mental Retardation and Developmental Disabilities, has invested considerable resources in the area of Medicaid accountability. Accountability functions are divided among the following OPWDD units:

- *The Medicaid Standards Unit:* issues Administrative Memoranda to both the State operations and not-for-profit agency providers establishing Medicaid billing and documentation standards. This unit also provides training on these standards.

- *The Bureau of Compliance Management (BCM):* conducts Limited Fiscal Reviews (LFRs) which, until June 1, 2010, included routine Medicaid Billing and Claiming reviews based on the standards established by the Medicaid Standards Unit. BCM also conducts special reviews of providers targeted by OPWDD's Medicaid Analysis Unit through data analysis activities and due diligence reviews of provider self-disclosures. In the past year, OMIG has worked with OPWDD in reviewing OPWDD providers' self-disclosures. OPWDD performed the audit review work for each disclosure and submitted a report to OMIG for review and approval. OMIG has agreed with the OPWDD review results; but also found areas for improvement. OMIG consulted with OPWDD and the agencies worked together to improve the review reports.

- *The Medicaid Internal Review Unit:* implements desk reviews of Medicaid paid claims, oversees provider voids on eMedNY and repayments to the Department of Health. The unit also oversees claim voids associated with BCM Medicaid Billing and Claiming reviews, and maintains an account of the dollar value of all voids/repayments to Medicaid. This unit is responsible for reporting F-SHRP recovery information to OMIG on a quarterly basis.

- *The Medicaid Analysis Unit:* conducts Medicaid analyses required to support OPWDD's Medicaid accountability functions described above. The unit also identifies needed eMedNY edits and works with DOH on implementation.

Data Summary – OPWDD Medicaid Activities

OPWDD recovered a total of $5.1 million in Medicaid dollars through its Medicaid accountability activities, including desk and field reviews. During the 2009 calendar year, BCM conducted a total of 124 field reviews that comprised a Medicaid related component or components:

Review Type	Total Reviews Conducted
Review of Allegations/Complaints	10
Due Diligence Review of Provider Self-Disclosures	8
IRA Full Month/Half Month Reviews	3
Limited Fiscal Review with Billing and Claiming Review Component(s)	55
Billing and Claiming Reviews and/or Expanded Billing and Claiming Reviews	48
Total	**124**

OPWDD also referred 17 providers to OMIG in 2009 for further review/investigation of potential Medicaid fraud, waste, and abuse and/or systemic Medicaid billing issues.

Office of Children and Family Services

The Office of Children and Family Services (OCFS) Bridges to Health (B2H) Home and Community-Based Medicaid Waiver program was phased into statewide operation over a three year period beginning on January 1, 2008. OCFS's Office of Audit and Quality Control performed its first B2H audit in October 2009. A final report has not yet been issued. B2H provider audits will continue in 2010.

Commission on Quality of Care and Advocacy for Persons with Disabilities

The Commission has a seven person fiscal bureau to perform duties covering a broad spectrum of oversight mandates regarding Medicaid and non-Medicaid funded programs. During the 2009 calendar year, the Commission completed an investigation of Europa Associates for Community Services, Inc., a licensed OPWDD agency which was wholly funded by Medicaid. At this agency, the Commission found a number of programmatic and fiscal irregularities, including falsified documents, misappropriation of agency assets and agency funds being used to pay for the personal expenditures of the executive director. There were also some findings that could have led to Medicaid disallowances; however, the Commission worked successfully with OPWDD to close the agency and transition the consumers to more appropriate providers. The potential for Medicaid disallowances became a moot issue, as the agency was not financially viable and therefore, would not have been able to pay any potential Medicaid disallowances.

New York Leads the Way

Data Mining

A cornerstone of OMIG's strategy to detect and prevent fraud, waste and abuse in the Medicaid program is to continually use technology to detect behaviors, control point of service transactions, review select claims and provide agency staff with critical support data.

Bureau of Business Intelligence

The Bureau of Business Intelligence (BBI) provides a spectrum of data related services to support the agency's mission. Their tasks include targeting, conducting provider analysis, supporting targeting tools, creating data match algorithms, and providing pre-audit analysis and audit samples. In addition, the BBI performs hundreds of desk audits annually. These audits (aka system matches) are based on algorithms designed with specific knowledge of various provider types and the guidelines that govern the corresponding claim submissions.

OMIG's long term goal is to integrate data analysis tools, capabilities and data access into the work of every employee performing audit, investigative and program integrity functions. In an effort to promote the creativity and field knowledge of the program staff while simultaneously creating a center of data mining activities and strategies, OMIG has a data mining task force which helps steer the agency's data mining efforts. The key areas of OMIG's data mining focus over the past year are highlighted below.

Data Warehouse and Analysis Unit

The Data Warehouse and Analysis Unit consists of eight individuals who possess experience auditing the Medicaid program and have backgrounds in accounting, business, fraud detection, nursing and computer programming. Staff effectively combine their experience and backgrounds with their expertise in using data mining technology. The unit provides data and analysis primarily in the areas of managed care, provider audit, nursing homes and other rate based entities. The unit also created a process for analyzing Medicare Crossover data to identify overpayments, and identifies new potential targets for audit and/or recovery for OMIG's Division of Medicaid Audit.

Tools

Data Warehouse - New York State's Medicaid Data Warehouse continues to be OMIG's most valuable resource for data mining. The warehouse stores five years of Medicaid claims with payments exceeding $200 billion. Tools inherent within the system include a graphical user interface which assists users in the compilation of queries. More sophisticated users have access to the data through the use of Structured Query Language (SQL) which allows for more complicated queries. As OMIG has expanded and matured the capabilities of the BBI, OMIG's ability to leverage this important resource has grown correspondingly.

Desktop Graphical User Interface Tool – OMIG has completed the procurement of Salient Corporation's Medicaid MuniMinder Software and associated Data Center Hosting Services. This tool provides ease-of-use through a graphical user interface, yet allows the user to make complex queries and effortlessly drill down into increasing levels of detail. This tool holds the promise of engaging a greater percentage of OMIG staff beyond the typical IT/power user audience. OMIG production use of the tool began in July, 2010.

Link Analysis Software - Following a successful pilot of IBM's Entity Analytics Software (EAS), OMIG completed a purchase of the product as well as expert consulting services to install and implement our initial algorithms. The software specializes in resolving entity relationships (e.g. identity attributes) from disparate data sources. The initial implementation logic included the identification of duplicate Medicaid recipients, deceased recipients, deceased providers, providers who are recipients and connections between providers/business associates who have been sanctioned. Staff are currently analyzing the results and making necessary adjustments to the logic and match thresholds. Once completed, OMIG will address the initial match population and conduct periodic match runs for each of the described algorithms. Staff are also working on additional data feeds and matches.

Collaboration

A key challenge to maximizing data mining efforts is to ensure that a two-way exchange of support between data mining staff and field staff from our Division of Medicaid Audit and Division of Medicaid Investigations exists. Some key examples of this type of collaboration are outlined below.

Customized Audit Samples - To support our field auditors, BBI staff routinely prepare audit packages consisting of the audit sample, universe and provider-specific support data.

Prenatal Care Assistance Program - This audit addresses multiple issues of erroneous billings for Medicaid clients who are receiving pre-natal care services (PCAP). The match includes the identification of multiple initial visits; post-partum services billed at initial or follow up rates; PCAP service for inpatients; physician services; laboratory services, ordered ambulatory services and prenatal vitamins billed as fee for service which are included in the PCAP rate.

Inpatient Crossover With Clinic/ER Claims - Inpatient, emergency room, and clinic services provided by a hospital can be individually billed to Medicaid under the same provider number. During a Medicaid client's hospital stay, the inpatient rate is an all-inclusive rate and there should be no emergency or clinic billings by the hospital for that client during their hospital stay. This match identifies the Medicaid payments and the providers that have billed Medicaid for either clinical or emergency room services during a patient's stay in the hospital.

Physician Place of Service – This audit looks at all physician claims submitted by individual physicians and physician groups that were paid the $30 office visit fee. If the physician saw patients in a hospital clinic, the physician is not allowed to bill $30, but could receive reimbursement based on an established fee schedule that takes into consideration the

physician's specialties. The specialists' reimbursement rates found in the Medicaid Management Information Systems (MMIS) Physician's manual can range from $5.50 to $25.00.

Radiology Services - This audit identified radiologists who billed more than the 40 percent professional component for radiology procedures performed on hospital inpatients. The inpatient hospital rate includes the technical component, so the radiologist is only entitled to 40 percent of the total fee.

Net Applicable Monthly Income (NAMI) – OMIG, in conjunction with one of its contractors, has begun a review of providers who receive available income from Medicaid recipients which should be used to offset the amount claimed from Medicaid. This review seeks to identify situations where the provider has a credit balance due to this unreported income.

Medicaid Program Integrity and Third Party Activities

Third party activities have traditionally been limited, by definition and scope, to the identification of a liable third party and the retroactive pursuit of recoveries. Below are several examples of how OMIG is expanding the scope of third party activities to specifically target payment initiatives.

Credit Balance Reviews

The Bureau of Third Party Liability's Credit Balance Reviews are now predicated on integrating various aspects of OMIG's Medicaid Match & Recovery Program. More specifically, the Bureau takes the following three-pronged approach:

- **Traditional Review -** Provider-generated reports drive the traditional credit balance review. Each account in "credit balance" status is manually reviewed.
- **Inter-Provider Review -** Provider specific issues can be identified during the course of a review. Potential issues are examined in a post-review environment to determine whether follow-up is needed.
- **Intra-Provider Review -** Detection of community wide issues generally requires robust data mining capabilities. Targeted findings are reviewed with all providers.

Credit Balance Reviews play a crucial role in the Bureau's ability to effectively leverage data mining capabilities as well as improve the enforcement of New York Medicaid billing and reimbursement policies. For example, a claim that is satisfied during one of the Third Party Reviews can be fed into the Credit Balance process for a secondary review if there is sufficient evidence to merit such review. Another example consists of analyzing payments and denials that are received as part of the Bureau's direct billing to detect providers who are engaging in potentially fraudulent or abusive billing practices.

These reviews have been expanded to include long term care facilities.

“e-Review” expansion

TPL staff continue to work with commercial carriers and Pharmaceutical Benefit Managers on suspected duplicate payment reviews using the carrier claim information as source data. This “e-audit” initiative is a more in depth forensic analysis of the return information of the Bureau’s routine third party reviews and direct billing efforts payments.

Home Health Aide Overlapping Payment Review

OMIG continues to examine the “overlapping payment” universes excluded from the Home Health Aide (HHA) Demonstration project. Findings from data analysis of the Medicaid paid claims show that within the overlap of Medicare and Medicaid coverage, Medicaid is paying an excessively large portion of the home health aide services; services that represent the highest utilization dollars in most cases. A probe review of three Certified Home Health Agency providers was initiated with ten home health care cases per agency that showed the highest utilization cost to Medicaid, while also under a Medicare PPS payment(s). TPL will use these findings to refine the review protocol. TPL will target future reviews based on the information provided from the demonstration project and then request provider specific detail through the Medi-Medi project.

Federal-State Health Reform Partnership

On September 29, 2006 the Centers for Medicare and Medicaid Services (CMS) approved New York State's request to enter into a waiver project to reform and restructure the state's healthcare system. The approved project, entitled the Federal-State Health Reform Partnership (F-SHRP), took effect October 1, 2006.

The partnership's goal is to promote the efficient operation of New York's healthcare system. The federal government will invest a total of $1.5 billion, $300 million annually, in agreed upon reform initiatives. These investments are subject to conditions and milestones that the state must meet.

F-SHRP is a five-year demonstration project that ends on September 30, 2011. The waiver for this project cannot be renewed. Over the course of the demonstration, New York will be required to report quarterly and annually to CMS on the waiver's progress.

Medicaid data for the Federal Fiscal Year (FFY) 2005 indicated that the state recovers less than one percent of its total Medicaid expenditures. By the end of the demonstration, the State will be responsible for increasing its fraud and abuse recoveries to at least 1.5 percent of the $42.9 billion total Medicaid expenditures for FFY 2005.

The conditions and required state milestones are clearly defined in the CMS agreement. The two conditions are:

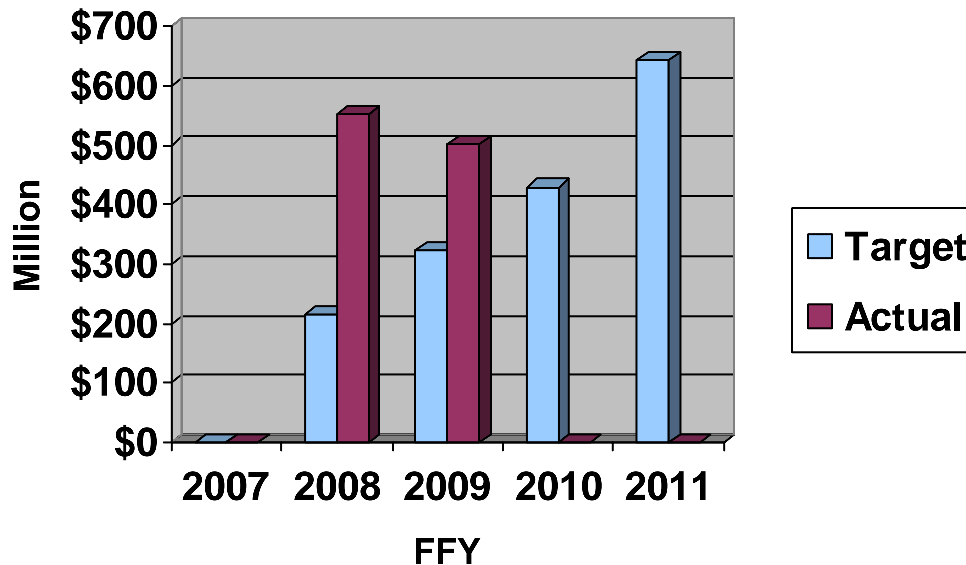
1. The F-SHRP waiver must generate federal savings sufficient enough to offset the federal investment in the state; and
2. New York must meet a series of established performance milestones in the waiver terms and conditions.

In order to receive the $1.5 billion in federal financial participation (FFP), the following milestones must be met:

- By October 31, 2006, the state was required to develop and submit to CMS its plan for achieving this milestone by the end of the demonstration period, including details of Office of the Medicaid Inspector General (OMIG) staffing and new budget proposals to further enhance OMIG resources. This goal was achieved.
- By December 31, 2008, for the period of October 1, 2007 to September 30, 2008, the state had to demonstrate its annual levels of fraud and abuse recoveries are equal to .5 percent of total computable Medicaid expenditures for the federal fiscal year, or $215 million. The State's accomplishment for FFY 07-08 was $551.6 million.
- By December 31, 2009, for the period of October 1, 2008 to September 30, 2009, the state had to demonstrate its annual levels of fraud and abuse recoveries are equal to .75 percent of total computable Medicaid expenditures for the federal fiscal year, or $322 million. The State's accomplishment for FFY 08-09 was $500.2 million.
- By December 31, 2010, for the period of October 1, 2009 to September 30, 2010, the state must demonstrate its annual levels of fraud and abuse recoveries are equal to 1

percent of total computable Medicaid expenditures for the federal fiscal year, or $429 million.

- By December 31, 2011, for the period of October 1, 2010 to September 30, 2011, the state must demonstrate its annual levels of fraud and abuse recoveries are equal to 1.5 percent of total computable Medicaid expenditures for the federal fiscal year, or $644 million.



Achievement of the above milestones will be assessed by CMS within 90 days of the end of each year in the demonstration. If the state does not meet the targets in any of the years, it will be required to repay to the federal government the dollar difference between actual and target recoveries, whichever is less. This value can go up to, but not exceed, $500 million for the five year demonstration period. Additional funds that exceed single year targets cannot be carried over into the next year for use at meeting the subsequent year's requirements.

Work Plan

> *"The work plan offers a transparent look into how the OMIG operates, which can be valuable to providers in any state. Providers can look to the work plan when determining possible Medicaid vulnerabilities. This is particularly important now because Medicaid enforcement efforts have been on an upswing."*
>
> --*Health Media Leaders*
> May 6, 2009

In 2009, for the second consecutive year, Medicaid Inspector General Sheehan released a work plan to cover the state's 2009-10 state fiscal year (April 1, 2009-March 31, 2010). The document offers a road map to providers, accountants, compliance officers and other professionals involved in promoting the integrity of New York State's Medicaid program. It has also proven useful to state officials and staff at other state agencies.

Projects outlined in the document reflect work begun in April 2009 that is now underway. Both the 2008 and 2009 work plans are posted on the agency's Web site (www.omig.ny.gov), and demonstrate ways in which OMIG's staff seeks to validate that providers meet program quality standards for Medicaid enrollees in a system free of waste, fraud, abuse and improper payments.

In making the work plan public, OMIG acknowledged the efforts of New York State's health care providers, as well as their compliance officers, and billing and coding staff, to adhere to the rules of the Medicaid program. By adding the work plan to the Web site, OMIG emphasized the agency's transparency of operations to the public and providers. This action also demonstrates a commitment to collaborate with providers to ensure that Medicaid enrollees have access to a quality health care system and enables them to receive appropriate services.

The 2009 plan emphasizes the role that effective compliance programs have in maintaining the integrity of the Medicaid program in New York State. In October 2009, a new state regulation took effect, requiring all Medicaid providers who bill or receive more than $500,000 annually to certify to OMIG that they have developed and implemented an effective compliance plan by December 31, 2009. Providers will be required to re-certify annually.

The plan also stresses self-disclosure guidance, released in 2009, which directs healthcare providers to identify, reveal and return Medicaid overpayments. OMIG developed this guidance to encourage and offer incentives for providers to conduct internal investigations and report matters involving potential fraud, waste and/or abuse, or inappropriate payment of Medicaid funds, whether intentional or unintentional.

Division of Medicaid Investigation

"'When people do not follow the rules, document or show what they've done or delivered, there's the possibility – often times the reality – of an abuse of the program,' said James Sheehan, New York State Medicaid Inspector General."
--Seth Voorhees, writing in
The Rochester Democrat and Chronicle
February 24, 2009

Functional Description

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billings and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are thereby removed from the program or prevented from enrolling. Recipients found abusing the system are not removed from the Medicaid program, but their access to services is examined and restricted, as deemed appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

DMI focuses on five main areas that address the integrity of the Medicaid program - fraud, waste, and abuse; intra- and inter-agency cooperation; deterrence; education and outreach; and quality of care.

Although DMI is divided into specific units, matters addressed by DMI impact every section of the Division and OMIG. Unraveling the complexities within the Medicaid system where the trajectory of fraud and deceit begins, requires an overarching theory of investigation. Any patient could be a DMI undercover investigator. Recipient and provider records are scrutinized through surveillance, forensic accounting of subpoenaed bank records and billings, medical record reviews, witness testimony, site visits, and data mining.

Investigations in the fee-for-service or managed care arena often commence with an allegation, complaint, initiative, the identification of unusual connections between providers, data analysis, a referral, or even newspaper articles about particular issues in health care. Leads also come from the thousands of Explanation of Medical Benefit forms sent to recipients, OMIG's Bureau of Allegations and Complaints or even tips from other providers or their associations.

Cases involving providers conducting suspected illegal activities are forwarded to the New York State Deputy Attorney General for Medicaid Fraud Control (MFCU), the United States Attorney, or local district attorneys for civil or criminal prosecutions. If convicted, these providers and recipients may face confinement and/or restitution.

Providers that commit unacceptable practices may be subject to administrative remedies. Such actions may include exclusion, censure, restitution, and/or imposition of penalties.

Under certain circumstances, OMIG may enter into a Corporate Integrity Agreement (CIA) with a provider requiring specific performance standards and reporting requirements. OMIG investigators, working in concert with the Bureau of Corporate Compliance, monitor the providers, and take action if the CIA is violated.

If DMI identifies improper provider billing practices, OMIG's Division of Medicaid Audit may also commence an additional review resulting in recoupment and systemic improvements.

Fraud Activity Comprehensive Tracking System

The Fraud Activity Comprehensive Tracking System (FACTS) is an electronic drawer, composed of numerous and varying databases and interfaces that permits efficient access to current and historical information on all audit and investigative activities involving Medicaid providers and/or recipients. The application is web-based and is accessible in real-time by over 1,200 users across the State. FACTS centralizes information about investigations and audits, providing a current, accurate and reliable data source and reduces the time it takes to react to new situations by building a complete history of any prior provider or recipient related activity and making it immediately available to auditors and investigators. Users can collaborate on assignments, and managers can keep up with audits and investigations in real-time. Imaged case documents are available within FACTS and allow all audit and investigative documents to be accessed electronically in real-time through FACTS.

In 2009, OMIG completed Phase I of the DMI redesign of FACTS. This major redesign involved the collaboration of each unit pursuing the common goal to enhance the tracking of investigative outcomes while also keeping the system user-friendly. Training of staff to use the new FACTS system commenced at the end of December, and is ongoing.

Targeting

Effective targeting starts with collecting relevant data and then analyzing it in order to obtain the most accurate picture before initiating investigations. This is crucial both for maximizing resources, and ensuring more tangible results.

The Administrative Reporting and Tracking Service (ARTS) Unit is developing methodologies for targeting providers for DMI investigations. Data based queries are used to identify outliers on quality, cost and outcomes. These data mining techniques help determine cost avoidance, referrals, and other administrative action. Data mining also allows measurement of the "sentinel effect." Since the act of observing disturbs the observed, the existence of OMIG has affected the provider community. ARTS not only measures this deterrence factor, but is able to measure outcomes of investigations, ensuring the most efficient use of time and resources.

Targeting is a tool to aid investigators and is not meant to substitute for human scrutiny and logic. What it does allow for, is a way to assess where DMI can most efficiently focus resources and investigative energies when identifying fraudulent practices that are siphoning dollars away from the Medicaid program.

DMI Units

Administrative Remedies Unit

The Department of Health's Office of Professional Medical Conduct (OPMC) and the State Education Department's Office of Professional Discipline (OPD) issue disciplinary consent orders stipulating agreements between themselves and providers. Once OPMC and OPD impose penalties of license surrenders, revocations, suspensions and other disciplinary actions, copies of these consent orders are sent to the Administrative Remedies Unit within DMI.

These consent orders are thoroughly reviewed by medical, investigative, administrative, and legal staff to determine if exclusion, termination, or censure of the provider is warranted. This Unit's investigation section obtains the full investigative file and considers the underlying facts in order to make an independent decision on whether administrative action is warranted.

OMIG's decision to take action on a provider or individual is independent from OPMC and OPD. OMIG may decide to exclude the provider or individual if the behavior has the potential to negatively impact the Medicaid program either through quality of care issues, or in fraudulently billing services.

Pharmacy Investigations Unit

DMI faces significant challenges dealing with fraud, waste and abuse in the pharmacy arena. On October 1, 2009, DMI formed the Pharmacy Investigations Unit to meet these challenges. The Unit is well versed in New York State pharmacy regulations, knowledgeable of current fraudulent pharmacy trends and maintains its edge by building a network within the pharmacy community. This Unit is responsible for triaging all pharmacy cases, investigating ones that require special handling, developing policies and procedures, and proactively ferreting out fraud, waste, and abuse in the pharmacy industry while ensuring that there is a consistent, fair, and assertive approach to handling these cases statewide.

In matters relating to pharmacy, the Unit acts as a liaison with all outside entities, including those on the state and federal levels. This Unit conducts investigations of pharmacies and pharmacists involved in: off-label use of medications, 340B pharmaceutical programs, select Medi-Medi referrals, kickback schemes, adherence to compliance programs, hotline complaints, referrals from other agencies or bureaus, drug diversion, quality of care

complaints, steering, DUR overrides/contraindicated medications, and auto-refilling of medications.

Recipient Fraud Unit

At the end of 2008, the Recipient Fraud Unit (RFU) changed the focus of its attention and reintroduced itself to the Local Districts of Social Services (LDSS). RFU's goal was to become a trusted conduit between LDSS and OMIG. In order to accomplish this undertaking, RFU attended the regional New York Welfare Fraud Investigators Association trainings and spoke about OMIG's intentions and goals for the future. The message was well received, leading to RFU visiting each local district, initiating discussions identifying OMIG's goals, and advising the local districts about how RFU could assist with investigations of fraud.

RFU also changed its complaint intake process. RFU's new process includes a "front end" investigation, which begins with evaluating complaints received by the unit. If potential fraud is discovered RFU conducts a full investigation, including collecting all available data, before making referrals to Local District (LD) investigators. This lessens the burden on the LD investigators, providing a better outcome for an investigation because the LD and OMIG are working in concert.

Investigators assigned to the RFU are trained to identify forgeries and recipients involved in drug diversion. The amount of identified forgeries evaluated and processed for referral to either law enforcement or the LDSS significantly increased from 304 cases in 2008 to 683 in 2009.

The RFU identified new means to combat Medicaid fraud throughout the state by participating in regional Medicaid fraud meetings, meetings with local District Attorneys (DA), and joining law enforcement task forces at the state and federal level. Through these connections RFU was able to learn best practices to identify, deter, and combat fraud. RFU developed a News Bulletin to share information about these practices which was well received by DAs and LDSS Commissioners.

Throughout 2009, the RFU assisted LDSS in the investigations of recipient eligibility cases, which rose in number from 282 cases in 2008, to 405 in 2009. There has been a significant increase in substantiated cases and/or administrative actions taken against the recipients due to these efforts and enhanced relationships. Increased efforts by the RFU resulted in a 50 percent increase in substantiated cases.

For 2010, RFU has set a goal of increasing the number of successful prosecutions. Augmenting staffing has allowed RFU investigators to devote more time and energy to each case resulting in an even stronger product. In addition, a project is underway to refer these stronger cases directly to law enforcement, thus boosting successful prosecutions.

Upstate Undercover Investigation Unit

During 2009, the Undercover Investigations Unit expanded its upstate footprint to further OMIG's mission to preserve the integrity of the Medicaid program. In February 2009, undercover investigators were hired and the upstate Undercover Investigations Unit was born. The unit contributes to investigations by identifying fraud and assisting other investigators in confirming the existence of fraud in upstate New York. Undercover investigators blend into the recipient community, identifying and interacting with recipients knowledgeable of suspicious activity.

Equipped with pseudonyms, undercover investigators seek services from Medicaid providers to accurately record the providers' conduct during an undercover operation. The unit is supported by the Administrative Reporting and Tracking Service (ARTS) Unit, which is developing various targeting methods to ensure optimal results from undercover operations. In addition, ARTS reconciles the investigators' reports with Medicaid billing to identify discrepancies. In 2009, ARTS contacted upstate Local District Social Services (LDSS) to enlist their assistance in obtaining Medicaid cards to match undercover identities. OMIG currently has county cooperation with six upstate counties, and intends to expand to other counties in 2010.

Referrals to AG and Other Agencies

Pursuant to state statute, OMIG refers suspected fraud or criminality committed by Medicaid providers to the Attorney General's Medicaid Fraud Control Unit (MFCU) for possible criminal prosecution. In 2009, preliminary findings led to 208 referrals to MFCU; a 136 percent increase from 2008. While the majority of these referrals involved Medicaid providers, DMI also referred 23 non-enrolled providers and two enrolled recipients.

OMIG works in close collaboration with the New York City Human Resources Administration (HRA) Bureau of Client Fraud Investigation and the 57 other Local District Social Services (LDSS) to encourage recipient compliance in order to maintain the integrity of the Medicaid program. In 2009, 552 cases were referred to HRA and 186 cases were referred to LDSS for appropriate action.

DMI maximizes the outcomes of its investigations by sharing its findings with agencies such as the Office of Professional Discipline, Office of Professional Medical Conduct and law enforcement agencies. In 2009, a total of 783 cases were referred to these other agencies.

Collaborative Efforts

DMI collaborates with other governmental agencies including the Department of Health's Office of Professional Medical Conduct (OPMC) and the Bureau of Narcotic Enforcement (BNE), State Education Department's Office of Professional Discipline (OPD) and the federal Health and Human Services' Office of Inspector General (HHS OIG), when

appropriate. Membership in the New York Health Care Fraud Taskforce facilitates the sharing of information regarding providers and fraudulent practices.

OMIG's joint investigations with the Federal Bureau of Investigation, the United States Department of Health and Human Services Office of Inspector General, New York State Attorney General's Medicaid Fraud Control Unit, Bureau of Narcotic Enforcement, State Insurance Fund, New York State Insurance Department, Worker's Compensation Board Inspector General, local district attorneys' offices, and the Special Investigation Units of numerous health insurance providers have lead to prosecutions and administrative actions.

Federal Health Care Strike Force

In October 2009, the Deputy Chief of the Justice Department's Criminal Fraud Section, invited OMIG's DMI to participate in the DOJ Health Care Fraud Task Force which was established in the Eastern Judicial District of New York. DMI designated investigative personnel to this strike force. On December 15, 2009, DMI's Deputy Medicaid Inspector General and Medicaid Investigator in Charge, together with the Department of Health and Human Services Secretary, were invited to attend the press conference held in the Eastern District of New York at which the first arrests relating to strike force operations in this area were announced. During the course of the federal arrests, OMIG investigators obtained evidence, interviewed defendants, and secured arrest locations.

Federal Health Care Fraud Task Force in New York City

In 2009, DMI partnered with the FBI directed Health Care Fraud Task Force. The New York City Office of DMI has been providing investigative support to this task force throughout the year. This assistance has been in the form of conducting Medicaid-related records searches, making undercover investigators available for pharmacy investigations, as well as providing DMI's Spanish, Russian, Armenian and Chinese speaking staff members to assist as translators for on-going investigations.

DEA Task Force

In 2009, DMI entered into a working relationship with the Drug Enforcement Agency's (DEA) Office of Diversion Control (ODC). The ODC consists of diversion investigators, special agents, chemists, pharmacologists, and program analysts. A DMI Senior Investigator joined the DEA Task Force's New York Tactical Diversion Squad (NYTDS).

The primary mission of NYTDS is to investigate and combat the diversion of controlled pharmaceuticals and chemicals. Diversion cases include physicians who sell prescriptions to drug dealers or abusers; pharmacists who falsify records and subsequently sell the drugs; employees who steal from inventory; executives who falsify orders to cover illicit sales; prescription forgers, and individuals who commit armed robbery of pharmacies and drug distributors.

One of the significant issues addressed by the DEA Task Force is the criminal activity of physicians and pharmacy personnel. DMI's success in exposing diversion of prescription drugs by various healthcare providers led to its selection by the DEA Task Force for membership in the Task Force.

DMI began planning its involvement with the DEA Task Force during 2009, with an official implementation date of January 1, 2010.

Albany FBI-Managed Care Task Force

In 2009, DMI staff participated in meetings of the Albany FBI Managed Care Task Force. The FBI initiated this task force to provide a forum for managed care plans and various federal and New York State agencies to meet and discuss current trends and developments in the health care arena. In addition to representation from managed care plans, the State and federal agencies represented include the FBI, the NYS Workers Compensation Board, the New York State Insurance Fraud Bureau, NYS Commission of Quality Care, the U.S. Department of Labor, the U.S. Health and Human Services Department, the U.S. Attorney's Office, the New York State Attorney General's Office Medicaid Fraud Control Unit and the U.S. Department of Internal Revenue. These meetings are held quarterly at the FBI offices in Albany.

Pediatric Dentistry Investigation

New York State and the federal government took action against a pediatric dentistry chain operating in New York State after hearing allegations that the management allowed improper practices in treating children, specifically Medicaid recipients. These practices included performing poor quality work, restraining small children during lengthy dental visits, performing root canals and placing crowns on baby teeth, and not allowing parents to accompany children during dental treatment. A prepayment review of several locations of the pediatric dental chain was completed by OMIG's Prepayment Review Unit in 2009. As part of this joint effort, $423,702 in pended claims was denied which included four individual providers and two groups (71 individual providers).

OMIG departments worked with the Medicaid Fraud Control Unit (MFCU) and the New York State Office of Professional Discipline (OPD) during the investigative process. State agencies also cooperated with federal authorities, including the Department of Health and Human Services Office of Inspector General and the United States Department of Justice.

OMIG divisions developed and implemented a corporate integrity agreement (CIA) with the chain. As a condition of this agreement, the dental chain will reimburse New York State $2.3 million to settle outstanding OMIG audit findings. The New York CIA was agreed to on the same day as a federal CIA with the United States DHHS/OIG as well as a $24 million national settlement. New York State will receive $1.15 million from that settlement. Today, the offices are staffed with new dentists and a new manager.

DMI Highlights

Upstate Recipient Fraud Unit Investigates Drug Diversion Ring

This investigation started with a hot-line complaint alleging that a Medicaid recipient stole a prescription pad from a doctor's office in Manhattan. DMI investigators worked closely with the doctor's office, Human Resources Administration (HRA) in New York City, and the pharmacy where the forged prescriptions surfaced to verify the forgeries and locate the recipient in question.

DMI uncovered information indicating that other prescriptions had been obtained from hospital emergency rooms in other states that contained forged Federal Prisoner Discharge Medical Documentation indicating the patient was HIV positive and needed medications. The FBI, working in concert with HRA Bureau of Fraud Investigations and OMIG, arrested this individual for diverting HIV drugs. When interviewed, the subject admitted to paying homeless people cash for their Medicaid card. The subject was convicted of health care fraud, conspiracy, wire fraud, and identity theft and is awaiting sentencing. The Medicaid recipients whose cards were used were interviewed and their cases forwarded for action.

Home Care Agency Excluded From Medicaid for Employing and Billing for Unlicensed Nursing Services and Services Not Rendered

DMI received a hot-line complaint from a recipient who alleged this home care agency billed her for services which were never provided. After further DMI review it was disclosed that eighteen nurses employed at this agency did not have a valid New York State license and one licensed professional nurse had a limited permit. The agency billed for 17,748 service hours for these employees amounting to $427,968 in fraudulent claims. In addition, there was no documentation for 2,090 service hours amounting to $51,838; and billing for 1,216 hours where services were not provided amounting to $29,054. The investigation also revealed that the agency used valid license numbers from other nurses to bill for services provided by unlicensed nurses. DMI determined this was a willful act of fraudulent billing and referred this case to MFCU. In April 2009 the owner/operator of the home care agency was convicted. Twenty-four staff members were also convicted on subsequent dates. The home health agency was excluded from the Medicaid program on April 29, 2010.

Dentist Immediately Excluded for Health and Safety Issues

The upstate Provider Surveillance Utilization Review System (SURS) Unit originally targeted this provider for an unusually high number of claims for a particular medical service. The provider did not comply with DMI's initial requests for records. In September 2009, investigators from DMI's New York City office conducted an on-site visit at the provider's office in Brooklyn in order to retrieve charts requested by the Provider SURS Unit. During this visit, investigators observed conditions that were "unsanitary and deplorable", and detrimental to the health and safety of the patients. These conditions

included the provider attending to a patient in a dirty exam room; clogged sinks at patient stations; uninspected x-ray equipment; and paint and plaster hanging from the ceiling due to water leakage.

In addition, the provider did not have a hazardous waste disposal contract, and medical waste was found stored in a closet in this office. Investigators took photos documenting these conditions and forwarded them to DMI's Upstate Exclusions Unit for immediate termination of this provider. DMI also made referrals to the New York State Office of Professional Discipline, and the New York City Health Department.

OMIG's presence on-site in medical facilities not only protects the integrity of the Medicaid program, but also ensures that beneficiaries are given quality care from providers.

Eight Charged with Medicaid Fraud Involving Four Manhattan Pharmacies

This was a joint investigation with the FBI, NYC HRA Bureau of Fraud Investigation, and OMIG DMI. The targets of the investigation were four pharmacies operating in upper Manhattan allegedly diverting drugs, committing financial fraud and misusing Medicaid recipients' identification cards. The flagrantly fraudulent acts included billing the Medicaid program for prescriptions that were never filled, giving recipients cash in lieu of medications, and selling controlled substances without a prescription. DMI investigators personally served Notices of Immediate Agency Action excluding the four pharmacies from participation in the Medicaid program.

In 2009, several individuals were arrested and charged with violation of the United States Code 1347 - Health Care Fraud, and the United States Code 1349 - Conspiracy to Commit Health Care Fraud. An individual who owned one of the pharmacies pled guilty to health care fraud and was sentenced to 18 months in federal prison. An employee of one of the pharmacies pled guilty to health care fraud and was sentenced to time served and 18 months of supervised probation. Another owner pled guilty to health care fraud, was sentenced to 78 months in federal prison, and was ordered to pay $3,024,822 in restitution to the Medicaid program.

Summary of Fraud Financial Investigations and Referrals

Investigations are opened and closed by OMIG and often result in referrals to other entities for closure. Some of these investigations can also result in dollar findings.

Investigations	Initiated	Finalized	Findings	Recoveries
2009	13	11	$3,495,493	-$65,559*

* Fraud Financial recoveries for calendar year 2009 include refunds to providers of monies withheld in previous years in the course of DMI investigations. Corresponding refunds resulted in a negative balance for 2009.

OMIG refers preliminary findings to many different agencies. The first table below shows referrals made to the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) for 2009. The second table shows investigative referrals made to outside agencies other than MFCU.

Provider Type	2009
Child Care Institution	1
Clinical Psychologist	1
Dental Groups	2
Dentist	32
Diagnostic & Treatment Ctr.	5
Enrolled Recipients	2
Home Health Agency	20
Hospital	1
Medical Appliance Dealer	28
Non-enrolled Providers	23
Nurse	16
Optician	8
Optometrist	2
Pharmacy	61
Physician	2
Transportation	4
Total	**208**

Agency	2009
Bureau of Narcotic Enforcement	2
Center for Medicare & MA	1
H.I.P	2
Law Enforcement Agency	2
Local District Social Services	186
NYC HRA Bureau of Client Fraud Investigations	552
OMH	1
OMRDD	2
Off. of Prof. Discipline	8
Off. of Prof. Med. Conduct	1
Off. of Welfare Insp. General	1
Other DOH Unit (not OMIG)	7
Other Federal Agency	7
Other State Agency	11
Total	**783**

Division of Medicaid Audit

Functional Description

The Division of Medicaid Audit (DMA) professional staff conducts audits and reviews of Medicaid providers to ensure compliance with program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; ensure the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and reduce the potential for fraud, waste and abuse.

DMA's field staff have a broad range of experience in health care programs. This affords the DMA the opportunity to organize and coordinate statewide projects to address the spectrum of Medicaid-covered services and the various program initiatives of the Department of Health (DOH), Office of Mental Health (OMH), Office for People With Developmental Disabilities (OPWDD), and the Office of Alcoholism and Substance Abuse Services (OASAS).

Pursuant to 42 USC § 1396(5); §§ 20, 34, and Article 5, Title 11 of the New York Social Services Law, and Chapter 436 of the Laws of 1997, DOH is the designated single state agency responsible for administering and supervising the Medicaid program in New York. That responsibility includes ensuring the quality of care within each facility, establishing the rates of payment to be paid to each facility for Medicaid-covered care (Public Health Law Article 28), validating the appropriateness of payments on delayed or denied claims, and the responsibility of assuring the accuracy of the promulgated rates of payment through the audit of cost reports (Social Services Law § 368-c). To carry out the latter responsibility, DOH conducts audits and reviews of various providers of Medicaid-reimbursable services.

Medicaid program participation is a voluntary, contractual relationship between the provider of service and the state (Social Services Law § 365-a; 18 NYCRR Part 504). Satisfactory compliance with program rules and regulations is a condition of continued participation in the Medicaid program.

By choosing to participate as a Medicaid provider, a participant assumes responsibility for meeting all requirements as a prerequisite for receiving payment and maintaining continued status as an enrolled provider (18 NYCRR Parts 504, 515, 517 and 518). Enrollment as a provider, along with participation and submission of billings certifying compliance with those rules and regulations (18 NYCRR §§ 504.3 and 540.7(a) (8)), connotes acceptance of the contractual responsibilities.

DOH regulations (18 NYCRR Subchapter E) define the requirements for participation, as well as the rules, regulations and statutes of general applicability to the provider type in question. The rules governing the establishment of Medicaid rates by DOH are enumerated in 10 NYCRR Subpart 86-2.

Audit Process

The Medicaid program requires participating providers to maintain adequate records to support their billings to the program. Cost-based providers must maintain financial and statistical records which are used for the purpose of establishing reimbursement rates. This includes all underlying books, records and documentation that form the basis for the financial and statistical reports which the provider files with the Bureau of Long Term Care Reimbursement (BLTCR). The BLTCR is responsible for establishing the payment rates.

Fee-for-service providers, paid in accordance with DOH-established rates, fees and schedules, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the Medicaid program. The provider must keep all records necessary to disclose the nature and extent of services furnished and the medical necessity of the service, including any prescription or fiscal order for the service or supply, for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later.

DMA's goal is to implement a system of paperless audits for rate-based provider audits. DMA chose the TeamMate audit software program to facilitate more efficient and consistent rate-based provider audits statewide. During 2009, DMA implemented the TeamMate program for all rate-based provider audits. In 2010, all new rate-based provider audits will be initiated and performed in TeamMate. In addition to performing the audits in TeamMate, DMA will be able to build a database of findings from the audits performed.

DMA publishes its annual work plan to assist compliance offices in developing their own organization-specific audit and monitoring activities.

Data Warehouse and Analysis Unit

The Data Warehouse and Analysis Unit (DWA) provides data, analysis and support for all three bureaus within DMA, as well as completing ad hoc requests for data from DMA management.

DWA staff use data mining technology to pull data for mail outs, reports and field audits. The unit regularly identifies areas with overpayments.

DWA staff creates and maintains algorithms for data pulls, cleanses the data and provides databases for recovery/review in a format useful to the auditor. When requested, recovery project tracking databases are created and updated regularly. Reports and summaries are provided for project monitoring. As data file extraction proceeds, DWA and the requestor discuss and agree to all subsequent criteria revisions such as scope and additional fields.

The DWA unit also provides the Bureau of Rate Audit with data and statistics. In 2009, DWA began gathering information and collaborated on ways to monitor the risk of duplicate claims being submitted, paid and remaining undetected. After collaborating and sharing information between the different divisions within OMIG and DOH, the DWA created a process to identify and monitor the risk of duplicate claims being paid to the provider. The DWA will recover Medicaid overpayments and provide the Payment Controls and Monitoring Unit with a list of providers who

continue to bill Medicaid directly and fail to adjust/void duplicate claims. The providers on this list will then be considered for prepayment review.

Selection of Audit Subject Areas, Providers and Methods

DMA uses a variety of analytical tools and data mining techniques to identify providers for audit purposes. Successful initiatives in Medicaid program integrity in other states, current academic and public policy organization analyses of health care issues, and program ideas and directives from the CMS Medicaid Integrity Program, which has federal responsibility for guiding and overseeing OMIG's work, are all considered by DMA when preparing for an audit. DMA works closely with the Department of Health, the Department of Law and the Office of the State Comptroller in identifying program vulnerabilities.

The Department of Health and Human Services' Office of Inspector General (OIG), oversight agencies, newspaper articles and OMIG's hotline all make recommendations to OMIG. An integral part of the selection process is a review of oversight agency survey reports or other provider reviews. DMA uses this information to determine whether or not to perform an audit, and, if so, the type of audit to perform. For example, DMA has the option of performing a documentation and coding audit or a clinical audit of fee-for-service providers, or a combination of those audit approaches.

Project Notification

An on-site audit begins when DMA notifies a provider by sending a project letter. In 2008, OMIG revised the project letter to require providers to submit certain audit documentation to OMIG within 30 days. This enables DMA to perform audit procedures prior to beginning the field audit. The information includes audited financial statements, tax returns, a list of related parties and selected analysis of work. In addition, the provider is directed to notify its outside accountants of the audit in writing, so that the DMA can gain access to their workpapers.

Entrance Conference

DMA conducts an on-site entrance conference with each individual provider to discuss the nature and extent of the audit. For rate-based audits, specific issues to be addressed in the audit are discussed based on pre-audit reviews of documents. For fee-for-service audits, DMA is able, in certain instances, to give providers the specific date of service or cases under review. In other instances, DMA gives the provider sample selections periodically during field work which may include ranges of dates of service.

Statistical Sampling

Accounting firms, national healthcare consulting firms, the Department of Health and Human Services, and the Office of the Inspector General (OIG) have historically used statistical sampling for audit purposes. In many instances, statistical sampling allows an audit of an account to be conducted that would otherwise be too voluminous or complex to audit in its entirety. Some of the sampling techniques generally used by auditors, including the DMA, are as follows:

- *Population or sampling frame* - the entire set, comprised of individual elements, under consideration. In the context of third-party insurer audits, the population might be the set of all claims made over a certain period of time or the set of all recipients of medical care.

- *Sampling unit* - the individual elements that comprise the population or sampling frame. In the case of an insurer audit, the sampling unit might be the insurance recipient or the individual insurance claim or transaction.

- *Probability sample* - a sampling procedure in which the probability that any member of the population will be included in the sample is known in advance. For example, in a simple random sample, each member of the population has an equal chance of being included in the sample. Valid estimation procedures require probability samples.

- *Random sample* - a group of sampling units from a population where each unit has an equally likely chance of being independently selected from the population or sampling frame.

- *Sampling procedure or technique* - the method used to select units for inclusion in a probability sample. For instance, choosing every tenth unit (systematic sampling), or using a random number table.

- *Estimator* - the mathematical rule by which an estimate of some population characteristic is calculated from the sample results.

- *Estimate* - the value obtained by applying the estimator to the random sample, and projecting it to the larger population. A **point estimate** is an estimate in which a single number is used as an estimate of a population characteristic. An **interval estimate** is one in which the estimate is given as a confidence interval within which the population characteristic will lie with a certain confidence level.

- *Unbiased* - an estimator is unbiased if the average value of the estimate, taken over all possible samples, is exactly equal to the true population value.

- *Confidence interval, confidence level* - the confidence interval is the range of values in which a population characteristic will lie with a given level of certainty (confidence level, expressed in percent). For example, we might be “95 percent confident” that the mean of a sampling frame is between two values, X1 and X2, which are the upper and lower bounds of the confidence interval.

DMA uses the services of a recognized statistician to assist in the development of sampling techniques and analysis and identification of the results of a statistical sample.

Audit Field Work

DMA's standard request for documents include audited financial statements, tax returns, information on related parties and access to the workpapers of independent certified public accountants. This information facilitates the review and, at times, enables DMA to reduce the audit procedure. Additionally, DMA reviews enrollment records and annual certification for paper and electronic submission of claims.

DMA is streamlining the audit process based on comments from trade associations and providers. The goal is to share the preliminary findings, including work papers, during field work with the intent to resolve any differences before an exit conference.

DMA has incorporated into its audit process a review of medical necessity for services rendered to eligible recipients and billed to the Medicaid program. The purpose of the medical necessity review is to determine if services are reasonable and necessary, and, therefore, reimbursable through Medicaid. OMIG clinical staff has the requisite training needed to review clinical documentation and make determinations regarding the appropriateness of the services provided to Medicaid recipients.

Exit and Draft Reports

Upon completion of a field audit, DMA conducts an exit conference with the provider to discuss preliminary findings. Afterward, the DMA issues a draft audit report that identifies any proposed recoupment and the basis for the action. The provider has 30 days to respond to the draft audit report. If the provider objects to the draft audit report, the DMA considers the provider's response, including any supporting documentation, before issuing a final audit report. If the provider fails to reply within that time frame, the DMA issues a final report.

The provider has 60 days after receiving the final audit report to request an administrative hearing. If granted, the administrative hearing will be limited to only those matters contained in the provider's objection to the draft audit report. If the provider disagrees with the hearing decision the provider has the option to undertake an Article 78 proceeding.

Bureau of Provider Audit

DMA conducts billing audits of provider services rendered to eligible recipients paid on a fee-for-service (FFS) basis. These audits focus on ordering practices of hospitals, diagnostic and treatment centers, physicians and other health care providers. The division is responsible for coordinating all Medicaid-related "self-disclosure" cases. DMA also conducts audits to determine the medical necessity and quality of care rendered to eligible recipients.

Provider Audit Disallowance System

The Provider Audit Disallowance System (PADS) is an electronic workpaper program in development for OMIG Fee for Service (FFS) auditors. When fully functional, PADS will completely standardize the audit process for each audit type across the state, facilitate supervisory and managerial review of audit workpapers during all phases of the audit, and serve as an electronic repository for the workpapers and supporting provider documentation. During calendar year 2009, the PADS workgroup - consisting of auditors, supervisors, managers and IT programmers - met numerous times to develop application requirements, such as the detailed screen designs and internal reports required. The program was piloted in the audit areas of Pharmacy and Diagnostic & Treatment Center, with four reviews completed statewide.

Pharmacy Projects

In 2009, DMA continued to maintain and update Audit Protocols. Training sessions and presentations continue to be made to staff and pharmacy association groups, statewide.

During the year, 39 pharmacy audits were opened, while 35 audits were finalized. These audits had findings totaling $608,407 and recoveries totaled $3,158,249.

Self Disclosures

"In a new self-disclosure program, the New York State Office of Medicaid Inspector General invites providers to divulge potential violations of all kinds in exchange for a considerable break in fines, repayments and other sanctions (e.g., Medicaid exclusion). OMIG's version is 'significantly more expansive' than the HHS Office of the Inspector General's self-disclosure protocol, according to the self-disclosure guidance, published March 12."
--HCCA-AIS Medicaid Compliance News
April 2009

DMA is responsible for the statewide provider "self-disclosure" process for all Medicaid providers, regardless of provider type. OMIG conducts active outreach with various provider associations, professional societies, other state agencies and the New York State Bar Association to encourage providers to come forward when internal issues of fraud, waste, abuse and billing errors are identified.

DMA's disclosure process describes the steps a provider should follow to identify the reason(s) for the disclosure, the financial impact to the Medicaid program as well as the corrective measures implemented to prevent the reoccurrence of the error. The DMA takes steps to ensure the parameters of the disclosure are true and correct through data analysis of the claims, medical and/or billing record review, along with assessing the financial data. If the provider contracts with an outside consultant to perform an internal review, the DMA requires that the disclosure include an engagement letter, a description of the methodology used to examine the

provider's records, the sampling technique used to extrapolate findings and overpayments to include a universe of payments as well as the sample cases, and a description of the documents reviewed.

Self disclosures for 2009 have identified a number of issues that will lead to future statewide audits, including reviews of: all inclusive hospital clinic rates that were modified to remove physician costs from the rate and allow them to bill separately; audits of home care providers to ensure Medicaid is not being billed for travel time for aides providing home care services; audits of renal care providers to ensure Medicaid is not being billed for services that are all inclusive in Medicare rates; audits of teaching hospitals' medical education rates, which include Medicaid funding, to ensure only qualified residents are included in the program.

In 2009, 136 self-disclosures were received and 98 were finalized with findings of $9,931,991, and recoveries of $9,324,972.

Diagnostic and Treatment Centers

During 2009, DMA initiated 18 and finalized 23 Diagnostic and Treatment Center (D&TC) audits. Audit staff reviewed case record documentation to ensure compliance with applicable laws, regulations, rules and policies of the Medicaid program. The total findings for these audits are $7,280,315.

Future audits will include time tracking, workflow, integration with the Data Warehouse, template storage, and the import of completed audits functionalities.

Chemical Dependence Providers

OMIG's DMA continues to emphasize the importance of reviewing clinical documentation to support the provision of patient-centered and clinically necessary services to demonstrate quality of care. In 2009, OASAS's Bureau of Quality Management (BQM) staff trained DMA nurses to review chemical dependence clinical records for compliance with quality services and medical necessity standards regarding evaluations, treatment planning and progress note documentation. This training is provided to additional DMA nurses as they are added to these projects. OASAS's BQM staff were asked to spot check OMIG's reviews and to confirm OMIG's decisions as needed. DMA refers policy questions pertaining to chemical dependence audits to OASAS for program guidance and solutions.

Outpatient Chemical Dependence Providers

DMA conducted audits and pursued recoveries of Office of Alcoholism and Substance Abuse Services (OASAS) outpatient chemical dependence providers. DMA reviewed case record documentation to determine compliance with OASAS regulations and Medicaid billing requirements. DMA Audits emphasized the clinical documentation to support the provision of patient-centered and clinically necessary services to demonstrate quality of care. The audit protocols were updated and revised.

During 2009, DMA initiated 18 outpatient chemical dependence audits, of which 8 were finalized. In 2009, an adverse hearing decision for $52 million impacted OMIG's OASAS fee-for-service audit finding amounts. As a result of the hearing decision, total findings were $(44,335,348); and total recoveries totaled $1,742,015. Several audits have been reviewed by clinical staff to evaluate services for medical necessity. These audits have not been finalized, but it is anticipated that these will be completed in 2010.

Inpatient Chemical Dependence Providers

In 2009, DMA initiated two (OASAS) inpatient chemical dependence rehabilitation audits and three were finalized with total findings of $655,644. Total recoveries in 2009 amounted to $876,739.

Outpatient Mental Health Services

Audits and reviews of providers of outpatient mental health services licensed by the Office of Mental Health (OMH) remain integral to DMA billing and documentation audit projects. During calendar year 2009, 17 outpatient mental health audits were initiated and 16 were finalized with total findings of $2,973,670. Total recoveries in 2009 amounted to $1,949,322.

In addition to billing documentation, several audits conducted in 2009 involved the review by OMIG's peer consultant of clinical documentation for medical necessity and quality care.

OMH Rehabilitative Services

Reimbursement under the Medicaid program is available for OMH Rehabilitative services provided by residential programs that are licensed in accordance with the provisions of Article 31 of the Mental Hygiene Law. Residential programs primarily have a rehabilitative focus and provide an array of rehabilitative and supportive services to individuals diagnosed with severe and persistent mental illness. The purpose of these programs is to provide varied services which support and assist individuals with their goal of integration into the community.

In 2009, OMIG initiated five audits and finalized one. These audits focused on adult recipients. Going forward, OMIG anticipates enlarging the scope to include family-based programs as well.

COPS/CSP-Overpayment Recoveries

OMIG and the OMH performed a review of mental health providers who received COPS/CSP (community support programs) overpayments for the three years ending June 30, 2005 for NYC based OMH providers and December 31, 2005 for all others. COPS are supplemental payments in addition to the provider's Medicaid rate. The amount of COPS reimbursement that a provider can receive is limited to a threshold amount and any COPS received in excess of that amount can be recouped. CSP payments in excess of a formulated reimbursement rate are also subject to recovery. Recoveries of COPS and CSP overpayments are for the period of

local fiscal year (LFY)2002/03—2004/05 for New York City providers and county year (CY) 2003-2005 for the rest of the state.

In 2009, 217 OMH-COPS/CPS audits were initiated. Total recoveries amounted to $144,110. It is expected that these audits will be completed in 2010.

Office for People With Developmental Disabilities (formerly OMRDD)

In 2009, DMA pursued audit projects related to the Office for People With Developmental Disabilities' (OPWDD) residential habilitation and Medicaid service coordination programs.

Additionally, OPWDD's Bureau of Fiscal Audit conducts limited fiscal reviews, which include routine Medicaid billing and claiming reviews as well as special reviews of selected OPWDD providers. Also, OPWDD fiscal units conduct claim-based audits of residential therapy, transportation and DME/OTC service providers that are opened and tracked for collection purposes through OMIG's Fraud Activity Comprehensive Tracking System (FACTS).

For calendar year 2009, 259 audits were initiated and 310 were finalized with total findings of $3,200,404. Total recoveries amounted to $3,275,751.

Ambulatory Surgery

The Medicaid program reimburses ambulatory surgery centers at a higher payment rate than it does if the same services were to be performed in a physician's private office. If the service is performed in an ambulatory surgery center, it must be justifiable for reasons of patient safety and administration of anesthesia. OMIG reviewed physician and ambulatory surgery center medical charts to ascertain if documentation demonstrated that the procedure needed to be performed in an ambulatory surgery setting.

During the fiscal year 2009, Fletcher Allen in Vermont was audited and a final report was issued for $7,131,062. Sharon Hospital in Connecticut was also audited and a final report was issued for $1,234,509.

Hospital Outpatient Departments

Hospital outpatient department (OPD) billing audits continued in 2009. OPD audits include emergency room/clinics, referred ambulatory services and laboratory services.

During 2009, 17 hospital outpatient department audits were initiated and 10 were finalized, with total findings of $3,089,187.

Laboratories

During 2009, three audits of independent laboratories were initiated and one was finalized, with findings of $77,776. In addition, seven hospital laboratory audits were initiated and terminated due to a change in policy concerning dual eligible recipients.

Exception Code Project

The Medicaid program requires providers to submit claims within 90 days from the date of discharge (inpatient) or the date of service (outpatient). In keeping with general industry standards, DMA reviewed the dates of service using a 180 day claim submission period rather than Medicaid's standard of 90 days from the date of service. If no valid reason for the late claim submission is demonstrated, the claim is denied.

DMA expanded the number of audits and reviews of late claims submission to the Medicaid program into more categories of service. During 2009, DMA sent letters to 163 providers in the categories of service of Home Care Program, Diagnostic and Treatment Centers, Personal Care and Home Health Agencies in addition to OASAS, OMH and hospital-based inpatient and outpatient services requesting documentation to support their need for late claim submission.

In 2009, total recoveries for the exception code project were $484,996.

Durable Medical Equipment

There were 11 DME audits finalized in 2009 with total findings of $7,609,912. Major issues included incomplete information on fiscal orders, failure to produce documentation related to dual eligible recipients and potential duplicate payments related to claims for individuals residing in institutional settings. A number of DME reviews have also been completed as part of the County Demonstration Project.

Home Health

In 2009, DMA issued three final reports for Certified Home Health Agency audits with findings totaling $1,662,386. Ongoing reviews have added a clinical assessment element to the audits utilizing the expertise of OMIG nurses and a Physician consultant.

Personal Care

In 2009, DMA issued three final reports with findings totaling $473,825. Four audits are currently in progress. Included in these reviews are assessments of providers billing under the Consumer Directed Personal Assistant Program. The reviews done to date have been upstate. The emphasis for the current year will be on audits of providers located downstate where the majority of Personal Care dollars are spent.

Transportation

Medicaid recipients may be eligible for transportation to and from Medicaid-approved medical services. The Medicaid program will cover the costs of emergency and non-emergency transportation if it has been determined by a physician that such transportation is necessary

based on the medical condition of the recipient. Non-emergency transportation includes ambulance, ambulette and taxi/livery.

Historically, DMA has focused more on the ambulette transportation providers. In 2009, OMIG began developing audit protocols for the taxi and livery categories of service and these areas, as well as ambulettes, will be the focus for 2010. In 2009, 78 audits were initiated and four were finalized with total findings of $49,711. OMIG realized $191,671 in recoveries.

Traumatic Brain Injury

During 2009, DMA continued to expand its audits to encompass more of the downstate areas of Westchester, Mid-Hudson and Long Island. Auditors were trained in policy and manual standards, retrieval, review and evaluation of Traumatic Brain Injury (TBI) documentation. Auditors worked with experienced staff to ensure their proficiency in conducting this type of provider audit.

Auditors revised case record documentation to determine the adequacy of provider records in support of their claims to Medicaid and their compliance with applicable rules and regulations.

Thirteen TBI provider audits were initiated and five audits were finalized. The total findings for these audits are $1,756,581. Total year's recoveries are $1,092,131.

Bureau of Rate Based Audit

The Rate Based Audit Management and Development (AMD) Bureau, within the Division of Medicaid Audit, is responsible for financial audits and desk reviews of cost reports used to set rates for Medicaid providers. AMD performs billing audits of Medicaid providers who are paid on a pre-determined rate basis - for example, residential health care facilities and managed care plans. AMD auditors also conduct match projects to determine whether rates have been appropriately billed to Medicaid for certain beneficiary groups (e.g., incarcerated or deceased enrollees). DMA staff routinely use the audits and desk reviews to make these determinations.

Residential Health Care Facilities

Residential health care facilities (RHCFs) are reimbursed for covered services to eligible Medicaid recipients based on prospectively determined rates. Through 2009, the prospective rates were comprised of two components - an operating component and a property/capital component.

The operating component was based on the 1983 reported costs of the RHCF, or the first full year of operation, whichever was later; or on a current basis to reflect, among other events, a change in ownership or construction of a new facility. The base year for the operating portion

is fixed. The same reported costs, with appropriate inflation factors, are used for multiple years of reimbursement for the operating portion until a new base year takes effect.

The property/capital component is based on costs reported in each year with a two-year time lag. Mortgage expense is the exception and is based on rate year costs.

New York passed legislation in 2006 to rebase the 2009 operating component of the Medicaid rate from 1983 to the year 2002. The legislation takes effect retroactively to April 1, 2009 pending federal Centers for Medicare and Medicaid Services (CMS) approval. Effective April 1, 2010, the method used to reimburse RHCFs for services provided to Medicaid patients was scheduled to be revised and is under discussion at the Department of Health.

AMD audits identify inappropriate or unallowable costs, services dropped by the RHCF, but included in the reimbursement formula, rate appeal adjustments, and prior audit adjustments to property and operating costs that need to be carried over into subsequent rates (rollovers).

Activity in this chart represents residential health care facility audits issued in 2009. As designated in the chart, AMD issued 127 RHCF audits and identified $38.6 million in overpayments.

Audit Type	2009	
	Audits Issued	Findings (millions)
Base Year	24	$ 16.4
Dropped Services	22	5.8
Property	42	14.3
Rollover	39	2.1
Total	**127**	**$ 38.6**

Audit Process

DMA's goal is to implement a system of paperless audits for rate-based provider audits. In 2008, a team of auditors instituted a pilot program utilizing electronic work papers and chose the TeamMate audit software program to facilitate more efficient and consistent rate-based provider audits statewide. This program was implemented in all new rate-based provider audits during SFY 09-10. In conjunction with the implementation of the TeamMate software, AMD developed a training manual and outline for all rate-based provider audits.

Base Year Audits

Reported base year costs, with appropriate inflation factors, are used for multiple years of reimbursement for the operating and property component until a new base year is set. For example, an audit of base year costs for three RHCFs identified the following disallowances:

- unsubstantiated expense
- prior period expense
- duplicate expense
- non-allowable mortgage cost
- non-allowable late fees
- interest on non-compete agreement
- real estate tax disallowance

These three audits resulted in an overpayment of $6,678,818 in 2009.

Dropped Services Audits

OMIG conducted an audit of a RHCF's ancillary services for the three years ending December 31, 2006. The audit identified ancillary services which, subsequent to the base year, were dropped, but the facility's Medicaid rates still included the cost of the ancillary services. Where Medicaid is paying the outside fee-for-service provider in addition to the RHCF for the same ancillary services, duplicate reimbursement occurs. The audit resulted in an overpayment of $1,435,226. This audit is one example of the dropped services audits performed in 2009.

Property Audits

Reported RHCF property costs are used as a basis for the property/capital component of the facility Medicaid rate on a two year lag basis. For example, property/capital audits of three facilities' costs identified significant issues, including:

- Disallowance of mortgage interest
- Offset of investment income
- Disallowance of unnecessary working capital interest expense
- Disallowance of movable equipment depreciation
- Disallowance of equipment rental expense
- Disallowance of capitalized lease expense
- Disallowance of mortgage amortization
- Funding of depreciation disallowance
- Non-patient care disallowance

These three audits resulted in overpayments totaling $4,503,716.

Rollover Audits

Base year operating costs are increased by an inflation factor and used as a basis for RHCFs Medicaid rates for subsequent years. During 2009, OMIG carried forward base year operating cost audit findings into subsequent rate years. The three largest Medicaid rollover facility impacts totaled $2,002,026.

Home Health

In 2009, DMA developed audit programs for review of certified home health agencies (CHHA) and long term home health care (LTHHC), and initiated two CHHA audits and two LTHHC audits.

These audits review reported costs to identify inappropriate and unallowable costs included in promulgated Medicaid rates. Additionally, rate add-ons are audited, such as Worker Recruitment and Retention (WRR); Recruitment, Training and Retention (RTR); and Accessibility, Quality and Efficiency (AQE), to ensure compliance with statutory requirements.

Adult Day Health Care

During 2009, DMA initiated one audit of an adult day health care (ADHC) center to determine whether there was duplicate Medicaid payment for transportation of the ADHC participants.

Chemical Dependence Inpatient Rehabilitation Services

In 2009, DMA developed an audit program for review of Office of Alcoholism and Substance Abuse Services (OASAS) rate-based inpatient chemical dependence providers. These audits review reported costs to identify inappropriate and unallowable costs included in promulgated Medicaid rates. DMA initiated one of these audits in 2009.

Diagnostic and Treatment Centers

During 2009, DMA finalized one audit of a diagnostic and treatment center's (D&TC) Medicaid rate. The audit identified Medicaid overpayments of $931,442.

Bureau of Managed Care and Provider Review

Managed care plans coordinate the provision, quality and cost of care for its enrolled members. In New York State, several different types of managed care plans participate in Medicaid managed care, including health maintenance organizations, prepaid health service plans, managed long-term care plans, primary care partial capitation providers, and HIV special need plans. The Medicaid managed care policy and billing procedures are found and referenced

relative to the sections found in the Medicaid managed care/Family Health Plus contract. The managed care contract describes the responsibilities and agreements established between a managed care organization and the New York State Department of Health (Medicaid).

In October 2008, DMA established the Bureau of Managed Care Audit and Provider Review ("MCA&PR") to specifically address audit issues related to managed care, assure that managed care organizations are in compliance with program requirements, and identify and recover any overpayments. The Bureau performs various match-based targeted reviews and audits in the area of managed care that identify and recover overpayments, in addition to submitting and implementing corrective action procedures that address system and programmatic issues/errors. In 2009, 192 new audits were opened in seven project areas, and 290 audits were finalized, recovering $34.4 million related to managed care audit projects.

In addition to its managed care related activity, the bureau is also responsible for assisting the division in other audit related functions. In 2009, 103 audits were opened and 73 were finalized related to special project areas; recovering $6.2 million.

Following is a summary of the project activity in 2009.

Improper Multiple Client Identification Numbers for One Enrollee Payments

In prior years DMA recovered directly those capitation payments made incorrectly to managed care organizations (MCOs) for Medicaid enrollees who were already enrolled in the MCO under another client identification number (CIN) through the normal audit process. In 2009 DMA changed their recovery process by notifying the local district to first retroactively disenroll the incorrect CIN, and then notify the MCO to submit a void on the inappropriate payments. Recoveries related to this project are now included in the "Recovery of Capitation Payments for Retroactive Disenrollment Transactions" project narrative. Three final reports to complete the project activity for 2008 were issued in 2009. A workgroup formed with staff from the Attorney General's Medicaid Fraud Control Unit (MFCU), the New York State Department of Health's Office of Health Insurance Programs (OHIP), New York City Human Resources Administration (NYC HRA), and OMIG continues to meet and develop corrective action procedures to address and reduce the causes of duplicate CINs being issued.

Recovery of Capitation Payments for Retroactive Disenrollment Transactions

The Medicaid managed care and Family Health Plus model contract, Section 8.2, requires MCOs to void premium claims for any months where a managed care enrollee is retroactively disenrolled from managed care, and the MCO was not at risk to provide medical services to the enrollee during the month. OMIG will continue to identify and review retroactive disenrollment of beneficiaries on an annual basis to ensure that the MCO repays, or voids, capitation payments when the MCO was not at risk for the provision of benefit package services during any month. In 2009 35 MCO's retroactively repaid $7 million related to disenrolled beneficiaries.

Managed Care – Incorrect Locator Code Designations

Each managed care enrollee is assigned a three digit number that identifies that enrollee's county of residence, termed the enrollees locator code, which assures that the appropriate capitation and/or supplemental payment(s) are made to the managed care organization on the enrollee's behalf. In 2009 OMIG initiated 5 audits of MCO's that received higher than their appropriate capitation and supplemental payments as a result of incorrect and/or inaccurate identification of the enrollee's county of residency.

Improper Retroactive Supplemental Security Income Capitation Payments

In 2009, the DMA continued its review of retroactive Supplemental Security Income (SSI) capitation payments made to MCOs. The Medicaid managed care contract, Section 10.29, Prospective Benefit Package Change for Retroactive SSI determinations, states that, despite the fact that an enrollment status may be changed using retroactive dates, MCOs may not bill capitation payments retroactively to a listed date of SSI eligibility. Only prospective billing can be used from the date the plan is notified via the roster of the status change to SSI. In 2009, sixteen audits were finalized recovering $513,028.

Family Planning Chargeback – MCO

Medicaid enrollees have the right to go outside their MCO to receive their family planning services. In instances where the enrollee has chosen to go outside the health plan network for family planning services, those claims are identified on an annual basis and are recoverable from the MCOs, as stated in the managed care contract, Appendix C, Part II, and Section 2b. In 2009 DMA opened 31 and finalized 49 audits in this area; recovering approximately $18 million.

Family Planning Chargeback – FFS

MCOs are responsible for reimbursing their network providers for services provided to their Medicaid enrollees. In this review DMA identifies family planning services that were billed as a fee-for-service from a network provider of the MCO, and recovers the fee-for-service payment made by Medicaid to the network provider. In 2009, DMA opened 70 audits and finalized 53 in this area; recovering $909,078.

Capitation Payments for Deceased Managed Care Enrollees ("Death Match")

Matching the New York State Medicaid database with vital statistics for New York State and New York City generates a list of Medicaid managed care enrollees and payments made on behalf of MCO enrollees who remain enrolled following the date of their death. As part of the agreement between New York State and the MCOs, any capitation payments made on behalf of deceased enrollees are recoverable from the MCO, and the local districts are informed to take

the appropriate action on behalf of any of the active cases/enrollees. In 2009 DMA opened 63 and finalized 79 audits in this area; recovering $4.4 million.

Capitation Payments for Incarcerated Managed Care Enrollees ("Prison Match")

In accordance with the Medicaid managed care contract, OMIG identifies capitation payments made on behalf of managed care enrollees while they are incarcerated, and pursues recovery of the payments from the MCO. In 2009, DMA opened 6 and finalized 41 audits in this area, recovering $876,455.

Billing for Managed Care Capitation Payments Prior to Recipient Date of Birth

In 2009, DMA opened 15 and finalized 13 audits in this area; recovering $46,316 related to inappropriate capitation payments made to an MCO on behalf of managed care enrollees for dates of service prior to the enrollee's month of birth.

Supplemental Capitation Payments Made Without Corresponding Encounter Data

MCOs are entitled to a supplemental newborn capitation payment (paid under the newborn's recipient ID) and a supplemental maternity capitation payment (paid under the mother's recipient ID) in instances where the MCO paid a hospital for the newborn/maternity hospital stay and/or birthing center delivery. In accordance with the Medicaid managed care and Family Health Plus contract, Section 3.8 (Payments for Newborns) and Section 3.9 (Supplemental Maternity Capitation Payments), if the MCO cannot provide documentation to support the newborn/maternity billing, OMIG will request repayment of the supplemental capitation payment. In 2009, DMA finalized 35 audits, recovering approximately $3.7 million.

Audit of Quarterly Medicaid Managed Care Operating Reports

In 2009 DMA opened two audits related to a review of the reported costs used by the DOH in finalizing the MCO's rate. OMIG is determining the accuracy of the information reported and is conducting electronic analysis of the MCO's reported paid claims to confirm that reported medical costs were incurred and paid in compliance with provider contracts. DMA is also conducting an analysis of the reporting and propriety of third-party recoveries; a review of the appropriateness and allocation of direct and indirect administrative costs; an analysis of related party transactions and contracted expenses; and a review of the accuracy of incurred but not reported (IBNR) accruals by product line.

Nursing Home – Bed Reserve Audits

In 2009 OMIG continued their review of bed reserve payments to assure that facilities are in compliance with Title 18 NYCRR § 505.9(d) requirements, State laws, rules, regulations and

policies that govern the New York State Medicaid bed reserve program. In 2009, DMA initiated one and finalized four audits; recovering approximately $3.6 million.

FQHC Supplemental Review

In 2009, DMA initiated three probe audits of Supplemental Transitional Payment Program shortfall payments made to Federally Qualified Health Centers (FQHC) for the two years ended December 31, 2005. No final reports have yet been released.

Newborn FFS-MC Crossover

In 2009, OMIG opened 94 and finalized 66 audits where auditors identified instances in which a hospital received a Medicaid payment while the newborn was enrolled in managed care, and the MCO also received a capitation and supplemental payment in the month of delivery, indicating the hospital was eligible to receive a payment from the MCO related to the newborn's birth; recovering $2.6 million.

Transportation – Taxi/Livery

In 2009, OMIG opened 5 audits to review claims and supporting documentation of selected transportation providers who provided taxi and/or livery services to Medicaid recipients. The scope of OMIG's review was to ensure that providers were in compliance with regulations governing the program as stated in 18 NYCRR Section 505.10.

Graduate Medical Education (GME) Payments

All Medicaid managed care organizations are required by law and by the terms of their managed care contract to provide the New York State Department of Health, with accurate encounter data related to health care claims adjudicated for services provided to Medicaid beneficiaries enrolled in managed care. OMIG identified numerous instances where a hospital's GME billings had no corresponding managed care encounter data that showed adjudicated and paid health care claims for the same enrollees and dates of service. In 2009, DMA finalized three audits with no findings.

Summary of Audit Activities

2009 Audits				
Audit Dept.	**Audits Initiated**	**Audits Finalized**	**Audit Findings**	**Audit Recoveries**
Provider Audit Total	1443	561	$ 7,916,632	$ 33,601,062
Rate Audit Mgmt. & Dev.	114	132	39,598,252	53,563,763
Managed Care	295	360	36,463,866	34,682,619
Total	**1,852**	**1,053**	**$ 83,978,750**	**$ 121,847,444**

Division of Administration

Bureau of Budget and Fiscal Management

The 2009-10 Enacted State Budget provided $91.1 million to support the continued operations of OMIG, which reflected a $1.3 million decrease from the 2008-09 Budget. Such savings were achieved through the reduction of certain contractual service expenditures and utilization of OMIG staff to perform these functions. The Budget provided funding to support OMIG's anti-fraud capabilities through the provision of new staff, additional technologies and enhanced anti-fraud measures, including:

- Expanded audits of fee-for-service providers, which have had no or diminished comprehensive audit activity in past years;
- Expanded front-end editing and prepayment review functions, and enhanced data mining technology and software.
- Development of compliance guidance for hospitals and managed care entities, and encouragement of self-disclosures by providers.
- Expansion of the Cardswipe and Post & Clear Programs. The Cardswipe Program was developed to reduce the incidence of recipient card loaning and theft by unauthorized or Medicaid ineligible individuals. The Post & Clear Program reduces the incidents of stolen prescriptions by requiring prescribers to post the prescriptions they write on the eMedNY Medicaid Eligibility Verification System, and requiring pharmacies to clear the prescriptions before they are dispensed.

Through these efforts, OMIG achieved State savings of $1.020 billion in State Fiscal Year (SFY) 2009-10 through a combination of cash recoveries and cost avoidance activities. This reflects an $870 million (State share) Audit Plan goal pursuant to the enacted 2009-10 State Budget and an additional $150 million (State share) savings associated with the Deficit Reduction Plan. The total SFY 2009-10 Audit Plan target reflects a 240 percent increase since the inception of OMIG in 2006.

Bureau of Collections Management

The Bureau of Collections Management (BCM) continues to make progress toward proactive management of accounts, and has improved the speed and efficiency of the collection processes, and the clarity of the financial data being collected and reported.

Bureau accomplishments and initiatives for 2009 are as follows:

- **Automation of Collection Process**:
  - Fraud Activity Comprehensive Tracking System (FACTS) electronic integration of refunds and releases - source data is now being electronically loaded into FACTS

- Collection Request Tracking System (CRTS) – program rolled out for use by BCM staff to track internal work flow and progress of accounts
    - Continue to find ways to improve the timeliness of collections to increase recoveries that will satisfy OMIG audit plan requirements

- **FACTS – Monthly Report of Collection Activity** – a dashboard was completed which serves as a repository for collection activity data. This data can be used in reports and to track progress within the Bureau.
- **Request to Suspend Collection procedure** – a request form must be completed and approved by an authorized manager before a collection is suspended.
- **New BCM unit - Provider Research & Call Center (PRCC)** - For providers who are not actively billing Medicaid and therefore not liquidating amounts owing via the Medicaid withhold recovery method, PRCC will conduct research using eMedNY and Accurint to locate providers and reach out to them to obtain commitment for payment. Additionally, PRCC will conduct regular searches for OSC Unclaimed Funds and Surety Bonds.

Bureau of Human Resources Management

Workforce and Succession Planning

Presently OMIG has a workforce consisting of 604 filled positions. Of these 604 positions a large number are filled by individuals who, within the next two to three years, will be eligible to retire from state service either with or without penalty. On the basis of these numbers, the agency has embarked on an aggressive path to ensure that it will retain the institutional knowledge and experience that will leave with these retirees. This becomes especially important if the agency is to continue to fulfill its core mission to improve the integrity of the Medicaid program by conducting and coordinating fraud, waste and abuse control activities for all State agencies responsible for services funded by Medicaid.

OMIG has been in the process of developing and implementing strategies to address the loss of its experienced staff, and to minimize the impact that these losses will have on the agency's ability to fulfill its core mission. Many of the steps that OMIG is pursuing are detailed in the Department of Civil Service/Governor's Office of Employee Relations Workforce and Succession Planning Guide.

Division of Technology and Business Automation

Bureau of Payment Controls and Monitoring

System Edits

Edits are one of the most effective tools, and the first line of defense OMIG uses to prevent fraud, waste and abuse. These are automated controls built into the Medicaid claims system, eMedNY, to help ensure the proper payment of all Medicaid claims. Developed collaboratively by staff of OMIG, the Office of Health Insurance programs (OHIP), and the DOH fiscal agent, Computer Sciences Corporation (CSC), edits serve to meet budgetary goals, as well as aid in controlling fraud, waste and abuse as identified by audits and investigations.

For 2009, eMedNY System Edits that were modified or created by OMIG resulted in approximately $210 million in cost-avoidance.

Prepayment Review

The Prepayment Review Unit uses capabilities within the Medicaid claims processing system to review some or all of the claims for providers of interest. Using this capability, unit staff are able to monitor and review the claiming of providers who demonstrate inappropriate billing practices. Through the use of data mining tools, data warehouse queries and post payment reviews, as well as referrals from within OMIG and outside agencies, OMIG staff selects providers and builds edit criteria to review targeted claim submissions. The benefits derived from this process are unique, and prepayment review can be used as a compliance and training tool, a deterrent to a specific activity and as a powerful fraud detection and prevention tool.

The Prepayment Review staff has a variety of backgrounds, including staff with clinical backgrounds. In calendar year 2009, staff reviewed nearly 1,000 providers, including dentists, pharmacies, outpatient clinics, diagnostic and treatment centers, durable medical equipment providers, physical therapists, and out of state hospitals.

The review activities of the Prepayment Review Unit differ from traditional auditing activities. Claims are reviewed and adjudicated on a prepayment basis allowing for more flexibility to react to issues. Prepayment review affords OMIG the opportunity to build editing criteria into the claims processing system and, in some instances, has allowed OMIG to use prepayment review to manually respond to issues while waiting for the implementation of permanent edit solutions.

The areas of focus during calendar year 2009 included:

- Referral of providers to DMI or DMA
- Provider education
- Provider compliance
- Possible exclusion or sanction of providers for egregious billing and medical practices

- Identification of claims edit weaknesses
- Dental claims for duplicate, excessive and unnecessary services
- Orthodontics
- System editing
- Closing case process
- Continued collaboration project within and outside OMIG
- Data mining and targeting

For 2009, cost savings for the PPR unit totaled $8,861,842 for medical prepayment review and $957,800 for dental prepayment review. In addition:

- 738 providers were placed on medical prepayment review
- 39 individual providers and 14 groups were placed on dental prepayment review
- 5 medical referrals and 9 dental referrals were made to OMIG's Division of Medicaid Audit
- 5 medical referrals and 19 dental referrals were made to OMIG's Division of Medicaid Investigations (DMI)
- 1 dental collaboration project was conducted with the New York State Attorney General
- 6 dental collaboration projects with DMI
- 176 referrals made to the Recipient Restriction Unit
- 6 medical referrals were received from the Post and Clear Unit, Computer Sciences Corporation and DMI
- 4 medical referrals were received from OMIG's Enrollment Unit

DTBA Highlights

OMIG's Efforts at the National Level Result in Retaining the Prescription Serial Number Field on the Uniform Pharmacy Claim Form

In early 2009, OMIG learned that the prescription serial number field would not be included on the uniform pharmacy claim form, NCPDP D.0., which had been adopted under HIPAA II for implementation January 1, 2012. In New York State, Medicaid requires pharmacies report the prescription serial number on all claims for billing transactions; otherwise, without the prescription serial number preprinted on the Official NYS Prescription form, the billing transaction will be denied. In NYS, the Serialized Prescription Program has resulted in substantial cost savings and has been a deterrent to prescription fraud within Medicaid. Moreover, in October 2008, the CMS tamper-resistant prescription law went into effect requiring all prescriptions for fee-for-service Medicaid patients be fully compliant with federal and/or state guidance for tamper resistance. The requirements for the NCPDP D.0 claim form were finalized ahead of this CMS requirement, making it more challenging for State Medicaid programs to use the claim form to make full use of this key control information.

In May 2009, OMIG officially requested the National Council for Prescription Drug Programs (NCPDP) Board to reconsider its decision not to include the prescription serial number field on the NCPDP D.0 claim form. OMIG's request included a business case justification for retaining the prescription serial number field, as the loss of this data would impair OMIG's ability to reduce fraud, waste, and abuse in the Medicaid Program.

In June 2009 the NCPDP Board submitted OMIG's business case justification to the federal Department of Health and Human Services and various representatives of the CMS Office of e-Health Standards and Services (OESS). Essentially, the NCPDP Board requested the correction of the NCPDP Telecommunication Standard Implementation Guide Version D.0. The NCPDP opined that when the NCPDP D.0 claim form was reviewed and approved, the business case for the current field, scheduled prescription ID number, was not brought forward and the situation for use of the field was designated as "not used" in billing transactions.

In July 2009, the NCPDP received approval from the CMS Office of e-Health Standards and Services to modify the NCPDP D.0 claim form so the prescription serial number field could be included on the uniform pharmacy claim. NCPDP republished the implementation guide for Version D.0, changing the field, scheduled prescription ID number, from "not used" to "required if necessary for state/federal/regulatory agency programs." As a result of NYS OMIG's timely and proactive efforts, the development and expansion of Medicaid Programs to control and prevent fraud, waste and abuse can continue on track.

Medical Prepayment Review highlights from 2009

Durable Medical Equipment Providers Dispensing Orthopedic Shoes

Prior reviews of Durable Medical Equipment (DME) providers in 2007-2008 indicated that claims were submitted for orthopedic shoes that were inappropriate and did not meet the definition of orthopedic shoes as defined in the Medicaid Management Information System (MMIS) DME Manual, as well as in regulation 18 NYCRR § 505.5. OMIG initiated another review of DME providers dispensing orthopedic shoes. Two DME providers on review in 2009 were identified as dispensing sandals, sneakers and winter boots and submitting corresponding claims for orthopedic shoes. These claims are being denied and additional providers are targeted for review.

Pharmacy Providers Entry of Prescribing Provider NPI

In September 2008, providers were put on notice in an article published in the Department of Health's *Medicaid Update* that National Provider Identifier (NPI) numbers shall be used to identify the prescribing provider on all pharmacy claims. At present the eMedNY claims processing system is unable to identify the NPI of non-enrolled Medicaid providers. In addition, there is no hard (automated) edit to prevent claims from processing with a facility NPI or non-existent NPI. Prepayment review has developed criteria to deny payment for claims that report a facility or non existent NPI in the prescribing provider field of a claim. Providers are educated regarding accurate submission of the prescribing providers NPI and are afforded the opportunity to resubmit claims

using the correct NPI. Currently 142 providers are being monitored for this activity. This review will remain in place until a permanent edit is implemented in the claims system.

Creation of a Provider Correction Letter Documenting Provider Reviews

This past year, the Prepayment Review Unit worked with OMIG's Office of Counsel to establish a provider correction letter. This letter will be implemented in 2010 and will document all deficiencies noted in a prepayment review. The letter will be sent to the provider at the conclusion of the review. The letter formally outlines the providers claiming deficiencies and the changes necessary for compliance.

If the provider does not correct the deficiencies, the letter indicates that additional actions and sanctions may occur.

Inappropriate Use of Facility ID

The New York State Department of Health's *Medicaid Update* states that it is inappropriate to use a facility's Medicaid identification number in the ordering/referring/prescribing provider identification field on Medicaid claims. If the facility MMIS number matches to a physician's license number, the edit is not invoked.

OMIG prepayment review staff developed criteria to deny payment for claims that report a physician profession code of 060 with a facility number in the prescribing provider's license field. Providers are educated regarding accurate submission of prescribing providers on claims and are afforded the opportunity to resubmit claims using the correct prescribing provider. Currently 357 providers are being monitored for this activity.

Inappropriate Use of Enhanced Rate Code 3092 - Chemotherapy Clinic Service

In February 2008, staff identified 27 hospital outpatient clinics that were submitting claims for enhanced rate code 3092 with no corresponding diagnosis of cancer. Criteria were developed and inserted into the claims processing system to pend all claims for further review that had enhanced rate code 3092 with no diagnosis of cancer. Each individual claim, as well as the recipient claim history, was reviewed for a period of two years. This review, which concluded in 2009, has resulted in substantial savings to the Medicaid program as well as educating providers regarding the use of this enhanced rate code. Prepayment Review further collaborated with OMIG's Systems Match and Review (SMR) Unit for post payment recoveries on this issue. To date, SMR has identified over $900,000 in recoveries.

Inappropriate Use of Rate Code 2877 - Ambulatory Surgery Hospital Based

Since April of 2007, Prepayment Review has been monitoring out-of-state hospitals use of rate code 2877. Rate code 2877 is to be used only for hospital based ambulatory surgery. It was noted

that out-of-state hospitals were using this rate for general office visits and other non-surgical procedures. Criteria have been in place to pend this rate code for 34 out-of-state hospital providers. Referrals to OMIG's Division of Medicaid Audit were made last year; and the Bureau of Audit Resources Management has initiated audits of these providers. Recoveries identified in the audit of two providers totaled over $7,953,610.

Cardswipe Program

OMIG designates providers, based on various criteria, to become a mandatory "swiper" as part of the Cardswipe program. The program is designed to ensure that an eligible Medicaid recipient is present at the location where Medicaid services are provided. The swipe is accomplished using a standard device (terminal) which is similar to those used commercially to process credit cards. For designated providers, the terminal is supplied to the provider at no cost and the provider is required to swipe the recipient's Medicaid card in a substantial number of billing transactions.

At the end of calendar year 2009, 793 providers were designated as swipers. As part of the Point-of-Service Unit's on-going activities, the providers are constantly monitored for swipe rates. During the year 75 providers were removed from the program and an additional 67 providers were added.

Mobile Card Swipe Terminal Expansion Project

OMIG spent a great deal of effort planning a major expansion of the Cardswipe Program. Software is being developed and added to mobile units (wireless cardswipe terminals) to enable private duty nurses and non-emergency transportation carriers to swipe Medicaid identification cards at the point of service. Highlights of this expansion and the associated activities include:

- $3.25 million procurement approved to acquire approximately 2,000 wireless Medicaid card swipe machines.
- Card swipe machine software customized for use by transportation and private duty nursing providers.
- Providers using the wireless technology can transmit and receive Medicaid enrollee information using cellular technology.
- Information transmitted and received is encrypted in accordance with the Health Insurance Portability and Accountability Act (HIPAA).
- Development of reports to show transactions and provider swiping percentages.
- Schedule outreach and publish *Medicaid Update* article informing providers of the mobile expansion project.
- Web page designed and linked into OMIG's public website allowing the providers an avenue to find out information regarding the program.

The mobile expansion program is expected to begin its rollout, at low pilot levels, in mid-2010.

Landline Expansion Project

In December 2009, the card swipe program began a program expansion to include additional pharmacies, dentists and physicians. During December, 2009, 49 new pharmacies were added.

Pharmacies should swipe the Medicaid enrollee's card when the prescription is *picked up*. Non-pharmacy providers must swipe the card *on the date of service*. If the Medicaid enrollee does not provide the card, assuming that the provider is familiar with the Medicaid enrollee and can verify their ID number, service may be provided. The provider should instruct the Medicaid enrollees to have their card available the next time they require service(s). If a Medicaid enrollee arrives with a temporary Medicaid ID card, the provider can use the card swipe terminal keypad to input information from the temporary card to access eligibility information.

OMIG is actively working with providers and local districts to assist in raising the awareness of the program requirements for cardswipe providers and for recipients to present their card.

Post and Clear Program

The Post and Clear Program is a set of enhanced controls designed to ensure that Medicaid claims for ordered services are actually ordered by the provider indicated in each claim. Providers selected for the program must electronically "post" their orders to the Medicaid claims processing system. This establishes a record of the care, services or supplies ordered by the provider, and enables OMIG to verify that the order has been requested by the ordering physician before paying a provider who submits a claim for furnishing the service. When claims are received identifying a "posting provider" as the orderer, a matching "clear" transaction performed by the provider furnishing the service must also exist before a claim can be successfully adjudicated.

Providers are selected for reviews in accordance with a process that includes, but is not limited to:

- Providers who have had security breaches such as stolen or misused prescription pads.
- Referrals from other OMIG Bureaus, such as the Division of Medicaid Investigations, and other agencies' bureaus, like the Department of Health's Bureau of Narcotic Enforcement.
- Providers that generate large numbers of orders (in excess of $500,000) or bill for a high volume of patients.
- Providers that prescribe a high volume of drugs that can potentially be abused and/or marketable on the street for resale.
- Providers whose prescribing patterns fall outside their specialty (e.g. a psychiatrist prescribing antihistamines).
- Providers treating patients who fall outside the expected age group of their specialty (e.g. pediatricians treating adults).
- Enrollees who patronize several pharmacies for prescriptions ("pharmacy hopping") in an attempt to fill duplicate prescriptions or obtain early refills.

Being selected for the Posting Program does not imply that the provider is engaged in inappropriate behavior. Rather, the program serves to protect both the provider and the Medicaid program, ensuring that only claims representing authorized services and supplies receive payment. The program helps curtail fraudulent practices such as forged prescriptions, or duplication of services. Some providers voluntarily participate in the program, recognizing the benefits of the program in protecting the integrity of their medical practice.

At the end of calendar year 2009, there were a total of 248 providers designated as posters.

For 2009, the Cardswipe and Post and Clear programs created cost savings totaling $143.7 million.

Bureau of Third Party Liability

Identification of Third Party Insurance

Medicaid is the payor of last resort, but providers often do not bill the responsible third party insurer. A significant amount of the State's Medicaid recoveries are the result of OMIG's efforts to obtain payments from third party insurers responsible for services inappropriately reimbursed by Medicaid funds.

The following two main methods are used to determine if a recipient has third party insurance coverage:

- identification of insurance during the Medicaid eligibility intake process at the local district, and
- a state contractor identifies the client's third party insurance not reported during intake.

Third party insurance coverage, Medicare and/or commercial insurance, should be identified during the intake process at the local districts. Applicants for Medicaid complete paperwork at the local Social Services district (LDSS) and identify any third party health insurance coverage they have, including policy information. In addition, a State contractor routinely processes matches with the Centers for Medicare & Medicaid Services (CMS) and commercial insurance carriers to identify third party insurance coverage. Additional third party information identified by the contractor is used to update the client eligibility file.

Application of Third Party Insurance

Currently, the State uses two approaches to ensure the application of third party coverage for Medicaid recipients:

- Claims Processing Edits. The Medicaid Management Information System (MMIS), eMedNY in New York State, applies edits that identify the existence of a recipient's other insurance during claims processing. Medicaid claims for these recipients are denied when

available third party insurance has not been used. These front-end edits prevent inappropriate payment from being made in cases where a third party carrier would cover part, or all, of the service provided (see Pre-Payment Insurance Verification).

- Post-payment Review and Recovery. A post-payment review of paid Medicaid claims is done by State contractors (HMS & UMASS) who test claims for the existence of responsible third party payors. The availability of third party insurance for the specific services provided is verified and, where determined appropriate, Medicaid recovery activities are undertaken.

Cost Savings

Pre-Payment Insurance Verification

Results of insurance matches are verified and loaded to eMedNY Third Party subsystem prior to inclusion in the Bureau's monthly retroactive recovery projects. This places the emphasis on the prospective cost avoidance of the insurance information while we continue our recovery efforts.

Actual eMedNY load results are recorded and tracked for a period of one year using an average saving per recipient as determined through data warehouse analysis of paid and denied claim information.

For 2009, the Bureau added 286,458 insurance segments to eMedNY. Estimated cost savings for those policies is $1.02 billion**.**

Recoveries

Medicaid Match and Recovery Contract (HMS)

The primary objective is to identify and maximize private health insurance and Medicare coverage. This enables the State and local governments to achieve cost avoidance savings and/or recover Medicaid funds. The contractor is expected to perform comprehensive third party identification and post payment recovery reviews. The contractor must have the ability to accommodate process enhancements, improvements, and/or expansion into new work areas to accomplish the mission of OMIG.

During the past year, OMIG, through its vendor HMS, initiated 5,634 third party reviews, with actual recoveries totaling $140,438,930.

Home Health Care Demonstration Project (UMASS)

OMIG continues to work with CMS and the States of Connecticut and Massachusetts under a pilot demonstration project that utilizes a sampling approach to determine the Medicare share of the cost of home health services claims for dual eligible beneficiaries that were inadvertently submitted to, and paid by, the Medicaid agencies.

This demonstration project replaces previous Third Party Liability (TPL) audit activities of individually gathering Medicare claims from home health agencies for every dual eligible Medicaid claim the State has possibly paid in error. This is an enormous administrative savings in resources for the home health agencies, as well as the regional home health intermediary and for the participating states. During the past year, this project recovered $226,259,647.

Legislative Initiatives

Implementation of Deficit Reduction Act 2005 changes related to Third Party Liability

The Deficit Reduction Act (DRA) of 2005 clarified the definition of "third party insurors" and "health insurors" to include employer self-funded ERISA plans, third party administrators (TPA), and pharmacy benefit managers (PBM), and required states to enact legislation to require "insurors" to provide coverage, and eligibility and claims data to identify liable payors. New York, at OMIG's urging, enacted the required legislation last year (Social Services Law, Section 367-A and Insurance Law, Section 320). OMIG is negotiating with major "insurors" subject to the DRA requirement to obtain the eligibility data required by law. This will enhance OMIG's third party insurance identification efforts.

Systems Match and Recovery Unit

In addition to the staff functions described for developing systems matches, the Bureau of Business Intelligence (BBI) includes the Systems Match and Recovery Unit (SMR) which is responsible for collecting the overpayments identified by each match. Since most matches are performed on a multi-year basis, the staff researches Medicaid policy and billing guidelines annually to ensure that each match is still accurate and optimal. Staff must review all data within the payment system that appears to contradict acceptable conditions for payment. Often, other OMIG audit activities serve as the identifying sources for these reviews. Providers receive the results of reviews via mail and are required to substantiate the payments received or, where payments cannot be substantiated, return any overpayments. During 2009, SMR initiated a total of 965 provider reviews with recovery activity totaling $11,584,783. Some of the specific highlights and areas of focus for 2009 are outlined below.

Prenatal Care Assistance Program

This audit addresses multiple issues of erroneous billings for Medicaid clients who are receiving pre-natal care services (PCAP). The match includes the identification of multiple initial visits; post-partum services billed at initial or follow up rates; PCAP service for inpatients; physician services; laboratory services, ordered ambulatory services and prenatal vitamins billed as fee for service which are included in the PCAP rate. During 2009 OMIG recovered $2,082,000 from this project.

Inpatient Crossover With Clinic/ER Claims

Inpatient, emergency room, and clinic services provided by a hospital can be individually billed to Medicaid under the same provider number. During a Medicaid client's hospital stay, the inpatient rate is an all-inclusive rate and there should be no emergency or clinic billings by the hospital for that client during their hospital stay. This match identifies the Medicaid payments and the providers that have billed Medicaid for either clinical or emergency room services during the patients stay in the hospital. During 2009 OMIG recovered $2,243,390 from this project.

Physician Place of Service

This audit looks at all physician claims submitted by the individual physicians and physician groups that were paid the $30 office visit fee, but where the location code was 7. If the physician saw patients in a hospital clinic the physician was not allowed to bill $30, but could receive reimbursement based on an established fee schedule that took into consideration the physician's specialties. The specialists' reimbursement rates found in the MMIS Physician's manual could range from $5.50 to $25.00. During 2009 OMIG recovered $2,126,916 from this project.

Radiology Services

This audit identified radiologists who are billing the Medicaid program for the technical component for radiology procedures performed on hospital inpatients. The inpatient hospital rate includes the technical component, which is provided by hospital employees. The radiologist is entitled to be paid only for his/her professional services, but billed as if he/she had provided the technician and equipment as well. During 2009 OMIG recovered $232,580 from this project.

Medicaid Fraud, Waste and Abuse County Demonstration Project

The Medicaid Fraud Waste and Abuse County Demonstration Project's (County Demonstration) purpose is to partner with counties and local social services districts in an effort to detect fraud, waste and abuse conducted by providers in the Medicaid program and recoup overpayments. Currently, sixteen jurisdictions have an executed Memorandum of Understanding in place with the state; of which eleven counties and New York City are actively participating in the County Demonstration. Presently, seven counties exclusively use contractors to conduct these audits. Two counties and New York City employ/use staff within the agency, and three counties use a combination of both contractors and staff for this project.

Audits are conducted and where overpayments are identified, recoveries are made as a result of the issuance of the final audit report. The counties are responsible for conducting each phase of the audit process, with OMIG reviewing and approving the work product prior to its release. Once repayment of the federal share has been made, the recoupments made are used to reconcile the expenses incurred by each county. Should there be a remaining balance, it is to be shared equally with the local social services district.

Since its inception, the County Demonstration has identified findings totaling more than $14.1 million, with collection of over $11.2 million to date. During 2009, the project yielded approximately $8 million in findings and $5 million in recoveries. An additional 85 audits are underway, with the estimated low point of those findings valued at $9.7 million. The County Demonstration has initiated 441 audits since its inception.

Bureau of Allegations and Complaints

The Bureau of Allegations and Complaints (BAC) became operational in June of 2009 to review, triage, and follow up on all Medicaid related allegations and complaints received by the Office of the Medicaid Inspector General. A staff of six experienced audit, investigative and administrative staff apply a consistent review process to determine which complaints warrant further examination and refer them to the appropriate OMIG unit or other New York State authority.

The Bureau's main functions are to centralize the intake of all allegations and complaints; triage all allegations and complaints to either transfer to the appropriate OMIG entity or refer to the appropriate external entity; and monitor and provide follow-up on transferred or referred allegations and complaints.

From June 2009 through December 2009, 666 allegations were received by the Bureau. Four hundred forty-four of these allegations were referred for further review or investigation; and 222 were closed for one of the following reasons: the allegation was previously received; sufficient information was not available to process the allegation; or the complaint was resolved within the Bureau.

Outreach and Communications Initiatives

"In an unusual move scheduled to begin on Oct. 1 [2009], the Office of Medicaid Inspector General (OMIG) will post on its Web site the names and addresses of providers who have billed Medicaid 'for services rendered after the date of patient death.' Providers facing this exposure will be forewarned by OMIG and have the chance to fix any information they believe is wrong, [Medicaid Inspector General] Sheehan said. They also will have to return overpayments and may be hit with other sanctions."

--Report on Medicare Compliance
August 24, 2009

Website

OMIG's website (www.omig.ny.gov) provides an outstanding outreach tool to all OMIG constituents. Not only does it contain background information on the office, it also features sections on:

- Agency regulations
- Annual reports
- Disqualified individuals (excluded, terminated or censured)
- Employment
- Final audit reports
- Payment Error Rate Measurement (PERM)
- Posting providers
- Presentations
- Press room
- Procurements
- Provider compliance (including annual compliance certification)
- Regulations
- Resources
- Self disclosure
- Subscribe to OMIG's list (a listserv feature that enables subscribers to automatically receive "breaking" news from OMIG as soon as it is ready to be posted on the Web site)

Additionally, consumers, providers or other observers may file a complaint about suspected fraud, waste or abuse directly through a link on the Web site. Both the 2008-09 and the 2009-10 work plans are posted, as is the 2009 budget testimony of Medicaid Inspector General, James G. Sheehan from his appearance before a joint session of the New York State Legislature on February 2, 2009.

During 2009, OMIG undertook a major renovation of the Web site, including a graphic redesign. This enabled OMIG to enhance the user-friendly aspects and interactivity of the site, as well as improve the site's graphic attractiveness. The Public Information Office, in conjunction with Information Technology Office staff, are constantly re-evaluating the site and soliciting input from OMIG staff from across the state. Enhancements made in 2009 included:

- New layout for final audit reports to include provider category
- Addition of diagnosis related groups (DRG) pairings to assist hospitals in determining how their own DRGs compare to those of other hospitals of similar size
- Information about OMIG's senior staff and other contacts
- Interactive online annual compliance certification form
- Corporate integrity agreements

External Speaking Engagements

Outreach through public speaking and public appearances is critical to an agency such as OMIG. In 2009, the office intensified efforts to create and market a speakers' bureau through the Web site. When a call comes through for the speakers' bureau, the public information officer contacts an appropriate speaker and arranges for a presentation. Requests came from a variety of sources in 2009.

In 2009, OMIG representatives spoke to a variety of groups, including:

- The New York State Society of Certified Public Accountants (CPAs)
- The New York State Bar Association
- The Healthcare Financial Managers Association
- The Greater New York Hospital Association
- The New York State Alliance for Children with Special Needs
- The American Healthcare Lawyers/Healthcare Compliance Association
- The Home Care Association of New York State
- The Adult Day Health Care Council
- The Cerebral Palsy Association of New York State
- The New York Association of Homes and Services for the Aging
- The Association of Healthcare Journalists
- The New York Association of Community and Residential Agencies

OMIG values regular communication with taxpayers, legislators, policymakers, providers, their associations and the associations of those professionals that represent the interests of providers, through audits, self-disclosures, and compliance initiatives. The Public Information Office will continue to conduct extensive outreach to promote OMIG's mission, discuss ongoing initiatives, and obtain constructive feedback. OMIG recognizes that many providers have established best practices, and we are interested in learning about those practices and sharing them with other providers with the hope of fostering high quality care and compliance throughout the healthcare industry.

Office of Counsel

The Office of Counsel (OC) promotes OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel. The OC is responsible for providing general legal services to OMIG. These services include providing advice and support regarding OMIG's programs and operations, representation at administrative hearings and assisting the Office of the Attorney General in its representation of OMIG in judicial proceedings relating to matters of Medicaid fraud, waste and abuse. The OC is also responsible for revising current regulations and promulgating new regulations to effectuate OMIG's statutory mission. One of the major responsibilities vested within the OC is to assess agency risk and ensure that fairness exists at all levels of agency process. The OC assists OMIG in pursuing its statutory mandate when appropriate evidence exists to support agency actions. Over the past year, the OC has seen a dramatic increase in its workload.

Administrative Actions

Sanctions – Terminations & Exclusions

OMIG has broad discretionary power to impose several different sanctions against "persons" as defined in its regulations[1] (including but not limited to Medicaid providers) based on its audit and/or investigative activities. Sanctions include: censure, exclusion, or conditional or limited participation in the Medicaid program (18 NYCRR § 515.3). A sanction may be imposed upon a finding that a person has committed an "unacceptable practice" pursuant to 18 NYCRR § 515.2. The Notice of Agency Action sent as a result informs the person of the right to appeal the determination through an administrative hearing, as well as the requirements and procedures for doing so.

OMIG may impose an "Immediate Sanction" when certain other conditions have been met in violation of the rules and regulations of the Medicaid program (18 NYCRR § 515.7). Immediate sanctions are imposed based upon a finding that a person has:

- been indicted with committing a felony relating to or resulting from the furnishing or billing for medical care, services or supplies;
- been convicted of a crime resulting from the furnishing or billing for medical care, services or supplies;
- demonstrated that their continued participation in the program would imminently endanger the health and welfare of the public or an individual;
- violated a state or federal statute or regulation, resulting in a final decision that the person engaged in professional misconduct or unprofessional conduct;

[1] Pursuant to 18 NYCRR § 504.1(17), "person" includes natural persons, corporations, partnerships, associations, clinics, groups and other entities.

A person sanctioned under these provisions is not entitled to an administrative hearing, but is permitted to submit an appeal, comprised of written arguments and documentation within thirty (30) days of the date of the notice. A person appealing an immediate sanction may submit written arguments and documentation on the following issues:

- whether the determination was based upon mistake of fact
- whether any crime charged in an indictment, or any conviction of a crime, resulted from furnishing or billing for medical care, services or supplies; and
- whether the sanction imposed was unreasonable

OMIG may impose a "Mandatory Exclusion" when certain other conditions have been met in violation of the rules and regulations of the Medicaid program (18 NYCRR § 515.8). Mandatory Exclusion is imposed based upon a finding that, among others, a person has been excluded from participation in the Medicare program. A person appealing a Mandatory exclusion may submit written arguments and documentation regarding whether the determination was based upon mistake of fact.

OMIG conducted investigations and imposed discretionary exclusions during this time period based upon:

- New York State Education Department actions such as license surrender, suspension and revocation, for Medicaid and non-Medicaid providers
- actions taken by the Office of Professional Medical Conduct (OPMC) involving professional misconduct and physician discipline actions including suspensions, revocations, surrenders and consent agreements
- correspondence received from the Department of Health and Human Services
- OMIG's internal enrollment files and eMedNY data which provided relative ownership information to determine affiliations of excluded providers

Forty-six (46) terminations and 712 exclusions were issued during 2009. During 2009, 70 appeals were filed. Of the 58 decided appeals, 7 exclusions were reversed, one appeal was not filed in a timely manner and was dismissed, and 48 appeals affirmed OMIG's initial determination to exclude the provider.

OMIG's current list of persons who are not eligible to participate in the Medicaid program is maintained on its Web site (www.omig.ny.gov) and contains 6,190 Medicaid and non-Medicaid provider exclusions.

Pre-Consent Orders – Beginning in August 2008, pursuant to an agreement with the Office of Professional Medical Conduct (OPMC) and the State Education Department (SED), OMIG started reviewing pre-consent orders on licensure actions to advise whether OMIG would exclude the provider from the Medicaid program. Any practitioner excluded following pre-consent documentation review is notified directly by the Office of Counsel of that decision. This process has eliminated previous situations where providers assumed the SED and OPMC consent order satisfied all concerns, only to then receive an exclusion determination from OMIG.

Monetary Penalties

In addition to a sanction, OMIG may impose a monetary penalty under 18 NYCRR § 516 when it is determined that a person has:

1) failed to either comply with the standards of the medical assistance program or of generally accepted medical practices in a substantial number of cases, or has grossly and flagrantly violated such standards; and

2) received, or caused to be received by another person, payment from the medical assistance program when such person knew, or had reason to know, that:

- the payment involved the providing or ordering of care, services or supplies that were medically improper, unnecessary or in excess of the documented medical needs of the person to whom they were furnished;
- the care, services or supplies were not provided as claimed;
- the person who ordered or prescribed care, services or supplies was suspended or excluded from the medical assistance program at the time the care, services or supplies were furnished; or
- the services or supplies for which payment was received were not, in fact, provided.

For 2009, three providers were issued monetary penalties totaling $58,500.

False Claims Act/*Qui Tam* Activities

In 2007, the State of New York passed the New York False Claims Act (FCA). The FCA mirrors the provisions of the Federal FCA with respect to whistleblower protections and the ability of whistleblowers to share in the proceeds of recoveries made as a result of disclosing information as a FCA filing to the New York State Attorney General.

FCA whistleblower actions are an important part of OMIG's efforts to encourage effective compliance programs and disclosure of overpayments by providers. Whistleblower actions receive timely and appropriate investigation.

OMIG works closely with the New York State Attorney General's Office and federal authorities to review and analyze allegations, decide whether to intervene in the case, investigate the allegations, and participate in litigation and/or settlement. A total of 61 *Qui Tams* were opened in 2009.

Agency Initiatives

Deceased Beneficiary Project

"In a sweeping plan to further crack down on Medicaid fraud and billing improprieties, New York State Medicaid Inspector General James Sheehan announced a plan this week to increase the penalties for billing Medicaid for services for patients who have died. In addition to fining the parties responsible and requiring them to pay back the money, Mr. Sheehan said, he will begin posting culprits' names on his office's Web site…Mr. Sheehan pointed out that some errors are intentional, while some are due to 'billing systems that run on autopilot.'"
--Crains Health Pulse
August 20, 2009

During 2009 OMIG staff worked with DOH-OHIP to create a process for matching death certificate data from vital statistics records to Medicaid provider and recipient information. This information is used to identify deceased recipients and providers on a timely basis. As this information is updated to the claims system, edits ensure that Medicaid will not be paying claims for deceased providers and recipients. This initiative was implemented in May, 2009.

These changes have improved OMIG's level of matching, but since there are inherent delays in the reporting and receipt of death data by the Medicaid program, a certain amount of claims continue to be paid after the date of death. In order to better understand the circumstances behind these claims, OMIG staff started a mailout process beginning with claims that were paid in October, 2009. In the mailout, providers were asked to explain the circumstances behind claims where data indicated that the recipient was deceased on the date of service. This process has identified a number of weaknesses in Medicaid provider claiming such as auto-refilling of prescriptions, claims for rental items for deceased recipients that are routinely billed to Medicaid without checking to see if the item is still required and identity theft by individuals who purport to be the deceased recipient in order to receive services covered under Medicaid. Providers who failed to respond to the mailout were posted on OMIG's website.

Mandatory Compliance Programs under Social Services Law §363-d

During 2009, OMIG continued to rollout its Provider Mandatory Compliance Programs and collaborated with the provider community to promote integrity on the front end of the Medicaid program. This remains one of OMIG's highest priorities.

After drafting the regulation and responding to public comment, OMIG adopted and published 18 NYCRR Part 521 implementing mandatory compliance programs for medical providers on June 24. The regulation took effect on July 1 and providers were given 90 days to comply with its provisions.

The regulation expands upon those providers mandated by statute to adopt and implement effective compliance programs (i.e., those subject to Articles 28 or 36 of the Public Health Law or Articles 16 or 31 of the Mental Hygiene Law) to also include providers ordering services or supplies or receiving reimbursement, directly or indirectly, or submitting claims for at least $500,000 annually.

The statute and regulation require that each covered provider assure that their compliance program has:

- a specific structure – that is, an eight-element program with organizational requirements;
- a series of processes – a method of addressing allegations, an audit plan designed to assess, monitor and assess risk areas, a process for identifying, reporting and refunding improper payments to government payers;
- outcomes – a requirement that the compliance program be effective; and
- an annual certification of effectiveness – attesting to the effectiveness of their program.

As of October 1, 2009, providers meeting established statutory and regulatory thresholds were required to adopt and implement effective compliance programs. Covered providers were also required to certify to OMIG by December 31, 2009 that they had adopted and implemented an effective compliance program. OMIG created an on-line certification process to both facilitate provider certification and enable more effective and efficient monitoring of this requirement.

OMIG also continued to engage providers in developing specific compliance program guidance that will promote the creation and implementation of effective compliance programs. Through this collaboration, compliance initiatives will be a significant tool for reducing fraud, waste and abuse in New York's Medicaid program.

Deficit Reduction Act of 2005

Section 6032 of the Deficit Reduction Act of 2005 (Act) added a new section, §1902(a)(68), to the Social Security Act. Under this new provision, entitled "Employee Education About False Claims Recovery," certain covered entities receiving $5 million or more in Medicaid funds are required to establish written policies for employees, contractors and other agents relating to false claims, whistleblower protections and entity programs designed to address program fraud, waste, and abuse. OMIG has responsibility for state oversight of provider compliance of the Act.

In order to ensure compliance, OMIG mandates covered providers to submit to OMIG a certification that the required written policies are maintained and that they meet the statutory obligations identified above. If a provider reached the threshold for federal fiscal year (FFY) 2006, then the provider was required to submit a certification by October 1, 2007. Future determinations and certification of compliance regarding a provider's responsibility will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the Medicaid program during the preceding FFY. OMIG created an on-line certification process to

both facilitate provider certification and enable more effective and efficient monitoring of this requirement.

Failure to submit, in a timely manner, the certifications, or failure to bring the written policies into compliance upon reasonable notice from the Medicaid Inspector General, may be considered unacceptable practices and subject the entity to sanctions and/or penalties. The Centers for Medicare and Medicaid Services may also, at its discretion, independently determine compliance through audits or other means.

Deficit Reduction Act requirements are also being incorporated into provider compliance guidance documents that OMIG will issue. Both OMIG and the DOH have disseminated all of the above information and requirements to the health care provider community through both OMIG's Web site and a Department of Health publication entitled *The Medicaid Update*.

Corporate Integrity Agreements

OMIG imposes Corporate Integrity Agreements (CIA) on those providers who refuse, or fail to meet their obligations, but whose removal from the Medicaid program would negatively impact access to necessary services. Under a CIA, a provider consents to implement specific compliance structures, processes and activities aimed at building integrity on the front end of providing and billing for care, services or supplies. Most CIAs include a provision requiring the provider to engage an independent review organization responsible for monitoring provider compliance with the provisions of the CIA. Providers that breach their CIA obligations will face sanctions in the form of stipulated penalties and/or exclusion from the Medicaid program.

OMIG executed its first four Corporate Integrity Agreements in December 2009:

Provider Name	Effective Date	Provider Type
Extended Nursing Personnel CHHA	12/16/2009	Home Care
Excellent Home Care Services	12/16/2009	Home Care
B & H Healthcare Services, dba Nursing Personnel	12/16/2009	Home Care
Medical Answering Services	12/22/2009	Transportation

Review of Off-Line Medicaid Expenditures

The Department of Health, which administers New York State's Medicaid program, and its fiscal agent, Computer Sciences Corporation, use eMedNY, a computerized payment and information reporting system, to process and pay claims submitted by providers who render services to Medicaid-eligible recipients.

Certain types of claims require special processing or fall under eMedNY limitations. Claims that are run through eMedNY but are not paid through the system are referred to as "adjudicated"

payments. Claims that are not run through eMedNY and not paid through the system are referred to as "offline" payments. Adjudicated claims include federal reimbursement amounts for state operating costs for the Office of Mental Health and Office of Persons With Developmental Disabilities. Off-line Medicaid claims include, but are not limited to, payments to providers from public goods pools established to reimburse providers for services rendered to indigent persons, payments of Medicare insurance premiums on behalf of Medicaid recipients, and reimbursements to local governments and state agencies for submitted off-line claims.

For calendar year 2009, OMIG reviewed the off-line Medicaid expenditures in New York with particular focus on Disproportionate Share Hospital (DSH) Payments - payments to providers from public goods pools established to reimburse providers for services rendered to indigent persons and local government Medicaid administrative expenditures.

Payment Error Rate Measurement (PERM) Program

New York State was part of the Federal PERM review for Federal Fiscal Year (FFY) 2008 (October 1, 2007 through September 30, 2008). The Centers for Medicare and Medicaid Services (CMS) and their contractor, Health Data Insights (HDI) reviewed 520 claims paid during the audit review period. The Office of the Medicaid Inspector General (OMIG) mirrored the Federal Review to ensure compliance by the selected providers, and refute errors when CMS and HDI misapplied federal or State regulations. OMIG was able to overturn two errors in the PERM Difference Resolution Process. There were many more potential errors that the PERM team was able to avert by contacting providers for missing documentation before an error was assigned. The highest error categories, nationally, in the Medical Review process were for MR-1 errors – no documentation, and MR-2 errors – incomplete documentation. New York State had no errors in the MR-1 category and only one error in the MR-2 category.

CMS and HDI only identified two payment errors, that is, claims submitted by providers which were not supported by appropriate medical records showing the need for and provision of the service. One error was for a claim that the provider admitted was billed in error (this was the MR-2 error); the second was for a coding error that had no dollar impact. OMIG also identified five additional errors that they reported to CMS. Two claims were found to have coding errors, one was not medically necessary; one claim had a policy violation and in another claim the provider over billed the number of services provided.

The main findings that CMS and HDI had for the fee-for-service claims were referred to as "Data Processing Errors". CMS and HDI identified eight claims in error. Seven of these errors were for claims filed untimely. New York State's (NYS) Medicaid program was cited for not having the documentation to justify the untimely filing of the claim. NYS required that the provider use an exception code when it filed an untimely claim to justify the lateness of the submission. The corresponding documentation supporting the exception code is audited after payment. CMS considered the lack of documentation for untimely claims to be a Medicaid error. The other data processing error occurred when the payment system failed to deduct the co-pay amount from the total payment amount (this programming error has been corrected).

Overall, the review went smoothly and the error rate assigned to the payment of Medicaid fee-for-service claims (excluding the errors found and reported by OMIG) was 1.4 percent. The next PERM cycle for NYS Medicaid claims is FFY 2011. Reviews will begin after the conclusion of the first quarter of that year - December 31, 2010.

PERM Plus

OMIG uses PERM staff and additional audit staff to expand upon the CMS review of Medicaid fee-for-service (FFS) claims in order to determine a benchmark percentage of Medicaid claims paid in error, and also the percentage paid as a result of potential fraudulent activity. PERM Plus activities go beyond the scope of the traditional PERM reviews by asking for additional documentation not requested in the PERM review. This additional documentation helps OMIG to identify overpayments and billing errors.

OMIG identified all FFS claims paid in Federal Fiscal Year 2009 (October 1, 2008 through September 30, 2009) and drew quarterly samples of 125 claims per quarter for review. Review of claim documentation from providers is currently underway for claims paid in the first quarter (October 1, 2008 through December 31, 2008). Several overpayments have been identified through the PERM Plus reviews, and several areas have been identified for further audit and investigation.

Problems and Concerns

At the time OMIG was created, one of the primary issues in controlling Medicaid fraud waste and abuse had been the lack of effective program integrity oversight of providers whose conduct did not meet the criminal threshold of intentional fraud provable beyond a reasonable doubt, but who were receiving Medicaid funds to which they were not entitled.

The Center for Medicare and Medicaid Services (CMS) issued a June 2006 report, stating it: "does not believe that New York's oversight of Medicaid program integrity is commensurate with the risk incurred by its Medicaid program, the largest in the country," and "Enforcement, not education, should be the primary goal of program integrity staff."

New York responded to this with the creation of OMIG in November 2006, resulting in a fundamental change in the structure and operation of its program integrity efforts. CMS's Medicaid Integrity Group (MIG) conducted a follow-up program integrity review of the New York State Medicaid Program with a focus on compliance with the findings and vulnerabilities discovered during its 2005 comprehensive review of the New York State Medicaid Program. The MIG conducted its onsite portion of the review at OMIG's Albany office in August 2008. As stated in CMS's letter to the Office of Health Insurance Programs, "the follow-up review showed that New York has addressed the two areas of non-compliance related to 42 CFR §§ 455.105(a) and 455.106(b)…The four areas of vulnerability noted in 2005 have also received attention from the State." "OMIG's authorized staffing has increased and, despite several vacancies, OMIG has a solid staff foundation, including core clinical staff, to support investigations."

However, significant impediments to OMIG's success remain:

Medicaid Data Warehouse and Claims Processing System Replacement:

The Department of Health's Office of Health Insurance Programs (OHIP) has two significant initiatives underway in which OMIG's involvement will be crucial. The Department's contract with its fiscal agent, Computer Sciences Corporation (CSC), will expire in July 2012. As the fiscal agent, CSC's two main responsibilities include operating the Medicaid data warehouse and the Medicaid claims processing system, eMedNY. In preparing for the expiration of CSC's contract, OHIP decided to separate these responsibilities and conduct two procurements: one for the data warehouse and one for the claims processing function. During 2009, the bid evaluation process continued for the Data Warehouse. During 2010, OHIP awarded the contract for the new Medicaid data warehouse to CMA Consulting and began working with the new contractor to begin scheduling design sessions. OMIG will participate in the application design sessions to ensure that our program integrity issues are addressed.

In 2008 OHIP, with the assistance of a vendor, FOX Systems, began the process of replacing the Medicaid claims processing system. FOX Systems and OHIP conducted assessment sessions using the Centers for Medicare and Medicaid Services (CMS) advocated Medicaid Information Technology Architecture - State Self-Assessment process.

CMS advised state Medicaid programs to use this process when preparing advance planning documents for this type of re-procurement. CMS uses the advance planning document review process and criteria when reviewing and approving a state's draft request for proposal before the state requests bids from potential vendors.

During 2009 and continuing in 2010, OMIG participated in these planning sessions to ensure the replacement systems address OMIG's needs and concerns relating to system integrity and preventing Medicaid fraud, waste and abuse. In addition, OMIG will participate in application design sessions once the contract is awarded.

Conclusion

The members of OMIG's staff appreciate the opportunity to address New York's Medicaid fraud, waste and abuse problems. As we end our third year we have strengthened our partnerships with other state agencies, allowing us to increase our abilities to effectively investigate and audit providers whose practices may be questionable, or who need to better control their Medicaid system.

Through our increased outreach efforts, we have had the opportunity to get out the message that the State of New York and OMIG insist on program integrity and quality from the state's Medicaid providers at all levels – whether physicians, dentists, nurses, pharmacists, rehabilitation professionals, home care providers, nursing facilities, hospitals, transportation providers, durable medical equipment vendors, or adult day care providers.

We look forward to increasing our efforts to control Medicaid fraud, waste and abuse in the upcoming year and to make program integrity a priority for everyone involved in New York State's Medicaid program. Through these efforts we will continue to strive to be a model for the rest of the nation to emulate.

Appendix

Operational Statistics

Appendix – Operational Statistics

2009 Investigations by Source and Region

Source	Downstate		Upstate		Totals	
	Initiated	Completed	Initiated	Completed	Initiated	Completed
Bur. of Payment Controls Management - Medicaid Systems	33	0	0	0	33	0
Bur. of Payment Controls Management – Pre-payment	2	0	0	0	2	0
CMS	5	9	1	1	6	10
CSC Fraud Unit	21	5	4	0	25	5
Correspondence	156	118	172	98	328	216
County Demo Project	29	9	1	1	30	10
CVR	0	4	1	1	1	5
DMI - Self Generated	255	274	769	242	1,024	516
DOH - Other Than DMI	17	6	11	8	28	14
DUR	0	0	0	2	0	2
Edit 1141	3	7	2	2	5	9
Enrollment	119	131	46	38	165	169
EOMB	40	33	49	29	89	62
Executive, Legislature, Administrative	3	1	2	3	5	4
F.B.I. Health Care Task Force	22	0	0	0	22	0
Fidelis	0	0	2	0	2	0
First Health PDP	0	0	1	0	1	0
HHS	1	0	0	0	1	0
H.I.P. Referral	1	0	2	2	3	2
Hotline	176	159	478	417	654	576
Internet	29	22	177	106	206	128
Law Enforcement	10	13	13	9	23	22
Local District	4	0	28	19	32	19
Managed Care	18	5	28	12	46	17
Medicaid Fraud Control Unit	3	0	2	5	5	5
Medi-Medi	0	2	19	18	19	20
Office of Professional Discipline	0	0	2	0	2	0
Office of Professional Medical Conduct	0	0	2	2	2	2
Office of the State Comptroller	9	0	1	1	10	1
OHIP (OMM)	66	33	18	19	84	52
OMIG Division of Medicaid Audit	7	5	7	5	14	10
OMRDD	0	2	1	0	1	2
Qui Tam	53	4	8	8	61	12
Restricted Recipient Program	0	0	1	0	1	0
Self-Disclosure	13	1	9	5	22	6
State Education Department	0	0	1	0	1	0
SURS	7	3	612	651	619	654
Telephone Call	18	16	33	20	51	36
Undercover Operations	1	0	71	11	72	11
Workers Compensation	1	0	1	0	2	0
Total	**1,122**	**862**	**2,575**	**1,735**	**3,697**	**2,597**

2009 Fraud Financial Investigations by Region and Project Type

2009 Downstate Fraud Financial Investigations				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Annual Ambulette Survey	0	0	$ 0	$ 6,065
Billing Issue	4	2	2,804,727	69,963
CVR – Transportation – Base	0	1	40,078	40,078
Diagnostic And Treatment Center	0	0	0	(956,169)
Fraud and Abuse	1	3	0	(104,148)
No Supervising Pharmacist	0	0	0	12,202
Nursing Home	0	0	0	126,000
Other	0	0	0	29,048
Pharmacies	0	0	0	(2,900)
Provider Prescription Fraud	1	1	0	0
Self Disclosure	1	1	255,931	255,931
Service Not Rendered	3	1	269,173	44,037
Total	**10**	**9**	**$ 3,369,909**	**$ (479,893)**

2009 Upstate Fraud Financial Investigations				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Annual Ambulette Survey	0	0	0	$ 6,021
Billing Issue	1	0	0	427,318
CVR – Transportation – Base	1	0	80,000	(19,638)
Fraud and Abuse	1	0	0	2,584
No Supervising Pharmacist	0	0	0	9,685
Personal Care	0	0	0	(17,322)
Service Not Rendered	0	1	45,584	0
Total	**3**	**2**	**$ 125,584**	**$ 408,648**

2009 Out-of-State Fraud Financial Investigations				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
No Supervising Pharmacist	0	0	0	$ 5,686
Total	**0**	**0**	**$ 0**	**$ 5,686**

2009 Total Fraud Financial Investigations				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Annual Ambulette Survey	0	0	$ 0	$ 12,086
Billing Issue	5	2	2,804,727	497,281
CVR – Transportation – Base	1	2	120,078	20,440
Diagnostic & Treatment Center	0	0	0	(956,169)
Fraud and Abuse	2	3	0	(101,564)
No Supervising Pharmacist	0	0	0	27,573
Nursing Home	0	0	0	126,000
Other	0	0	0	29,048
Personal Care	0	0	0	(17,322)
Pharmacies	0	0	0	(2,900)
Provider Prescription Fraud	1	1	0	0
Self Disclosure	1	1	255,931	255,931
Service Not Rendered	3	2	314,757	44,037
Total	**13**	**11**	**$ 3,495,493**	**$ (65,559)**[2]

2009 Summary of Civil Recoveries

Project Type	Identified	Recoveries
Credentials	$ 72,290	$ 1,092
Dentist	121,217	88,434
High Ordering Providers	1,374,798	55,182
Physician Reviews	218,596	126,133
Podiatrists	3,425	3,384
Total	**$ 1,790,326**	**$ 294,506**

[2] Fraud Financial recoveries for calendar year 2009 include refunds to providers of monies withheld in previous years in the course of DMI investigations. Corresponding refunds resulted in a negative balance for 2009.

2009 Provider Audits by Type and Region

2009 Downstate Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Assisted Living Program (ALP)	9	0	$ 0	$ 0
Ambulatory Surgery	0	1	331,336	4,099
Certified Home Health Agency (CHHA)	12	0	0	0
Death Match	0	1	31,764	35,921
Dental Clinic Services	1	0	0	0
Dentist	1	4	108,790	120,553
Diagnostic and Treatment Center	7	16	5,941,716	3,884,733
DME and Orthopedic Shoe Vendor	3	8	7,385,039	459,825
EPO/Aranesp Statewide Review	5	0	0	0
Epogen Clinic Review	7	0	0	0
Exception Codes	121	10	1,734,681	200,561
HHC – Long Term	5	0	0	0
High Ordering Providers[3]	4	1	(5,754)	34,285
HIV/AIDS	1	0	0	0
Hospice	1	0	0	0
Hospital Inpatient	10	1	432,439	432,439
Hospital Outpatient Department	8	4	2,575,997	2,023,339
Laboratories	0	0	0	61,251
Nursing Reviews	8	0	0	0
OASAS[4]	12	5	(45,005,128)	850,457
Ob/Gyn Services	1	1	89,500	206,186
OMH	6	8	1,529,401	707,676
OMH – Outpatient	0	0	0	80,196
OMH – COPS	98	0	0	144,110
OPWDD	128	156	2,276,345	2,352,100
Patient Review Instrument (PRI)	33	0	0	0
PCAP	0	0	0	46,991
PERM	2	1	173	173
Pharmacies[5]	11	1	(831,380)	241,756
Physician Reviews	12	1	53,668	31,055
Self Disclosure	55	41	6,427,428	5,883,178
Transportation	17	2	49,711	110,382
Traumatic Brain Injury (TBI)	2	1	294,091	294,091
Wal-Mart Statewide Project	12	0	0	0
Total	**592**	**263**	**$ (16,580,181)**	**$ 16,522,179**

[3] Audit findings lowered due to a stipulation agreement issued in 2009 related to a 2008 final audit.

[4] Audit findings for 2009 include an adverse administrative hearing decision which resulted in the reversal of a 2007 audit finding, and subsequent adjustment to finalized audit amounts.

[5] Audit findings for 2009 include an adverse administrative hearing decision which resulted in the reversal of a 2008 audit finding.

2009 Upstate Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
ALP	4	0	$ 0	$ 0
Certified Home Health Agency	0	1	81,343	81,343
Dentist[6]	1	0	(227,251)	16,853
Diagnostic and Treatment Center	7	7	1,338,599	743,087
DME and Orthopedic Shoe Vendor[7]	4	2	0	(6,553)
EPO/Aranesp Statewide Review	1	0	0	0
Exception Codes	21	3	452,469	357,046
HHC – Long Term	3	1	5,431	5,431
HIV/AIDS	1	0	0	0
Hospital Outpatient Department	4	6	513,190	632,975
Laboratories	8	0	0	0
Nursing Reviews	3	0	0	0
OASAS	6	3	1,060,403	1,295,778
Ob/Gyn Services	0	0	0	28,050
OMH	6	3	294,604	687,955
OMH – COPS	51	0	0	0
OMH Rehabilitation	2	0	0	0
OPWDD	69	82	534,186	541,344
Pharmacies	13	8	321,920	321,920
Physician Reviews	2	0	0	9,845
PRI	3	0	0	0
Self Disclosure	34	22	1,148,219	867,367
Skilled Nursing Facility – PRI/MDS	0	1	1,958,423	0
TBI	10	3	682,928	530,568
Transportation	30	2	0	81,289
Wal-Mart Statewide Project	25	0	0	0
Total	**308**	**144**	**$ 8,164,464**	**$ 6,206,670**

[6] Data correction applied to a 2008 final audit resulting in a reduction in audit finding amounts.
[7] Refund released to provider due to a stipulation agreement.

2009 Western Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
ALP	3	0	$ 0	$ 0
Certified Home Health Agency	3	2	1,581,043	1,581,979
Dentist	1	0	0	0
Diagnostic and Treatment Center	4	0	0	0
DME and Orthopedic Shoe Vendor	1	0	0	0
Duplicate Clinic Match	199	0	0	0
EPO/Aranesp Statewide Review	1	0	0	0
Epogen Clinic Review	1	0	0	0
Exception Codes	22	0	0	0
HHC-Long Term	3	0	0	0
Hospital Outpatient Department	4	0	0	0
Laboratories	1	0	0	0
Nursing Reviews	1	0	0	0
OASAS	2	3	264,985	472,519
Ob/Gyn Services	0	0	0	1,195
OMH	5	5	1,149,665	553,691
OMH – COPS	68	0	0	0
OMH Rehabilitation	3	1	0	0
OPWDD	62	72	389,873	382,307
Other	0	2	0	0
Personal Care	4	3	473,825	414,766
Pharmacies	14	26	1,117,867	2,594,573
Radiology	0	0	0	15,129
Self Disclosure	46	33	2,097,399	2,315,482
TBI	1	1	779,562	267,472
Transportation	30	0	0	0
Wal-Mart Statewide Project	44	0	0	0
Total	**523**	**148**	**$ 7,854,218**	**$ 8,619,131**

2009 Out-of-State Provider Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ambulatory Surgery	2	2	$ 7,916,538	$ 40,178
DME and Orthopedic Shoe Vendor	0	1	224,873	225,395
Exception Codes	6	0	0	0
Hospital Inpatient	4	0	0	0
Hospital Outpatient Department	1	0	0	0
Laboratories	1	1	77,776	77,776
Pharmacies	1	0	0	0
Self Disclosure	1	2	258,945	258,945
Transportation	1	0	0	0
Wal-Mart Statewide Project	3	0	0	0
Total	**20**	**6**	**$ 8,478,132**	**$ 602,294**

2009 Statewide Provider Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Assisted Living Program (ALP)	16	0	$ 0	$ 0
Ambulatory Surgery	2	3	8,247,874	44,277
Certified Home Health Agency (CHHA)	15	3	1,662,386	1,663,322
Death Match	0	1	31,764	35,921
Dental Clinic Services	1	0	0	0
Dentist[8]	3	4	(118,461)	137,406
Diagnostic and Treatment Center	18	23	7,280,315	4,627,820
DME and Orthopedic Shoe Vendor	8	11	7,609,912	678,667
EPO/Aranesp Statewide Review	7	0	0	0
Epogen Clinic Review	8	0	0	0
Exception Codes	170	13	2,187,150	557,607
HHC – Long Term	11	1	5,431	5,431
High Ordering Providers[9]	4	1	(5,754)	34,285
HIV/AIDS	2	0	0	0
Hospice	1	0	0	0
Hospital Inpatient	14	1	432,439	432,439
Hospital Outpatient Department	17	10	3,089,187	2,656,314
Laboratories	10	1	77,776	139,027
Nursing Reviews	12	0	0	0
OASAS[10]	20	11	(43,679,740)	2,618,754
Ob/Gyn Services	1	1	89,500	235,431
OMH	17	16	2,973,670	1,949,322
OMH – COPS	217	0	0	144,110
OMH Outpatient	0	0	0	80,196
OMH Rehabilitation	5	1	0	0
OPWDD	259	310	3,200,404	3,275,751
Other	0	2	0	0
PCAP	0	0	0	46,991
PERM	2	1	173	173
Personal Care	4	3	473,825	414,766
Pharmacies	39	35	608,407	3,158,249
Physician Reviews	14	1	53,668	40,900
PRI	36	0	0	0
Radiology	0	0	0	15,129
Self Disclosure	136	98	9,931,991	9,324,972
Skilled Nursing Facilities – PRI/MDS	0	1	1,958,423	0
Traumatic Brain Injury (TBI)	13	5	1,756,581	1,092,131
Transportation	78	4	49,711	191,671
Wal-Mart Statewide Project	84	0	0	0
Total	**1443**	**561**	**$ 7,916,632**	**$ 33,601,062**

[8] See footnote number 6 on page A5 of Appendix
[9] See footnote number 3 on page A4 of Appendix
[10] See footnote number 4 on page A4 of Appendix

2009 Rate Audits by Type and Region

2009 Downstate Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Clinic – Diagnostic and Treatment	0	1	$ 931,442	$ 0
GME – No encounter	0	3	0	0
Home Health Care (HHC)	1	0	0	0
HHC – Long Term	1	0	0	0
Medicare Crossover	0	1	17,153	370,496
OASAS[11]	1	0	0	(5,127)
Residential Health Care Facility (RHCF) Audits	44	38	12,838,357	29,648,911
Transportation	0	0	0	3,417
Total	**47**	**42**	**$ 13,786,952**	**$ 30,017,697**

2009 Upstate Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Adult Day Care	1	0	$ 0	$ 0
HHC	1	0	0	0
HHC – Long Term	1	0	0	0
RHCF Audits	15	29	8,568,692	9,626,220
Transportation	0	0	0	368
Total	**18**	**28**	**$ 8,568,692**	**$ 9,626,588**

2009 Western Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
HHC	2	0	$ 0	$ 0
HHC – Long Term	2	0	0	0
RHCF Audits	45	60	17,242,608	13,913,274
Transportation	0	0	0	6,204
Total	**50**	**60**	**$ 17,242,608**	**$ 13,919,478**

[11] Refund released to provider due to overcollection of funds from a 2008 stipulation agreement.

2009 Statewide Rate Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Adult Day Care	1	0	$ 0	$ 0
Clinic – Diagnostic and Treatment	0	1	931,442	0
GME – No Encounter	0	3	0	0
Home Health Care	4	0	0	0
Home Health Care – Long Term	4	0	0	0
Medicare Crossover	0	1	17,153	370,496
OASAS[12]	1	0	0	(5,127)
Residential Health Care Facility	104	127	38,649,657	53,188,405
Transportation	0	0	0	9,989
Total	**114**	**132**	**$ 39,598,252**	**$ 53,563,763**

[12] See footnote number 10 on page A8 of the Appendix.

2009 Managed Care and Provider Review Audits by Type and Region

2009 Downstate Region Managed Care and Provider Review Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Bed Reserve	1	3	$ 3,891,479	$ 3,579,511
Child Health Care Institute	0	0	0	33,532
Clinic – FQHC	2	0	0	0
Death Match	40	50	3,647,855	3,599,352
Duplicate CIN	0	2	1,600	1,600
Family Plan Chargeback/FFS	59	45	1,209,957	886,133
Family Plan Chargeback/MCO	18	29	17,403,424	16,966,131
Locator Code	1	0	0	0
Maternity/KICK Payment	0	0	9,437	4,771
Newborn FFS-Managed Care Crossover	57	35	1,328,373	2,262,477
No Reported Encounter Data	0	18	3,587,639	3,327,332
Prior to Date-of-Birth Payment	10	8	20,642	21,048
Prison Match	4	22	576,244	568,464
Rate Audit	1	0	0	0
SSI Retroactive Billing	0	8	363,673	363,673
Stop Loss	0	1	1,197	1,197
Transportation-Inpatient Crossover	2	0	0	0
Total	**195**	**221**	**$ 32,041,520**	**$ 31,615,221**

2009 Upstate Region Managed Care and Provider Review Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Clinic – FQHC	1	0	$ 0	$ 0
Death Match	10	11	708,611	637,655
Duplicate CIN	0	1	433	433
Family Plan Chargeback/FFS	5	3	17,498	917
Family Plan Chargeback/MCO	6	9	999,113	638,249
Locator Code	2	0	0	0
Newborn FFS-Managed Care Crossover	20	18	194,126	194,126
No Reported Encounter Data	0	9	94,843	83,755
Prior to Date-of-Birth Payment	4	4	7,536	8,081
Prison Match	2	10	232,932	202,819
SSI Retroactive Billing	0	3	33,473	33,473
Transportation-Inpatient Crossover	2	0	0	0
Total	**52**	**68**	**$ 2,288,565**	**$ 1,799,508**

2009 Western Region Managed Care and Provider Review Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Bed Reserve	0	1	$ 728,900	$ 0
Death Match	13	18	218,619	186,807
Family Plan Chargeback/FFS	6	5	24,600	22,028
Family Plan Chargeback/MCO	7	11	448,695	382,362
Locator Code	2	0	0	0
Newborn FFS/MC Crossover	17	13	158,176	158,176
No Reported Encounter Data	0	8	321,583	280,276
Prior to Date-of-Birth Payment	1	1	17,187	17,187
Prison Match	0	9	107,241	105,172
Rate Audit	1	0	0	0
SSI Retroactive Billing	0	5	115,882	115,882
Transportation-Inpatient Crossover	1	0	0	0
Total	**48**	**71**	**$ 2,140,883**	**$ 1,267,890**

2009 Statewide Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Bed Reserve	1	4	$ 4,620,379	$ 3,579,511
Child Health Care Institute	0	0	0	33,532
Clinic FQHC	3	0	0	0
Death Match	63	79	4,575,085	4,423,814
Duplicate CIN	0	3	2,033	2,033
Family Plan Chargeback/FFS	70	53	1,244,953	909,078
Family Plan Chargeback/MCO	31	49	18,851,232	17,986,742
Locator Code	5	0	0	0
Maternity/KICK Payment	0	0	9,437	4,771
Newborn FFS/MC Crossover	94	66	1,680,675	2,614,779
No Reported Encounter Data	0	35	4,004,065	3,691,363
Prior to Date-of-Birth Payment	15	13	45,365	46,316
Prison Match	6	41	916,417	876,455
Rate Audit	2	0	0	0
SSI Retroactive Billing	0	16	513,028	513,028
Stop Loss	0	1	1,197	1,197
Transportation-Inpatient Crossover	5	0	0	0
Total	**295**	**360**	**$ 36,463,866**	**$ 34,682,619**

2009 Medicaid in Education Reviews by Region and Type

2009 Medicaid in Education Downstate Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
SSHSP*	0	0	$ 38,779	$ 38,932
Systemic Review	0	0	492	492
Total	**0**	**0**	**$ 39,272**	**$ 39,424**

2009 Medicaid in Education Upstate Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
SSHSP	0	2	$ 25,403	$ 6,169
PSHSP**	0	0	8,500	8,500
Systemic Review	0	1	1,110,796	804,763
Total	**0**	**3**	**$ 1,144,699**	**$ 819,433**

2009 Medicaid in Education Western Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
SSHSP	0	0	$ 7,388	$ 7,388
PSHSP	0	1	24,090	12,845
Systemic Review	0	1	42,869	20,792
Total	**0**	**2**	**$ 74,347**	**$ 41,025**

2009 Statewide Medicaid in Education Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
SSHSP	0	2	$ 71,570	$ 52,489
PSHSP	0	1	32,590	21,345
Systemic Review	0	2	1,154,157	826,047
Total	**0**	**5**	**$ 1,258,317**	**$ 899,881**

*School Supportive Health Services Program
**Pre-School Supportive Health Services Program
***School Supportive Health Services Program – Intermediate Care Facility

2009 Systems Match and Recovery by Region and Type

2009 Downstate Systems Match and Recovery Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Deceased Recipients	195	79	$ 179,231	$ 182,393
Dental	0	22	76,864	179,203
General Clinic	0	1	1,403	23,138
Hemodialysis	0	12	140,067	254,159
Home Health	0	72	463,272	461,106
Home Health – Nursing Home	0	29	192,557	192,557
Hospice – Skilled Nursing Facility	0	1	1,268	1,268
Inpatient Crossover/Clinic/ER	69	60	1,880,271	1,394,785
Inpatient/Ancillary/Lab	0	24	71,899	107,628
Net Available Monthly Income (NAMI)	0	5	18,298	230,581
Non-affiliated Inpatient/Clinic/ER	0	2	1,030	802
PAC and PAS	0	8	1,380,114	1,743,052
Prenatal Care Assist Program (PCAP)	81	66	3,553,461	1,237,750
Physician – Place of Service	100	63	872,176	591,695
Radiology	105	39	169,482	138,989
Voluntary Refunds	3	1	15,885	15,885
Total	**553**	**484**	**$ 9,017,278**	**$ 6,754,991**

2009 Upstate Region Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	1	$ 117	$ 0
Deceased Recipients	48	15	34,255	34,255
Dental	0	2	0	4,461
General Clinic	0	6	719	95,829
Hemodialysis	0	6	12,484	12,484
Home Health	0	27	14,750	14,988
Home Health - Nursing Home	0	4	20,346	20,346
Hospice – Skilled Nursing Facility	0	1	797	797
Inpatient Crossover/Clinic/ER	42	42	375,241	367,398
Inpatient/Ancillary/Lab	0	23	30,411	30,227
PAC and PAS	0	3	502,965	502,965
PCAP	27	18	441,235	241,688
Physician – Place of Service	30	26	1,486,441	1,457,339
Radiology	46	14	92,611	40,932
Total	**193**	**188**	**$ 3,012,372**	**$ 2,823,709**

2009 Western Region Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Deceased Recipients	9	2	$ 2,340	$ 2,340
Dental	0	2	454	32,281
General Clinic	0	5	0	82,999
Hemodialysis	0	6	12,708	12,708
Home Health	0	18	24,163	23,587
Home Health – Nursing Home	0	6	19,889	19,759
Inpatient Crossover/Clinic/ER	49	47	342,529	342,528
Inpatient/Ancillary/Laboratory	0	17	24,906	24,876
PAC and PAS	0	4	466,495	549,823
PCAP	35	31	709,862	602,562
Physician – Place of Service	21	15	43,872	36,711
Radiology	44	20	152,132	43,975
Total	**158**	**173**	**$ 1,799,350**	**$ 1,774,149**

2009 Out-of-State Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Deceased Recipients	11	1	$ 0	$ 0
General Clinic	0	5	69	428
Inpatient Crossover/Clinic/ER	4	3	138,679	138,679
Inpatient/Ancillary/Lab	0	4	2,586	2,972
Physician – Place of Service	19	13	43,600	41,171
Radiology	27	9	57,402	8,684
Total	**61**	**35**	**$ 242,336**	**$ 191,934**

2009 Statewide System Match and Recovery Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	1	$ 117	$ 0
Deceased Recipients	263	97	215,826	218,988
Dental	0	26	77,318	215,945
General Clinic	0	17	2,191	202,394
Hemodialysis	0	24	165,259	279,351
Home Health	0	117	502,185	499,681
Home Health - Nursing Home	0	39	232,792	232,662
Hospice – Skilled Nursing Facility	0	2	2,065	2,065
Inpatient Crossover/Clinic/ER	164	152	2,736,720	2,243,390
Inpatient/Ancillary/Lab	0	68	129,802	165,703
Net Available Monthly Income (NAMI)	0	5	18,298	230,581
Non-affiliated Inpatient/Clinic/ER	0	2	1,030	802
PAC and PAS	0	15	2,349,574	2,795,840
PCAP – Prenatal Care Assist Program	143	115	4,704,558	2,082,000
Physician – Place of Service	170	117	2,446,089	2,126,916
Radiology	222	82	471,627	232,580
Voluntary Refunds	3	1	15,885	15,885
Total	**965**	**880**	**$ 14,071,336**	**$ 11,544,783**

2009 County Demonstration Project Audits by Region and Type

2009 Downstate County Demonstration Project Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
DME and Orthopedic Shoe Vendor	4	2	$ 2,860	$ 2,860
Pharmacies	91	17	6,136,029	3,470,437
Transportation	7	1	0	0
Total	**102**	**20**	**$ 6,138,889**	**$ 3,473,297**

2009 Upstate Region County Demonstration Project Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Dentist	0	1	$ 3,853	$ 3,853
OASAS	0	3	69,825	145,195
OMH	0	2	82,954	82,954
Pharmacies	32	44	2,178,596	1,048,131
Total	**32**	**50**	**$ 2,335,228**	**$ 1,280,133**

2009 Western Region County Demonstration Project Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
DME and Orthopedic Shoe Vendor	1	1	$ 46,224	$ 46,224
OMH	0	0	0	282,622
Pharmacies	5	21	306,558	589,509
Total	**6**	**22**	**$ 352,782**	**$ 918,355**

2009 Statewide County Demonstration Project Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
DME and Orthopedic Shoe Vendor	5	3	$ 49,084	$ 49,084
Dentist	0	1	3,853	3,853
OASAS	0	3	69,825	145,195
OMH	0	2	82,954	365,576
Pharmacies	128	82	8,621,183	5,108,077
Transportation	7	1	0	0
Total	**140**	**92**	**$ 8,826,899**	**$ 5,671,785**

Cost Savings Activities

Activity Area	2009
Card Swipe/Post and Clear	$ 143,664,924
Clinic License Verification	46,050,202
Duplicate Clinic/Nursing Home Claim Editing	81,742
Edit 1141 Activities	9,819,642
Edit 102	434,362
Edit 1236/1238 - Order/Servicing/Referring Provider # Invalid	20,215,699
Edit 1344 - Transportation Claims	709,472
Edit 1357	7,380,811
Edit 760 - Suspect Duplicate, Covered by Inpatient	7,325,004
Edit 903 - Ordering/Referring Provider Number Missing	40,644,806
Edit 939 - Ord Prov Excluded Prior to Ordt	17,667,146
Edit 941/944 - Practitioner Claims	400,781
Enrollment and Reinstatement	47,795,949
Exclusions/Terminations - Internal	8,570,516
Exclusions/Terminations - External	6,790,099
Part-time Clinic Verification	21,104,601
Pharmacies License Verification	27,709,933
Pharmacy Prior Authorization (Serostim)	52,540,072
Pre-Payment Insurance Verification - Commercial	726,238,965
Pre-Payment Insurance Verification - Medicare	257,250,699
Recipient Restriction	132,943,937
Serialized Prescription Program Edits	38,776,648
Transportation Crossover Edit	336,642
Totals	**$ 1,614,452,652**