New York State
Office of the Medicaid Inspector General

2013 Annual Report

Andrew M. Cuomo
Governor

James C. Cox
Medicaid Inspector General

Executive Summary

In 2013, the New York State Office of the Medicaid Inspector General (OMIG) achieved significant results in several areas of Medicaid program integrity. Some of the highlights include:

Recovered a record $879 million. With these record breaking figures in 2013, OMIG now has recovered more than $1.73 billion in improperly expended Medicaid funds over the past three years. This is a 34 percent increase over the prior three year period.

Identified more than $226 million through audit activities. These activities included record breaking years in the areas of fee-for-service and managed care audits, with $104 million and $47 million identified for recovery, respectively. Additionally, over $16 million self-disclosed by providers; over $7.2 million identified through the work of the County Demonstration program; and, over $7 million resulted from data mining initiatives.

$6.7 million resulting from OMIG investigations. These investigative financial activities are the result of OMIG's collaborative work with several law enforcement partners. These figures represent the highest total in five years.

Saved more than $2 billion for taxpayers through cost savings initiatives. OMIG utilized various cost saving program initiatives, including pre-payment reviews and corporate integrity agreement monitoring, to generate savings to the Medicaid program. These cost savings measures yielded a three year estimated total of $7.06 billion, an almost $2 billion increase over the previous three years.

Suspended $46 million in payments to providers under the Affordable Care Act. OMIG pursued credible allegations of fraud under the federal Affordable Care Act (ACA) with the New York State Attorney General's Medicaid Fraud Control Unit (MFCU), and suspended payments to prevent inappropriate expenditures of Medicaid funds.

Excluded or Terminated More Than 700 Providers. OMIG ended Medicaid program participation for 685 providers; and, 16 providers had their Medicaid contract terminated for licensure actions. These providers can no longer work in Medicaid-funded positions in health care-oriented businesses and organizations, or submit claims to the Medicaid program. Additionally, OMIG referred 164 providers to MFCU. These referrals may lead to potential criminal prosecution.

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MESSAGE FROM THE MEDICAID INSPECTOR GENERAL

Thanks to its tremendous staff, the Office of the Medicaid Inspector General (OMIG) had an impressive year. OMIG posted strong results across the board, and New York's Medicaid enforcement efforts lead the nation. We set a new record for recoveries at over $879 million, posted total estimated Medicaid cost savings to taxpayers exceeding $2 billion, and strengthened our existing tools, like Business Line Teams. All of this happened because of careful planning, the diligence of our team, and the strength of our techniques. These figures exemplify OMIG's continued efforts to enhance the integrity of the New York State Medicaid program.

We are pleased to report the record results of our investigative unit – over $6 million identified through investigative actions, and $46 million encompassing new, Affordable Care Act-related recoveries. The success of our efforts to investigate fraud, waste, and abuse in the Medicaid program are highlighted by these figures.

In 2012, OMIG focused on improving performance in audit operations; and, we are pleased to report the results of these improvements. In 2013, our audit team identified over $226 million in Medicaid overbilling, including $104 million from audits of fee-for-service providers, and $7.2 million from the County Demonstration program. Additionally, we used advanced data mining tools that identified $7.7 million in overbilling by providers.

In this, my third year as Medicaid Inspector General, I am very proud of the collaborative work being done in this agency, not only internally but with providers, managed care plans, beneficiaries, policymakers, and law enforcement partners. Through these cooperative and concerted efforts, we are working to safeguard the Medicaid program and achieve one of its primary directives: providing excellent health care at a cost that taxpayers can afford. The results of this work and the efforts of our staff have paid off. Over the last three calendar years, New York's enforcement efforts have recovered more than $1.73 billion, a 34 percent increase over the prior three-year period. Additionally, over the last five years, New York State alone accounted for more than 54 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement.

I am pleased to offer this Annual Report on behalf of OMIG.

Sincerely,

James C. Cox

James C. Cox
Medicaid Inspector General

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OMIG Background

On July 26, 2006, Chapter 442 of the Laws of 2006 was enacted, establishing OMIG as a formal state agency. The legislation amended the Executive, Public Health, Social Services, Insurance and Penal laws to create OMIG and institute the reforms needed to effectively fight fraud, waste, and abuse in the State's Medicaid program. The statutory changes separated the administrative and program integrity functions, while still preserving the single state agency structure required by federal law. Thus, although OMIG remains a part of the New York State Department of Health (DOH), it is required by statute to be an independent office. The Medicaid Inspector General reports directly to the Governor.

OMIG is charged with coordinating the work of fighting fraud, waste, and abuse in the Medicaid program. To fulfill its mission, OMIG performs its own reviews of the Medicaid program, while also working with other agencies which have either primary regulating authority or law enforcement powers. This means OMIG needs to understand Medicaid program regulations and guidance and use this knowledge to fight fraud and abuse, and to recommend improvements to the program.

Mission Statement

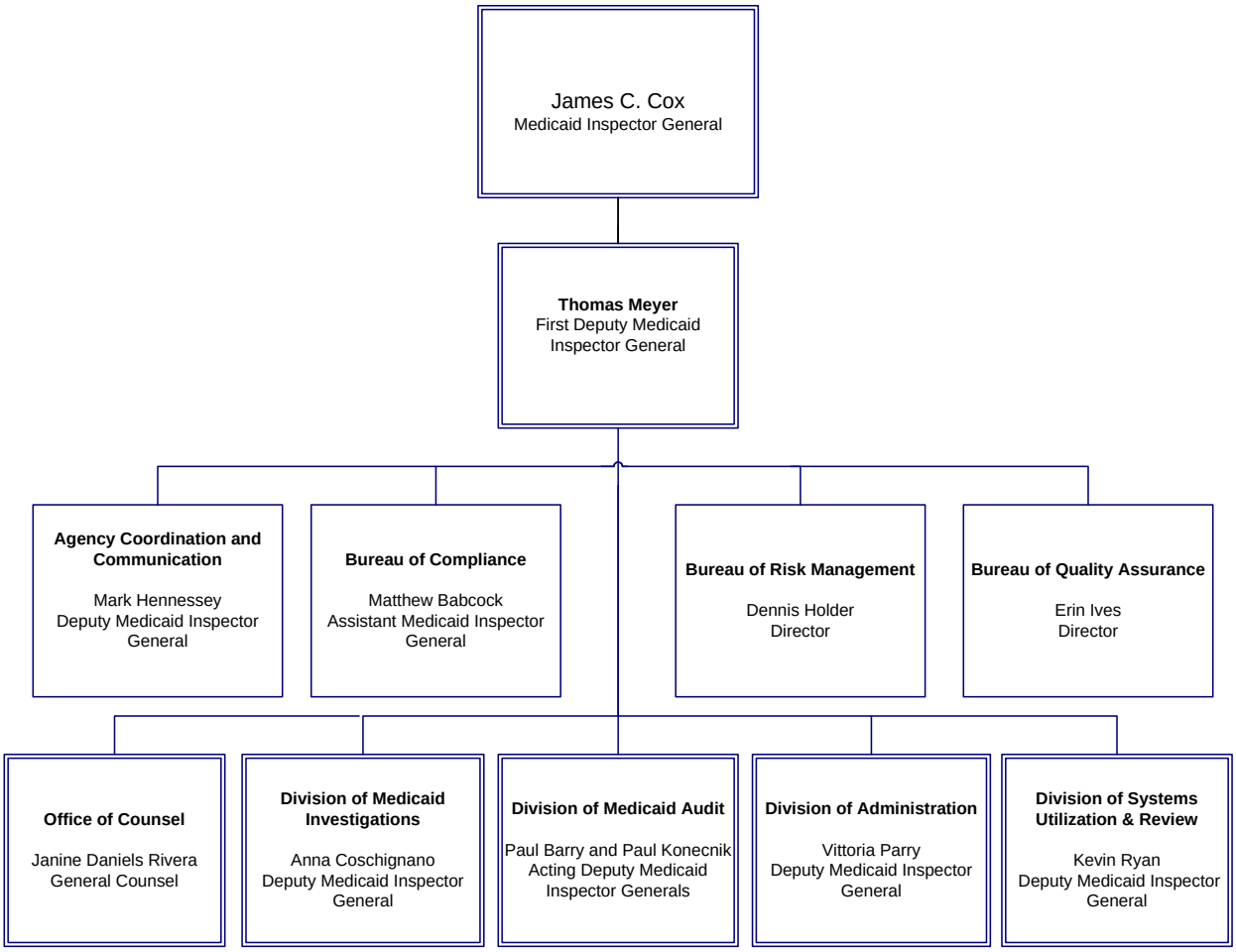
The mission of OMIG is to enhance the integrity of the New York State (NYS) Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds, while promoting high quality patient care.

Annual Reporting

As required by NYS Public Health Law §35(1), OMIG must annually submit a report that summarizes the activities of the agency for the prior calendar year. This Annual Report includes information about the audits, investigations, and administrative actions, initiated and completed by OMIG, as well as other operational statistics that exemplify OMIG's program integrity efforts.

Amounts reported within this document represent the value of issued final audit reports, self-disclosures, administrative actions and cost savings activities. OMIG recovers overpayments when it has been determined that a provider has submitted or caused to be submitted claims for medical care, services, or supplies for which payment should not have been made. OMIG recovers these amounts by receipt of cash, provider withholds, and/or voided claims. The recovery amounts may be associated with overpayments identified in earlier reporting periods. Identified overpayment and recovery amounts reflect total dollars due to the Medicaid program, as well as adjustments related to hearing decisions, stipulations and settlements.

OMIG Organizational Chart



OMIG Offices

OMIG is headquartered in Albany. Certain headquarter responsibilities, as well as field office functions, are based in New York City (NYC). Regional offices are located in White Plains, Hauppauge, Syracuse, Rochester, and Buffalo.

OMIG Initiatives

Social Adult Day Care Medicaid Program Integrity Efforts

As noted on the New York State Office for the Aging's (NYSOFA) website, social adult day care (SADC) services are provided as part of a structured, comprehensive program that provides functionally impaired individuals with socialization, supervision and monitoring, personal care, and nutrition in a protective setting; and is an important component of the community-based service-delivery system for older persons with cognitive and/or physical impairments. SADCs help to delay or prevent nursing home placement and the need for other very costly services, while providing vital assistance and support to the individual's informal caregivers. Transportation services may also be included as part of the SADC.

In addition, NYSOFA directly funds 17 SADC programs under a state-funded program (Section 215 of the NY Elder Law). All NYSOFA-funded SADC programs, those funded directly by NYSOFA and those funded by New York State's Area Agencies on Aging with aging funds administered by NYSOFA, must adhere to NYSOFA SADC Regulations (Title 9 of the New York Codes, Rules and Regulations §6654.20 Social Adult Day Care Programs). Although, SADCs do not receive funding directly from Medicaid, if the participating senior is eligible for enrollment in a Managed Long Term Care (MLTC) plan, a center may collect indirect Medicaid revenue by contracting with managed care plans. Since the State's move to mandatory MLTC, a proliferation of SADCs have emerged as operators seek contracts with MLTC plans. OMIG investigators and audit staff continue to work and cooperate with other state and federal agency partners to investigate, audit and, where appropriate, prosecute providers that do not adhere to the rules and regulations in providing these important services.

More information regarding OMIG's investigations of SADCs can be found later in this Annual Report within the "Collaborations with Other Agencies" section and the "Sanctions – Exclusions and Terminations" section. For additional information regarding SADCs generally, please see the NYSOFA website at: http://www.aging.ny.gov/NYSOFA/Programs/CaregiverSvcs/SADS.cfm.

Joint Warning Letter Issued to Nursing Facilities about Antipsychotic Drug Use

The Medicaid Inspector General and Commissioner of the Health Department jointly issued a letter on March 6, 2013 to all nursing facilities urging the proper use of antipsychotic medications for nursing home residents. The purpose of the letter was to provide resources to nursing homes that may assist in ensuring appropriate care for residents and compliance with federal regulation 42 CFR §483.25(l), and specifically highlight antipsychotic medications.

Based on the significant growth in the use of antipsychotic medications, OMIG and DOH felt it was important to notify nursing homes of the potential risks associated with the administration of these medications to their resident populations. Scientific studies indicate an increased morbidity and mortality rate in elderly individuals with dementia who are treated with these medications. In 2006, the federal Food and Drug Administration issued a "black box" warning noting these risks. Despite this warning, reports show that antipsychotic medications continue to be used to treat elderly nursing home residents with no prior diagnosis or history of psychosis. In its 2012 review, the federal Health and Human Services Office of Inspector General's report found "nearly all record [of nursing home residents receiving atypical antipsychotic medication] reviewed failed to meet one or more federal requirements for resident assessments and/or care plans." Nursing facilities are expected to utilize their full interdisciplinary team — including the medical director and attending physicians — to develop and review all policies and procedures regarding the use of antipsychotic medication.

OMIG and DOH's Office of Health Insurance Programs (OHIP) included several attachments intended to guide the establishment of protocols and procedures as well as further educate nursing facilities about managing dementia and Alzheimer's disease and the use of antipsychotic medications. The letter and its attachments are available on the OMIG website at the following link: http://omig.ny.gov/latest-news/662-omig-and-doh-send-letter-to-nursing-homes-on-antipsychotic-drugs

Compliance Activities

The Bureau of Compliance (BOC) is authorized to conduct reviews of providers meeting the requirements of NYS Social Services Law § 363-d and Title 18 of the New York Codes, Rules and Regulations (NYCRR) Part 521. These laws and regulations outline the specific criteria for determining which providers are required to adopt and implement a compliance program. For these providers, an effective compliance program is required in order to be eligible to receive Medicaid payments or submit claims for Medicaid services. If providers are not meeting specific compliance requirements, BOC identifies the specific statutory or regulatory insufficiency, suggests resolutions, requires the provider to submit plans of correction to address the insufficiencies, and monitors the provider's progress in resolving the insufficiency. When BOC conducts reviews of providers' mandatory compliance programs all reasonable steps are taken to work with providers to assist them in meeting these compliance obligations. BOC reserves the right to conduct unannounced follow-up reviews to confirm correction of the insufficiencies.

Providers that are required to have and maintain compliance programs must annually certify that their compliance programs meet all the statutory and regulatory requirements. OMIG actively oversees provider's performance through the certification obligation, by use of computer databases, and direct outreach to providers who appear to have failed to meet the annual certification requirement.

BOC's active role in the assessment process and monitoring of certification requirements supports its mission of educating and assisting providers in meeting their mandatory compliance program obligations.

Compliance Program General Guidance and Assistance

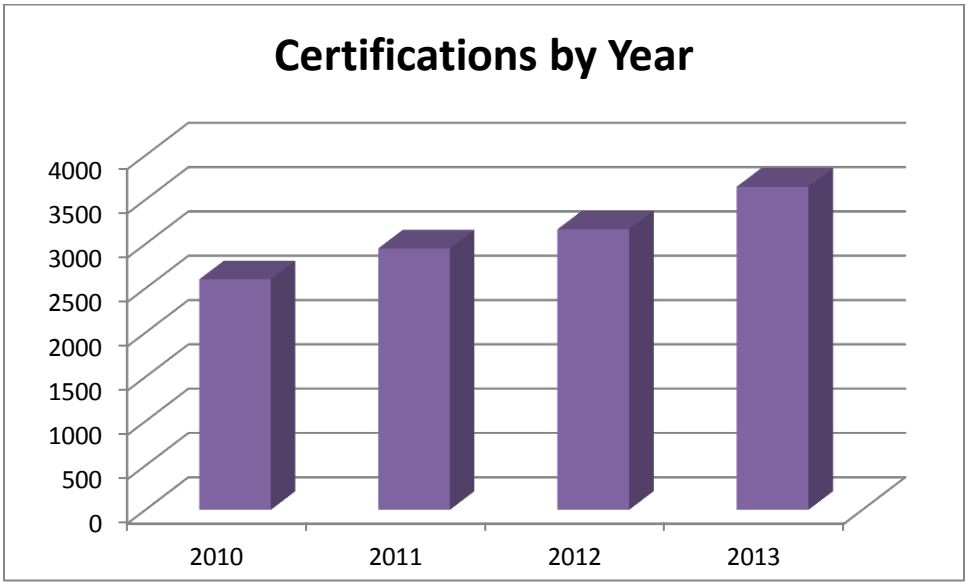
During 2013, BOC published 27 compliance related articles on OMIG's website and through DOH's *Medicaid Updates*. Additionally, BOC made 17 presentations at locations throughout the State, including two OMIG webinars. Among the more significant publications and presentations were the following:

- Updates to the BOC's observed provider compliance program Best Practices, Opportunities for Enhancement, and Insufficiencies;
- Webinar #18 – *OMIG's Certification for 2013: What Every Provider Needs to Know About Changes to the OMIG Compliance Certification Process*;
- Webinar #19 – *Governing Body's Role in Program Integrity*;
- University of Rochester's 15th Annual Compliance Symposium;
- Columbia Presbyterian Hospital and Mount Sinai Hospital – *OMIG: Past, Present, and Future*; and,

- Healthcare Financial Management Association – *Eight Elements' Compliance and Operational Intersects*.

BOC's dedicated telephone line and email address served as a main point of contact for compliance related questions from providers, provider groups, and the public. During 2013, BOC received 391 calls via the dedicated telephone number and 481 emails directed to the dedicated email address, an 82% and 81% increase, respectively, from the year before.

In reviewing provider performance related to the annual December certification requirement for 2013, BOC continued to refine its universe of providers that must have a compliance program to meet the annual certification obligation. The move to Medicaid managed care continues to result in a drop in the universe calculations, since historically, the universe has been based upon fee-for-service payments by the State. Despite that change, the number of providers completing the annual certification continues to rise. There was a 15% increase in the total number of providers certified by December 31, 2013 compared to the number that certified by December 31, 2012.[1] In 2013, BOC focused on conducting outreach to providers that failed to complete or were late in completing their 2012 certifications. Although there are multiple reasons why the number of providers certifying continues to increase, BOC believes that its education and outreach efforts have had an impact on the improvement in certification totals.



[1] Providers were compared based upon Federal Employer Identification Number (FEIN) which is the basis upon which the certification is reported.

Compliance Program Reviews

During 2013, BOC finalized desk, onsite and verification reviews of 21 Medicaid providers' compliance programs. BOC conducts onsite and desk reviews of providers that were identified by BOC as failing to meet the annual certification requirement, as well as through referrals from other OMIG units and other State agencies. BOC also conducts verification reviews. Verification reviews are typically follow-ups after a review is completed. The goal of the verification review is to verify the statements made by the chief executive officer (CEO) and chief compliance officer (CCO), as well as to verify that the plans of correction are, in fact, operating. Depending upon the severity of the problems, BOC could expand the verification review beyond a review of the plans of correction to other matters relevant to the compliance obligation.

Corporate Integrity Agreement Enforcement

OMIG imposes Corporate Integrity Agreements (CIA) on providers that fail to meet their compliance obligations, but whose removal from the Medicaid program would negatively impact access to necessary services. Under a CIA, in addition to addressing the conduct that was the subject of the settlement agreement, 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. CIAs include specific requirements that the provider engage an independent review organization to monitor compliance with the provisions of the CIA. Providers that breach their CIA obligations face sanctions in the form of stipulated penalties and/or exclusion from the Medicaid.

In 2013, OMIG developed a methodology to measure cost avoidance associated with CIA monitoring and enforcement. The analysis revealed that in 2013, there was more than $55 million in avoided costs to the Medicaid program that resulted from CIA monitoring and enforcement efforts (see Table 11.1).

Outreach and Educational Activities

OMIG offers outreach and educational presentations about the Medicaid program to providers and the public. In 2013, OMIG staff developed and presented educational sessions to a variety of outside consumer and professional trade association groups, including:

- The Albany Housing Authority
- The American College of Healthcare Administrators
- The Association of Community Living
- Association of Government Accountants
- The Chinese-American Independent Practice Association
- Community Health Care Association of New York State
- Greater New York Hospital Association
- Healthcare Association of New York State
- Health Care Compliance Association
- Home Care Association of New York State
- LeadingAge New York State
- Long Term Care Community Coalition
- Mount Sinai Medical Center
- New York State Bar Association
- New York Health Information Management Association
- New York Medicare-Medicaid Data Analysis Center
- New York Presbyterian Hospital
- New York State Association of County Health Officials
- New York State Association of Health Care Providers
- New York State Health Facilities Association
- New York State Rehabilitation Association/New York State Behavioral Association
- United Cerebral Palsy

Additionally, OMIG had a booth at the NYS Fair in Syracuse for two weeks, staffed by various OMIG personnel, including one day by the Medicaid Inspector General. This booth provided a unique opportunity to speak directly with more than 2,500 New Yorkers from across the State and address their concerns and ideas related to Medicaid fraud, waste, and abuse. As a participant in the *Somos el Futuro* and Black and Puerto Rican Legislators' conferences at the Empire State Plaza, OMIG also staffed a display booth.

Additionally, representatives from OMIG's procurement staff worked at the annual two-day exhibition for Minority and Women Business Enterprise (MWBE) exposition, also held in Albany, providing information to potential MWBE vendors that might wish to bid on upcoming OMIG procurement contracts.

OMIG presented two educational webinars to the general public in 2013, offered free of charge, broadcast to an audience whose members were able to send in questions during the session. All webinars are posted on OMIG's website for later viewing and listening at: http://omig.ny.gov/resources/webinars. Such educational opportunities assist providers in learning the latest developments in Medicaid program requirements and enable OMIG to reach a wide audience.

OMIG has a presence on Twitter, Facebook, and LinkedIn; and, makes frequent postings on social media sites, in addition to updating the website as appropriate. OMIG maintains a listserv with 4,000 subscribers that receive updates on an as-needed basis when the agency has important news to report.

Investigative Activities

OMIG's Division of Medicaid Investigations (DMI) monitors the Medicaid program for evidence of fraud and abuse, responds to detected fraud, imposes administrative sanctions to deter others, and promptly remedies program vulnerabilities. Through DMI, OMIG conducts investigations of all provider types including those furnishing medical and dental care, mental health care and counseling, pharmacy and durable medical equipment (DME), transportation, home health care, and skilled care in a nursing home or hospital setting. Additionally, Medicaid recipient misuse of the program, such as eligibility fraud and forged or altered prescriptions, are investigated by OMIG and referred to Local Departments of Social Services (LDSS) for action.

DMI's offices in Albany, NYC, White Plains, Hauppauge, Rochester and Buffalo are staffed by investigators, registered nurses, doctors, dental hygienists, dentists, pharmacists, auditors and administrative staff. Investigations are supported by a multi-lingual staff throughout DMI.

DMI contains multiple units, each with a different area of responsibility. Allegations from outside OMIG are received by the Bureau of Medicaid Fraud Allegations (BMFA). Cases are opened and an initial review is conducted by BMFA's licensed health care professionals, administrative and investigative staff. Cases are triaged by management and assigned to the appropriate unit within DMI.

Cases involving providers of Medicaid services, enrolled and non-enrolled, are assigned to the Provider Investigations Unit, where the allegations are analyzed utilizing a variety of methods, which include but are not limited to, data mining, undercover operations, analyses of returned Explanation of Medicaid Benefits (EOMB), and interviews of complainants and subjects. Evidence of suspected fraud and Credible Allegations of Fraud (CAF) are referred to MFCU, in compliance with applicable regulations and laws.

The Recipient Investigations Unit receives complaints and proactively investigates fraud in the recipient community. These allegations can include unreported income, false representations for eligibility, and allegations of prescription fraud or forgery.

DMI has strong working relationships with local, state and federal regulatory entities, law enforcement agencies and prosecutorial offices. OMIG has many examples of successful joint investigations that have utilized the specialized skills of DMI staff, all of which will be highlighted in later sections.

DMI has three units that are responsible for administrative program integrity functions: Recipient Restriction Program (RRP), Enrollment and Reinstatement Unit (EAR) and the Administrative Remedies Unit (ARU). RRP monitors misuse of Medicaid services by recipients. EAR conducts in-depth, front-end reviews of high risk providers that are seeking enrollment in the Medicaid program. ARU identifies existing Medicaid providers and other healthcare related persons and entities that have violated the Medicaid program rules and regulations.

Table 1.1 is a summary of investigations by type and region. Table 1.2 lists all investigations by the source of the allegation and region in which the entity is located. Tables 1.3 and 1.4 summarize the financial activities related to DMI's investigations during 2013. The dollars reported in Table 1.3 represent those monies associated with administrative financial actions taken by OMIG, as well as monies associated with OMIG's collaborative efforts with law enforcement entities that resulted in court ordered Medicaid restitution. Table 1.4 shows collections from providers during the year.

2013 Investigative Operational Statistics[2]

Table 1.1								
Investigations by Subject Type and Regions Summary								
	Downstate		Upstate		Out of State		Totals	
Subject	Opened	Completed	Opened	Completed	Opened	Completed	Opened	Completed
Enrolled Provider	707	572	322	277	13	14	1,042	863
Enrolled Recipient	1,243	1,083	486	559	0	0	1,729	1,642
Non Enrolled Individual	207	208	53	69	0	0	260	277
Non Enrolled Provider	201	72	40	24	60	25	301	121
Totals	2,358	1,935	901	929	73	39	3,332	2,903

[2] Cases completed may reflect projects that were opened in a prior reporting period.

Table 1.2 Summary of Investigations by Source of Allegation and Region								
	Downstate		Upstate		Out of State		Totals	
Initial Source	Opened	Completed	Opened	Completed	Opened	Completed	Opened	Completed
Anonymous	427	359	208	233	0	0	635	592
Bureau of Narcotic Enforcement	0	1	0	15	0	0	0	16
CQC	0	0	3	1	0	0	3	1
CSC Fraud Unit	4	2	0	1	0	0	4	3
Drug Enforcement Agency	10	0	15	6	0	0	25	6
Enrolled Recipient	192	199	66	67	2	3	260	269
Federal Department of Homeland Security	2	4	0	0	0	0	2	4
Federal Bureau of Investigation	20	2	0	0	0	0	20	2
General Public (Non-enrolled)	314	345	190	199	1	1	505	545
Health and Human Services	70	116	12	4	0	0	82	120
Law Enforcement	48	25	17	8	0	0	65	33
Local District Social Services	10	11	28	39	0	0	38	50
Managed Care Plans	95	75	36	30	3	0	134	105
NYS Department of Financial Services	0	0	2	4	0	0	2	4
NYS Department of Health (DOH)	28	24	13	16	0	0	41	40
NYS Department of Taxation and Finance	0	2	0	0	0	0	0	2
NYS Office for People with Dev Disabilities	1	0	2	2	0	0	3	2
NYS Office for the Aging	1	0	0	0	0	0	1	0
NYS Office of Health Insurance	20	15	34	21	1	1	55	37
NYS Office of Temporary and Disability Act	1	10	1	5	0	0	2	15
NYS Office of Attorney General	38	11	4	1	57	1	99	13
NYS Office of the Inspector General	14	8	3	0	0	0	17	8
NYS Office of the State Comptroller	3	9	0	0	0	0	3	9
NYS Workers Compensation Board	0	0	1	0	0	0	1	0
Non-Enrolled Provider	4	1	1	2	0	0	5	3
Non-Enrolled Recipient	3	10	0	0	0	0	3	10
OMIG Audit	29	23	18	17	0	0	47	40
OMIG Bureau of Compliance	6	1	2	1	0	0	8	2
OMIG Bureau of Payment Controls and Monitoring	10	3	7	4	0	0	17	7
OMIG Div. of Technology and Business Automation	28	4	4	2	0	0	32	6
OMIG Division of Medicaid Investigations	858	533	169	172	7	5	1,034	710
OMIG Executive	4	2	8	5	0	0	12	7
Provider	116	124	57	71	2	5	175	200
Qui Tam	0	6	0	3	0	23	0	32
Safe Guard Services	2	10	0	0	0	0	2	10
Total	2,358	1,935	901	929	73	39	3,332	2,903

2013 Investigative Financial Activities by Region and Provider Type

Table 1.3		
2013 Investigative Financial Activities		
Provider Type	Dollars Associated with Final Actions	Number of Final Actions
Dental Groups	$ 10,237	2
Dentist	6,606	1
Diagnostic & Treatment Center	5,159	1
Medical Appliance Dealer	1,002,500	1
Multi-Type Group	0	1
Recipient	7,005	3
Pharmacy	5,185,975	3
Physician	443,506	1
Transportation	65,060	1
Total	$ 6,726,048	14

Table 1.4				
2013 Investigative Financial Recoveries				
Provider Type	Downstate	Upstate	Upstate Western	Total Recoveries
Dental Groups	$ 0	$ 10,237	$ 0	$ 10,237
Dentist	10,644	0	9,442	20,086
Diagnostic & Treatment Center	4,046	0	0	4,046
Medical Appliance Dealer	16,449	0	0	16,449
Multi Type	42,867	0	0	42,867
Multi-Type Group	(122)	0	0	(122)
Optometrist	5,730	0	0	5,730
Recipient	0	0	1,949	1,949
Pharmacy	(171,939)	6,556	0	(165,383)
Physician	(1,427)	0	0	(1,427)
Podiatrist	436	0	0	436
Transportation	73,946	361,999	0	435,945
Total	$ (19,370)	$ 378,792	$ 11,391	$ 370,813

Medicaid Fraud Allegations

The BMFA receives allegations of potential fraudulent activity in the Medicaid program. The public, State and federal entities report allegations of fraud to BFMA utilizing a variety of methods including email, telephone, toll-free hotline (1-877-87-FRAUD), facsimile, OMIG's website (http://omig.ny.gov/), and U.S. mail. Allegations may be submitted anonymously. BMFA staff are responsible for reviewing and referring these allegations to the appropriate outside agency or unit within DMI for further investigation.

Table 1.5 below illustrates that in 2013, BMFA received 3,069 allegations of Medicaid fraud of which 2,562 were transferred for investigation. BMFA closed 507 cases after a preliminary review.

Table 1.5

Bureau of Medicaid Fraud Allegations

Manner of Receipt	Investigative Activities Initiated	Investigative Activities Closed	Investigative Activities Transferred
Correspondence	10	0	10
Email	691	36	655
Fax	59	6	53
Hotline	1,340	347	993
Internal	460	9	451
Internet	321	66	255
Telephone	1	0	1
US Mail	187	43	144
Totals	3,069	507	2,562

Provider Investigations

The Provider Investigations Unit reviews allegations of Medicaid fraud and abuse in all program areas including, medical and dental care, as well as pharmacy and transportation services among others. The unit also works with the special investigation unit's (SIU) within managed care organizations (MCO) to investigate potential fraud, waste and abuse in this new arena. Fraud, waste and abuse are deterred by scrutinizing provider billing, services rendered, and collaboration with other local, state, and federal agencies. Fraudulent Medicaid billing practices can include the following: billing for services not rendered, manipulating payment codes to inflate reimbursement, submitting inaccurate data on claims, rendering unnecessary

services, duplicate billings, up-coding (i.e., billing for more intensive services than those that were actually rendered), and kickbacks.

Table 1.6 represents all provider investigations conducted in 2013, summarized by the source of the allegation and the region where the provider is located.

Table 1.6
Investigations of Providers (Enrolled & Non-Enrolled)

Initial Source	Downstate		Upstate		Out of State		Totals	
	Opened	Completed	Opened	Completed	Opened	Completed	Opened	Completed
Anonymous	98	48	27	30	0	0	125	78
Bureau of Narcotic Enforcement	0	0	0	1	0	0	0	1
CQC	0	0	3	1	0	0	3	1
CSC Fraud Unit	4	2	0	1	0	0	4	3
Drug Enforcement Agency	10	0	15	0	0	0	25	0
Enrolled Recipient	87	75	42	40	2	3	131	118
Federal Bureau of Investigations	18	2	0	0	0	0	18	2
General Public (Non-enrolled)	92	61	32	45	1	1	125	107
Health and Human Services	32	74	4	2	0	0	36	76
Law Enforcement	36	15	6	3	0	0	42	18
Local District Social Services	5	7	9	11	0	0	14	18
Managed Care Plans	60	25	15	15	3	0	78	40
NYS Department of Health	15	11	12	14	0	0	27	25
NYS Dept. of Taxation and Finance	0	2	0	0	0	0	0	2
NYS Office for People with Dev Disabilities (OPWDD)	1	0	2	2	0	0	3	2
NYS Office for the Aging	1	0	0	0	0	0	1	0
NYS Office of Health Insurance	19	13	25	18	1	1	45	32
NYS Office of the Attorney General	36	10	4	1	57	1	97	12
NYS Office of the Inspector General	12	6	2	0	0	0	14	6
NYS Office of the State Comptroller	3	9	0	0	0	0	3	9
NYS Workers Compensation Board	0	0	1	0	0	0	1	0
Non-Enrolled Provider	1	1	1	0	0	0	2	1
Non-Enrolled Recipient	2	2	0	0	0	0	2	2
OMIG Audit	26	22	12	11	0	0	38	33
OMIG Bureau of Compliance	6	1	2	1	0	0	8	2
OMIG Bureau of Payment Controls and Monitoring	10	3	5	2	0	0	15	5
OMIG Div. of Technology and Business Controls	28	3	2	0	0	0	30	3
OMIG Div. of Medicaid Investigations	242	176	105	69	7	5	354	250
OMIG Executive	4	2	7	4	0	0	11	6
Provider	58	58	29	27	2	5	89	90
QuiTam	0	6	0	3	0	23	0	32
Safe Guard Services	2	10	0	0	0	0	2	10
Total	908	644	362	301	73	39	1,343	984

Dental Investigations

The Dental Investigations Unit reviews and evaluates dental services delivered to Medicaid recipients to identify fraud and recover improperly expended Medicaid funds while improving provider compliance with the rules and regulations of the Medicaid program. Data mining is conducted to monitor the billing patterns and claiming habits of Medicaid providers and to proactively identify potential fraudulent or abusive practices. The Unit also conducts Credential Verification Reviews (CVR) on dentists seeking enrollment into Medicaid. Examples of cases investigated by the Dental Unit are highlighted below.

OMIG Excludes Dentist Using Unsterilized Equipment

OMIG staff conducted a CVR of a dentist's office in Brooklyn, New York, and discovered that the dentist was performing procedures using unsterile instruments. The dentist failed to produce documentation to verify his sterilization process met acceptable standards. The dentist was immediately excluded from the Medicaid program based on the potential imminent danger to patients under 18 NYCRR § 515.7 (d). In addition to the exclusion, OMIG referred the dentist to the Bureau of Communicable Disease in the NYC Department of Health and Mental Hygiene and the New York State Education Department's (NYSED) Office of Professional Discipline (OPD) in NYC.

Dentist Recruited Homeless Recipients with Cash

OMIG referred a dentist to the MFCU and worked collaboratively with MFCU to assist in determining if the dentist had defrauded the Medicaid program through unlawfully paying recruiters to solicit homeless Medicaid patients with promises of cash, in exchange for coming to his practice. The dentist also billed Medicaid using his son's name for services that his son, also a dentist, never provided. During the investigation it was further determined that the dentist had failed to pay taxes on payments he received from other dentists working at his clinics. This dentist was excluded from the Medicaid program.

In 2013, the dentist pled guilty to two counts of Health Care Fraud in the Second Degree, and Criminal Tax Fraud in the Second Degree. The dentist was sentenced to one to three years in a NYS correctional facility and was ordered to pay over $550,000 in restitution and over $121,000 in back taxes.

Pharmacy Investigations

The Pharmacy Investigations Unit identifies aberrant pharmacy and prescription practices including billing for services not rendered, inaccurate data submission on claims, duplicate billings, rendering unnecessary services, services rendered by unlicensed or excluded providers and quality of care issues.

Pharmacy Inventory Reviews Yield Financial Restitution

In 2013, OMIG initiated 22 pharmacy inventory reviews. During the review process, payments made for prescriptions billed to the NYS Medicaid program were compared with the pharmacy's wholesaler purchases to determine whether the pharmacy had purchased enough medication to fill the prescriptions for which it billed the Medicaid program.

In 2013, based on the findings of pharmacy inventory reviews, three pharmacies were excluded and were ordered to reimburse the Medicaid program more than $2.4 million. As part of these actions, eight individuals were also excluded from the Medicaid program.

Pharmacist Sentenced to Prison Term for Fraud

OMIG referred a pharmacy to MFCU on allegations of billing for services not rendered and submitting claims for refills of prescriptions that the Supervising Pharmacist had previously reported as fraudulent. In August 2013, the owner of this pharmacy, who also owned three other pharmacies in New York, was sentenced to a prison term of one to three years for defrauding $7.7 million from the NYS Medicaid program. The four pharmacies, including the pharmacy that OMIG initially referred to MFCU, were convicted and sentenced to conditional discharges. OMIG immediately excluded the owner and all the pharmacies.

Collaborations with Other Agencies

OMIG and NYC Taxi and Limousine Commission Field Operations

OMIG/TLC 19-A Stop Operations are cooperative efforts between OMIG and the NYC Taxi and Limousine Commission (TLC). New York State Department of Motor Vehicles (DMV) requires a 19-A designation in order to operate an ambulette. Periodic operations are coordinated by the two agencies to conduct routine stops in specific areas known to have Medicaid providers with a high number of ordered transportation services. Transportation vehicles are stopped by TLC staff seeking paperwork from the driver, including NYS Driver's

License, TLC License, van registration and other TLC required documentation. During these stops, OMIG investigators interview the recipients. TLC has the authority to issue summonses, seize vehicles, and/or shut down the base station immediately. If an unacceptable practice is discovered, as defined by 18 NYCRR § 515.2, then OMIG may impose an administrative sanction, or if fraud is suspected, refer the case to MFCU.

In June 2013, a joint operation with TLC was conducted that identified unqualified drivers operating medical transportation vehicles within the Far Rockaway section of Queens. Six investigators from OMIG and 12 inspectors from TLC conducted a coordinated sweep that focused on pick-ups and drop-offs of Medicaid recipients at a local hospital. Additionally, Centers for Medicare and Medicaid Services (CMS) staff participated as observers. Of the 52 stops, four vans were seized and 18 summonses were issued for a total of $11,450 in fines. The infractions cited included unlicensed drivers, unlicensed vans, and cell phone conversations held without use of a hands-free device while driving.

The success of the 19A Stop project in NYC has led to its expansion in upstate New York. In September 2013, OMIG, in conjunction with NYS DMV and the New York State Department of Transportation (DOT), conducted routine inspections of 11 ambulettes from eight different providers in six Albany County locations. Investigators verified the driver's licenses, registration, inspection and insurance documentation. During these inspections, DMV issued six citations; DOT issued nine safety violations; and OMIG issued two provider education letters.

OMIG and MFCU Join Forces to Investigate Social Adult Day Care Centers

OMIG and MFCU continue to collaborate with state and city agencies that regulate MLTC and SADC services in NYC. OMIG and its partners conduct inspections of SADC Centers throughout NYS. Investigators examine providers' compliance with Title 9 of NYCRR, NYC Buildings Department Regulations, and the NYS Medicaid program regulations governing MLTC providers and SADC programs. In 2013, OMIG conducted more than 50 investigations of SADCs.

OMIG, MFCU, and partners in State and local government are continuing their efforts to protect the Medicaid population from unscrupulous providers to ensure that appropriate program services are provided, that services are rendered in facilities that are safe, and to collaboratively protect the integrity of the Medicaid program.

Recipient Investigations

The Recipient Investigations Unit investigates allegations of fraud and abuse in the Medicaid program that are committed by Medicaid recipients and non-enrolled individuals involved in recipient Medicaid fraud. Detecting eligibility fraud is integral to ensuring that only those persons meeting enrollment criteria receive Medicaid benefits. The unit also combats

prescription drug diversion through specific data mining efforts to identify recipients that fraudulently obtain prescriptions from providers. The unit validates allegations by obtaining evidence, and in concert with its law enforcement partners, assists in investigations which may result in civil actions, criminal prosecution, and restitution from recipients that fraudulently enroll and receive Medicaid benefits. The unit has maintained strong relationships with federal, state and local law enforcement, as well as regulatory agencies and district attorney offices.

Examples of recipient fraud can include: providing false information on a Medicaid application, lending Medicaid identification cards to another person, forging or altering a prescription or fiscal order, using multiple Medicaid ID cards and selling drugs or supplies provided to recipients by the Medicaid program. The following sections provide some actual cases investigated by the Recipient Investigation Unit.

High Living Medicaid Recipients Indicted and Sentenced for Welfare Fraud

OMIG used data mining to identify large numbers of Medicaid recipients living in a high-end, residential condominium complex in NYC. This investigation resulted in the indictment of four recipients, thus far. While claiming low incomes in order to qualify for Medicaid, these recipients lived opulent lifestyles, owning multiple high end vehicles such as Aston Martins, Porsches and BMWs, and shopping for luxury boutique clothing.

One of the recipients, who claimed on her Medicaid application to have less than $5,000 in savings and investments, was discovered to have purchased multiple apartments in the NYC complex between 2002 and 2010, in addition to properties owned in Bay Ridge, Long Island, and South Florida. In the course of the investigation, it was determined that she had made annual deposits of over $100,000 to several bank accounts that were both in her name and the name of her business. The subject flaunted her luxurious lifestyle on a social networking site, while she fraudulently collected more than $29,000 in Medicaid benefits. In April 2013, this recipient pled guilty to Welfare Fraud in the Fifth Degree and forfeited $85,000.

Caterer Hiding Income to Collect Medicaid Benefits Charged with Welfare Fraud

The Recipient Investigations Unit received an allegation that a Medicaid recipient owned a Binghamton catering business and was concealing business income while receiving Medicaid benefits. OMIG investigators utilized data mining techniques and reviewed social network information, which confirmed the recipient was in fact the owner of a catering business. OMIG referred this case to the Broome County Government Security Division, Case Integrity Unit. Using the information obtained by OMIG, Broome County investigators were able to confirm that the recipient failed to report his business income, allegedly defrauding the County of $8,952.

Enrolled Recipient Investigations

OMIG completed 1,642 investigations involving enrolled recipients, as set forth in Table 1.7, which shows investigations by allegation source and recipient location.

Table 1.7 Investigations of Enrolled Recipients						
Initial Source	Downstate		Upstate		Totals	
	Opened	Completed	Opened	Completed	Opened	Completed
Anonymous	318	297	170	190	488	487
Bureau of Narcotic Enforcement	0	1	0	14	0	15
Drug Enforcement Agency	0	0	0	2	0	2
Enrolled Recipient	31	42	12	16	43	58
Federal Department of Homeland Security	1	3	0	0	1	3
General Public (Non-enrolled)	184	227	145	136	329	363
Health and Human Services	15	21	8	2	23	23
Law Enforcement	6	3	10	5	16	8
Local District Social Services	5	3	16	22	21	25
Managed Care Plans	31	43	20	14	51	57
NYS Department of Financial Services	0	0	2	3	2	3
NYS Department of Health	7	12	0	2	7	14
NYS Office of Health Insurance	0	1	9	3	9	4
NYS Office of Temporary and Disability Act	1	10	1	5	2	15
NYS Office of Attorney General	0	1	0	0	0	1
NYS Office of the Inspector General	2	2	1	0	3	2
Non-Enrolled Provider	2	0	0	0	2	0
Non-Enrolled Recipient	1	4	0	0	1	4
OMIG Audit	0	0	1	1	1	1
OMIG Bureau of Payment Controls and Monitoring	0	0	2	2	2	2
OMIG Div. of Technology and Business Automation	0	1	2	2	2	3
OMIG Division of Medicaid Investigations	588	354	60	103	648	457
OMIG Executive	0	0	1	1	1	1
Provider	51	58	26	36	77	94
Total	1,243	1,083	486	559	1,729	1,642

OMIG also investigates individuals who are not enrolled in the Medicaid program. Table 1.8 shows the results of these investigations.

Table 1.8
Investigations of Non-Enrolled Individuals

Initial Source	Downstate		Upstate		Totals	
	Opened	Completed	Opened	Completed	Opened	Completed
Anonymous	11	14	11	13	22	27
Drug Enforcement Agency	0	0	0	4	0	4
Enrolled Recipient	74	82	12	11	86	93
Federal Department of Homeland Security	1	1	0	0	1	1
Federal Bureau of Investigations	2	0	0	0	2	0
General Public (Non-enrolled)	38	57	13	18	51	75
Health and Human Services	23	21	0	0	23	21
Law Enforcement	6	7	1	0	7	7
Local District Social Services	0	1	3	6	3	7
Managed Care Plans	4	7	1	1	5	8
NYS Department of Financial Services	0	0	0	1	0	1
NYS Department of Health	6	1	1	0	7	1
NYS Office of Health Insurance	1	1	0	0	1	1
NYS Office of the Attorney General	2	0	0	0	2	0
Non-Enrolled Provider	1	0	0	2	1	2
Non-Enrolled Individual	0	4	0	0	0	4
OMIG Audit	3	1	5	5	8	6
OMIG Division of Medicaid Investigations	28	3	4	0	32	3
Provider	7	8	2	8	9	16
Total	207	208	53	69	260	277

Prescription Fraud

Forged prescriptions can lead to thousands of illegal pills and other drugs being released into the community. Under DOH regulations, physicians are responsible for reporting lost or stolen prescription pads to DOH's Bureau of Narcotic Enforcement (BNE). Pharmacies can unknowingly fill an altered or forged prescription when such incidents are not reported. Pharmacy providers are required to question the authenticity of prescriptions and contact the physician and appropriate authorities when they suspect fraud.

Collaborative efforts between OMIG and BNE have provided OMIG with access to lost or stolen prescription pad reports. OMIG uses these reports, data mining techniques, and prescription serial numbers to identify potentially forged prescriptions and dispensing discrepancies by pharmacies. Early detection of forgeries prevents additional prescriptions from being filled, keeps illicit drugs out of the community, and saves taxpayers money. In 2013, OMIG completed 468 forgery investigations. A breakdown of the forgery investigations undertaken by DMI is in Table 1.9.

Table 1.9
Summary of Forgery Investigations by Source and Region

Initial Source	Downstate		Upstate		Totals	
	Opened	Completed	Opened	Completed	Opened	Completed
Anonymous	4	4	4	4	8	8
Bureau of Narcotic Enforcement	0	1	0	14	0	15
Enrolled Recipient	0	0	1	1	1	1
General Public (Non-enrolled)	2	3	2	2	4	5
Health and Human Services	1	0	7	0	8	0
Law Enforcement	1	2	2	1	3	3
Local District Social Services	0	0	2	2	2	2
Managed Care Plans	7	6	9	5	16	11
NYS Department of Health	1	0	0	0	1	0
NYS Office of Health Insurance	0	0	6	1	6	1
NYS Office of the Inspector General	1	1	1	0	2	1
Non-Enrolled Provider	1	0	0	0	1	0
OMIG Division of Medicaid Investigations	479	311	43	80	522	391
Provider	18	18	9	12	27	30
Total	515	346	86	122	601	468

Table 1.10 indicates the outside agencies to which OMIG referred recipients that may be involved with prescription forgeries.

Table 1.10
Forgery Referrals to Outside Agencies Recipients Only

Agency	2013
Bureau of Narcotic Enforcement	1
Law Enforcement Agency	24
Local District Social Services	25
NYC HRA Bureau of Client Fraud Investigations	291
Total	341

Program Integrity Referrals to MFCU and Outside Agencies

OMIG is required by NYS law to refer suspected fraud and criminality to MFCU. Additionally, in accordance with the federal ACA, OMIG must refer CAFs to MFCU for possible criminal prosecution. In 2013, OMIG referred 164 subjects to MFCU; 90 of these referrals were determined to be CAFs. Total referrals to MFCU are reported in Table 1.11; and the subset of ACA CAF referrals are reflected in Table 1.12.

Table 1.11
Referrals to MFCU

Provider Type	2013
Capitation Provider	4
Child Care Institution	1
Dental Groups	3
Dentist	3
Diagnostic & Treatment Center.	5
Enrolled Provider	3
Home Health Agency	16
Hospital	3
Long Term Care Facility	5
Medical Appliance Dealer	1
Multi-Type	6
Nurse	7
No Provider Type	3
Non Enrolled Provider	56
Pharmacy	16
Physician	19
Physicians Group	1
Service Bureau	1
Therapist	1
Transportation	10
Total	164

Table 1.12
Referrals of Credible Allegation of Fraud to MFCU

Provider Type	2013
Capitation Provider	4
Child Care Institution	1
Dental Groups	3
Dentist	3
Diagnostic & Treatment Center.	5
Home Health Agency	13
Hospital	2
Long Term Care Facility	5
Medical Appliance Dealer	1
Multi-Type	5
Nurse	5
Pharmacy	13
Physician	17
Physicians Group	1
Service Bureau	1
Therapist	1
Transportation	10
Total	90

In addition to the referrals made to MFCU, OMIG works in collaboration with New York City Human Resources Administration (NYC HRA) and other LDSSs on recipient referrals. Recipients that allegedly did not report income and filed fraudulent Medicaid applications, loaned out their Medicaid cards or forged prescriptions are referred to one of these agencies for further investigation and appropriate action. These recipients may be arrested and ordered to pay restitution to the Medicaid program.

OMIG also refers its findings to the agencies responsible for oversight of professional licensure, specifically, NYSED's OPD and DOH's Office of Professional Medical Conduct (OPMC). OPD and OPMC may take administrative action on individuals who hold professional licenses. These actions are in turn reviewed by OMIG to determine if a termination under 18 NYCRR §504.7(d) has occurred or if an immediate sanction under 18 NYCRR 515.7(e) is warranted.

In 2013, referrals to outside agencies totaled 1,131. A breakdown of these referrals can be found in Table 1.13.

Table 1.13	
Referrals to Outside Agencies	
Agency	2013
Bureau of Narcotic Enforcement	1
Centers for Medicare & Medicaid Services	1
Law Enforcement Agency	144
Local District Attorney	2
Local District Social Services	268
Managed Care Organizations	1
NYC HRA Bureau of Client Fraud Investigations	692
Office of Professional Discipline	11
Office of Professional Medical Conduct	2
Other DOH Unit (not OMIG)	7
Other Federal Agency	1
Other State Agency	1
Total	1,131

A total of 1,108 Recipient referrals were made to law enforcement and other State and federal agencies in 2013. Recipient referrals are shown in Table 1.14.

Table 1.14	
DMI Recipient Referrals to Outside Agencies	
Agency	2013
Bureau of Narcotic Enforcement	1
Law Enforcement Agency	144
Local District Social Services	267
Managed Care Organizations	1
NYC HRA Bureau of Client Fraud Investigations	689
Other DOH Unit (not OMIG)	5
Other Federal Agency	1
Total	1,108

Administrative Actions

Recipient Restriction Program

Recipient Restriction Program (RRP) is a medical review conducted by a team of physicians, nurses and pharmacists who identify recipients that have received Medicaid funded services that are duplicative, excessive, or contraindicated. This team also investigates recipients that have allegedly engaged in abusive practices, such as prescription fraud or card lending. RRP is an administrative mechanism used to promote coordinated medical care, reduce fraud, and save Medicaid dollars. Recipients that have demonstrated inappropriate utilization of Medicaid services are recommended to be restricted to specific primary providers such as a physician/clinic, pharmacy, or a hospital. LDSS and MCOs implement these restrictions.

The objectives of the program are to provide restricted enrollees with coordinated medical services to reduce inappropriate usage and improve the quality of their care. Additionally, cost savings are achieved by reducing fraud and misuse through eliminating abusive utilization behavior, by limiting Medicaid enrollee access to only medically necessary care.

As part of the Medicaid Redesign Team (MRT) managed care expansion, DOH mandated that each MCO providing services to Medicaid and Family Health Plus members implement an internal restriction program to control potential fraud and abuse. OMIG has assumed an increasingly pivotal role in the oversight of the managed care recipient restriction programs and has been a resource and administrative liaison between the MCOs and LDSSs. OMIG assists the MCOs by reviewing their policies and procedures to ensure compliance with the RRP provisions as detailed in the NYS Managed Care Model Contract.

OMIG established a referral process for MCO RRPs to use when a managed care enrollee is identified for possible inclusion into the MCOs RRP. Additionally, OMIG developed and implemented a process to share restriction information with MCOs, allowing for the restriction to follow the member regardless of his/her managed care enrollment status or specific plan membership. With OMIG's assistance, MCOs are able to implement and maintain restrictions while promoting the integrity of the NYS Medicaid program and provide quality care to their enrollees.

In 2013, OMIG coordinated meetings with NYC HRA, DOH and multiple NYC MCOs to discuss the overarching responsibilities related to the development of MCO initiated restriction programs. Contractual responsibilities and policies were discussed as well as a review of information specific to NYC HRA, including MCO responsibilities, clarification of the new primary provider change form requirements, and OMIG RRP's oversight responsibilities. Additional meetings were held with representatives from major substance abuse and detoxification inpatient and outpatient facilities in NYC. Risks associated with RRP substance

abuse enrollees, as well as ways to ensure appropriate identification and implementation of such enrollees in an MCO initiated RRP, were highlighted.

OMIG conducted 2,610 reviews, leading to 2,185 recommendations for restriction. These restrictions resulted in improved quality of care for the recipient and a cost savings to the Medicaid program of over $150 million. In 2013, the number of recipients on restriction averaged more than 8,700 per month. Cost savings associated with these restrictions are in Table 11.1, under "Recipient Restriction."

Enrollment and Reinstatement Activities

Prior to enrolling a provider in the Medicaid program, OHIP conducts an initial review of the applicant. Based upon this initial review, if an applicant is determined to be of moderate or high risk to the Medicaid program, OHIP will forward these applications for enrollment and reinstatement to OMIG's EAR unit for a more comprehensive review and investigation. EAR reviews these applications to identify fraudulent or abusive practices, and determine if applicants are unqualified, or present a potential danger to Medicaid recipients.

Through these front-end enrollment reviews EAR screens providers to enhance quality of care and regulatory compliance in the Medicaid program. On-site inspections and undercover operations are conducted, when needed, particularly in areas where licensing is not required, such as with DME companies. EAR also reviews several other provider categories where pre-enrollment reviews would be beneficial to avoid enrolling unqualified applicants, including pharmacy, transportation, opticians, laboratories, dental, physical therapy, portable X-ray, home health, personal care agencies (PCA), and nurse registries. Based on these investigations, applicants that do not meet the requirements of the Medicaid program are denied enrollment. Examples of the results of these reviews are highlighted below.

One Certified Fitter with Six Locations Nets Denial for DME

A DME provider submitted requests to be assigned the specialty of providing orthopedic footwear services in six of its enrolled locations. The provider was denied under 18 NYCRR §505.5 because the same orthopedic fitter was listed as the sole certified fitter for the company's six sites, even though they are scattered throughout Western NYS and Pennsylvania. DOH policy requires that an orthopedic fitter be present whenever footwear services are provided; and, because the same fitter was listed at every location, he clearly could not be present whenever these services were being provided. Further, moving between six disparate locations would make it impossible for him to be at any one for even one full day per week, severely limiting recipients' access to footwear services.

Pharmacy Denied Enrollment and Referred to State Education Department

A pharmacy on Long Island was denied for enrollment under 18 NYCRR §504.5(a)(13). An onsite investigation conducted by OMIG revealed 38 expired drugs in the pharmacy's inventory, including one that had expired in 2006. Investigators also found a dirty pharmacy refrigerator that contained food and had no inside thermometer, which is a program requirement. The pharmacy sink had no hot running water and its drain was clogged. In addition, the pharmacy counter was dusty and cluttered and the store was in such disarray that it would not be possible for a person with a disability to navigate the aisles. The pharmacy was referred to NYSED's OPD for further investigation.

Reinstatement Reviews

OMIG also receives provider requests for reinstatement or removal from OMIG's List of Excluded Providers. If a reinstatement application is denied, the applicant can appeal. Appeals are reviewed by a committee comprised of both DOH and OMIG staff.

Table 1.15
Applications Reviewed by EAR

Application Type	2013 Review Totals
Orthopedic Shoe Review	24
New Enrollment Review	554
Ownership Change Application	243
Reinstatement	41
Removal from Exclusion List	78
Total	940

Table 1.16
Enrollment Applications Dispositions

Disposition	2013 Totals
Approved	763
Denied	165
Withdrawn	36
Total	964

OMIG received 940 enrollment applications in 2013, as reported in Table 1.15. EAR denied enrollment, reinstatement or removal from OMIG's list of Excluded Providers to 165 providers (Table 1.16), resulting in over $32 million in Medicaid cost savings (Table 11.1).

Sanctions – Terminations & Exclusions

OMIG can impose sanctions on a provider including censure, exclusion, termination, or conditional or limited participation in the Medicaid program pursuant to 18 NYCRR §515. In 2013, OMIG conducted investigations and imposed exclusions based upon:

- NYSED actions, such as license surrender, suspension, and revocation, for Medicaid and non-Medicaid providers;

- Actions taken by OPMC involving professional misconduct and physician discipline actions, including license suspensions, revocations, surrenders, and consent agreements;
- Felony indictments and convictions of crime relating to the furnishing or billing for medical care, services, or supplies;
- Information received from the federal HHS OIG; and/or,
- OMIG's internal enrollment files and eMedNY data, which provides relative ownership information to determine affiliates of excluded providers.

OMIG excluded 685 providers and issued 16 notices of termination during 2013, as shown in tables 1.17 and 1.18. These individuals and entities are censured or excluded from the Medicaid program depending on the nature and severity of the offenses. ARU processes all exclusion actions and is responsible for maintaining the Exclusion and Termination Lists on the OMIG's website. The Exclusion list contains 5,099 Medicaid and non-Medicaid provider exclusions, and the list of Terminations has 1,170 entries. These lists are updated daily (except holidays and weekends) and are available to the public on OMIG's website, www.omig.ny.gov. Cost savings resulting from these exclusions and terminations totaled $20,431,596 (see Table 11.1).

Table 1.17
Sanctions By Type

Exclusion Type	Number of Actions
Affiliations – 18 NYCRR 515.3(c)	48
Unacceptable Practice – 18 NYCRR 515.2	4
Indictments – 18 NYCRR 515.7(b)	155
Convictions – 18 NYCRR 515.7(c)	170
Imminent Danger – 18 NYCRR 515.7(d)	3
Professional Misconduct – 18 NYCRR 515.7(e)	105
Mandatory Exclusion – 18 NYCRR 515.8	200
Loss of License Termination – 18 NYCRR 504.7	16
Grand Total	701

MFCU investigates referred allegations, which may lead to criminal charges and convictions. As a result, under 18 NYCRR §515.7, OMIG may then sanction any person or entity that has been charged with a felony, or convicted of a crime, related to the billing or furnishing of medical care, services or supplies. MFCU prosecutorial activity in 2013 led to OMIG issuing 185 Notices of Immediate Agency Action that excluded individuals and entities from the Medicaid program, as shown in Table 1.18.

Table 1.18			
Exclusion Actions			
Allegation Source	Exclusion 18 NYCRR 515	Termination 18 NYCRR 504.7	Number of Actions
Court	2	0	2
HHS	192	0	192
Internal Data Mining (County)	3	0	3
Medicaid Fraud Control Unit	185	0	185
OMIG	169	0	169
Office of Professional Medical Conduct	41	8	49
SED	67	8	75
US Attorney	26	0	26
Grand Total	685	16	701

Examples of OMIG's exclusion actions are presented below.

Albany Physician Reprimanded, Censured by OMIG, OPMC

An Albany-based surgeon provided medical care at a Capital Region surgery center to a patient who was scheduled to undergo an open carpal tunnel release and excision of a finger cyst and bone spurs. The provider deviated from accepted standards of medical care when he performed the operation on the incorrect finger. He noted the surgical error in the recovery room and subsequently performed the appropriate operation on the proper finger. The surgeon also provided medical care to a patient scheduled to undergo elbow surgery. His care of the patient deviated from accepted standards when he performed a different procedure, in error. He again recognized the error and subsequently performed the scheduled procedure. The provider did not contest the charge of negligence on more than one occasion, and OMIG censured him under 18 NYCRR 515.7(e), effective July 30. This provider was also censured and reprimanded by OPMC.

Social Adult Day Care Centers and Individuals Involved in Bribery Scheme

Pursuant to a federal complaint filed on April 2, 2013, OMIG acted swiftly to exclude the operators of two Bronx SADC centers from participation in Medicaid. Along with a Bronx Assemblyman, four individuals were all excluded effective April 18, 2013. All five were indicted for their roles in an alleged bribery scheme involving the centers. OMIG also took action against the two centers effective April 21, 2013. The complaint alleges that the four individuals conspired to bribe the Assemblyman to introduce a bill into the NYS Assembly that would place limits on the creation of any new SADC programs in the area. In return, the Assemblyman received $20,000 and one of the centers was renamed to honor his

grandfather. Less than a day after OMIG barred one of the centers from directly or indirectly receiving Medicaid funds, the center closed its doors on April 22, 2013. The indictment alleges that the Assemblyman told the developers he would help them get contracts with HMOs.

Affordable Care Act

In March of 2010, the ACA was enacted into federal law. The ACA includes numerous provisions designed to increase Medicaid program integrity. For OMIG, this entails excluding and denying enrollment of providers that are barred by other state and federal entities from participating in government funded health care programs. The ACA also requires states to suspend provider's Medicaid payments based on identification and subsequent pending investigations of CAFs, thereby preventing inappropriate payment of Medicaid funds.

Enrollment

Based on ACA regulations, OMIG expanded the categories requiring pre-enrollment on-site inspections to also include physical therapy and portable X-rays. The ACA also requires pre-enrollment on-site inspections for DME suppliers; however, OMIG was already requiring pre-enrollment inspections in this area prior to the ACA. If Medicare has not conducted an on-site inspection within the previous 12 months, the ACA requires pre-enrollment on-site inspections be conducted by state Medicaid agencies.

In addition to the requirements regarding pre-enrollment on-site inspections, ACA regulations require denials in situations where a provider has been convicted in the last 10 years of an offense related to Medicaid, where a provider has been terminated or excluded by another state since 2011, and where an applicant does not allow an on-site inspection to proceed.

In 2013, 10 providers, including three providers that were denied based on DME pre-enrollment onsite inspections, were denied enrollment or reinstatement by OMIG based solely or in part on ACA regulations.

Payment Suspension

In order to comply with the payment suspension provisions of the ACA, OMIG proposed revisions to the state regulation pertaining to the withholding of payments to providers. On August 22, 2012, the amendments to 18 NYCRR §518.7 took effect. Under these new provisions, OMIG must withhold payments, in whole or in part, when it has determined or has been notified that a provider is the subject of a CAF, unless it is determined that a good cause exception exists not to withhold payments. OMIG is required to refer all CAF to MFCU no later than the next business day. If MFCU does not accept the referral, OMIG may then refer the matter to another law enforcement organization. External law enforcement agencies other than MFCU may also request payment suspensions based on credible allegations of fraud.

Payment suspensions remain in effect until OMIG, MFCU, or other law enforcement organizations determine that there is insufficient evidence of fraud by the provider, or upon completion of all investigative and legal proceedings related to the provider's alleged fraud.

Table 1.19 is a summary of payment suspensions based on both OMIG and MFCU investigations of CAFs.

Table 1.19 2013 ACA Recoveries				
Provider Type	Downstate	Upstate	Upstate Western	Total Suspended Payments
Capitation Provider	$ 42,204,732	$ 0	$ 0	$ 42,204,732
Diagnostic & Treatment Center	202,203	0	0	202,203
Long Term Facility	3,281,713	0	0	3,281,713
Nurse	0	0	2,942	2,942
Pharmacy	6,038	0	0	6,038
Physician	20	0	249	269
Transportation	441,647	23,678	0	465,325
Total	$ 46,136,353	$ 23,678	$ 3,191	$ 46,163,222

Exclusions

Section 6501 of the ACA requires that, effective January 1, 2011, each state must terminate the participation of any individual or entity from the State Medicaid program if that provider has been terminated from Medicare, another State Medicaid program, or the Children's Health Insurance Program (CHIP).

Terminations can occur when:

- Medicare, Medicaid or CHIP programs revoke a provider's billing privileges;
- The provider has exhausted all applicable appeal rights, or the timeline for such appeal has expired;
- There is no expectation by any party that the termination is temporary; and,
- The provider would be required to re-enroll to have privileges reinstated.

The requirement for states to terminate applies only in cases when providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked "for cause".

OMIG has developed policies and procedures to comply with ACA §6501. OMIG regularly places on CMS's web portal, known as the Medicaid/Medicare Integrity Group Cumulative Revocation Report, those NYS providers whose exclusion, or "for cause" termination, has been deemed final. OMIG also searches this portal for any current NYS providers that another state has terminated "for cause". OMIG procures documentation from the other states regarding the termination, confirms that it was indeed "for cause" as described by the ACA, and then either excludes or terminates the provider.

Audit Activities

OMIG conducts audits of Medicaid providers with the goal of ascertaining whether providers adhere to applicable federal and State laws, regulations, rules, and policies pertaining to the Medicaid program. Additionally, if in the course of an audit, potential fraudulent or abusive billings or practices are detected, a referral is made to OMIG's DMI to investigate the issue. The following table is a summary of all audit activities for 2013.

Table 2.0
2013 Audits Statewide

Audit Department	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Fee-for-Service Audit Total	341	196	$ 104,761,144	$ 27,671,887
Rate Audit	624	151	39,223,782	39,819,797
Managed Care	484	474	47,738,726	45,783,900
Medicaid in Education	2	28	3,137,348	3,529,230
County Demonstration Program	11	62	7,232,149	1,145,790
Total	1,462	911	$ 202,093,149	$ 117,950,604

Fee-for-Service Audit Activities

OMIG conducts billing audits of provider services rendered to eligible beneficiaries paid on a fee-for-service (FFS) basis. Examples of these audits include home health care agencies (HHA), PCA, diagnostic and treatment centers (D&TC), hospitals, pharmacies, and other health care providers.

Audit protocols are developed for each FFS category or program audited by OMIG. The established review process includes gathering feedback from the oversight agency responsible for the respective program. Subsequently, OMIG shares the audit protocols with the applicable provider association for comment. OMIG provides clarification and education to the associations, based on their respective comments and concerns. Once the process of vetting the audit protocols is complete, they are posted on the OMIG's website. For 2013, a total of 20 audit protocols were posted to the OMIG website. This has resulted in a significant increase in the number of finalized audits for 2013 compared to 2012. All OMIG protocols are available at: http://omig.ny.gov/audit/audit-protocols.

Examples of OMIG's FFS audit activities are highlighted below.

Comprehensive Outpatient Program and Community Support Program Payments

Since 1991, NYS has provided supplemental Medicaid Comprehensive Outpatient Programs (COPS) payments to mental health providers for enhanced services to seriously and persistently mentally ill adults, and seriously emotionally disturbed children. These payments are made in addition to a provider's Medicaid rate and serve as a deficit funding mechanism. The COPS amount is limited to a specific yearly threshold amount set by Office of Mental Health (OMH), and is calculated on a provider and program specific basis. OMH has identified COPS reimbursements that exceed the threshold amounts for prior years; and, these overpayments are subject to recoupment by the State. Phase I of this project focused on excess COPS payments to mental health providers statewide for services from 2003 through 2005. Phase II focused on excess COPS payments to mental health providers for NYC only for services from 2006 through 2008. Both Phases of this project are ongoing.

Similarly, community support programs (CSP) payments in excess of a formulated reimbursement rate are also subject to recovery by the State. OMH is responsible for calculating these yearly threshold amounts and reimbursement rates. OMIG continues to partner with OMH to issue audit reports for any overpayments that are identified, and is also responsible for recovering any identified overpayments. In 2013, OMIG and OMH finalized 41 COPS/CSP audits, with identified overpayments of $35.5 million.

Certified Home Health Agencies

In 2013, OMIG posted audit protocols for Certified Home Health Agencies (CHHA). Auditors verified that required documentation was presented to validate the service was provided and was consistent with patient care plans. Additionally, as part of these audits, OMIG reviewed documentation to determine if overlapping payments for dually eligible Medicare and Medicaid patients were made, Medicaid spend down requirements were met, and whether the service should have been covered by a facility rate. These audits, however, do not include a review of the facility cost reports. The cost reviews of these providers are included in the “Rate Based Audit Activities” section of this report. In 2013, OMIG finalized three audits identifying $66.2 million in overpayments.

EPOGEN Clinic Review

As part of dialysis treatment, patients routinely receive the drug epoetin alpha (Epogen), which can be billed to Medicaid separately from the dialysis treatment visit. The objective of the audits conducted by OMIG was to determine whether the actual acquisition cost of the drug was used in order to bill the Medicaid program properly. OMIG staff examined claim information and facility documentation in order to make this assessment. In 2013, OMIG finalized 32 audits that identified overpayments of $3.3 million where the facilities billed Medicaid at an amount higher than the acquisition cost.

OPWDD Audit Activities

In 2010, OMIG became the lead audit organization in NYS for overseeing the integrity of the Medicaid program with respect to the Office for People With Developmental Disabilities (OPWDD) program services. OMIG audit protocols have been posted for Medicaid service coordination (MSC), individualized residential alternative (IRA) residential habilitation, day treatment, and day habilitation program services. OMIG conducts audits of these program services to determine whether the services were provided in accordance with Medicaid requirements and OPWDD policies and provider guidance documents. Details of each of these project areas are listed below:

Medicaid Service Coordination

MSC assists individuals with developmental disabilities and their families in gaining access to services and support appropriate to their needs. MSC is provided by qualified service coordinators, who develop and implement individualized service plans (ISP). The primary components that OMIG reviews in these audits are the *intermediate care facilities for individuals with mental retardation level of care eligibility determination* (ICF/MR LCED), the ISP, MSC service notes, and MSC agreements. Audit findings included unqualified MSC service coordinators, missing MSC agreements, the ISP lacking required elements or not being completed and distributed timely, as well as missing elements in the service notes. In 2013, OMIG finalized three MSC audits, with identified overpayments of $965,000.

Residential Habilitation

An IRA is a type of community residence that provides room, board and individualized service options. IRA residential habilitation services consist of individually tailored supports that assist with skills related to living in the community. OMIG reviewed the rehabilitation plan, the monthly summary notes, and determined the proper number of countable service days being billed. Audit findings included missing service notes, improper number of countable service days, missing elements in the residential habilitation plan, and missing monthly summary notes. In 2013, OMIG finalized four IRA residential habilitation audits, with identified overpayments of $631,000. An example of one of OMIG's IRA audits is highlighted below.

Audit of Westchester Outpatient Facility Identifies $254,000 in Overpayments

An audit of an outpatient developmental disability service provider in Irvington, NY, found overpayments of $254,357. Outpatient services provided to persons with developmental disabilities are offered at programs licensed by OPWDD. A comprehensive system of such services for people with intellectual and developmental disabilities are furnished at clinic and day treatment facilities, and through a home and

community-based federal waiver program. The audit covered four years of Medicaid funded services and found large amounts of information needed to support reimbursement for services were missing from the facility's medical records. The audit identified instances where the facility billed for more days of service than were documented, billed for services that lacked information about the beneficiary's response to the service, and billed for services without a required residential habilitation plan.

Day Treatment

An OPWDD day treatment facility is a certified free-standing or satellite site that provides a planned combination of diagnostic, treatment, and habilitative services for individuals with developmental disabilities. Individuals attending day treatment receive a broad range of services but do not need intensive 24-hour care and medical supervision. The individual program plan, the treatment plan, and the comprehensive functional assessment (CFA) were reviewed in the course of OMIG's audits. As a result, OMIG's findings included missing physician reviews of individual treatment plans, missing progress notes, incorrect rate codes billed, missing CFA, no documentation of service, and the duration of service not being documented. In 2013, OMIG finalized three day treatment audits, with identified overpayments of $6.6 million.

Tables 2.1 – 2.5 summarize the FFS activities for the year by project type and region.

2013 Fee-for-Service Audits by Project Type and Region

Table 2.1 2013 Upstate Region Fee-for-Service Audits				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
ALP	0	1	$ 11,443	$ 14,971
Diagnostic & Treatment Center	0	1	(8,639)	40,893
Duplicate Clinic Match	0	3	8,262	12,274
EPOGEN Clinic Review	0	6	155,293	155,293
Medicaid EHR Incentive Program	55	0	0	0
Medicare Crossover	2	1	0	155,722
MRT-154-8	5	2	21,731	3,970
OASAS	0	0	0	188,940
OASAS-Inpatient	0	1	950,729	950,729
OMH Rehabilitation	0	1	260,821	0
OMH-COPS Recon Project	0	1	430,843	2,159,253
OPWDD-Day Habilitation	9	0	0	0
OPWDD-Day Treatment	0	3	6,601,665	406,810
OPWDD-IRA Res Hab	9	2	456,938	456,938
OPWDD-MSC	0	2	318,466	61,372
PERM	0	1	0	0
Pharmacies	0	2	682,128	682,128
Physician Reviews	0	0	0	1,315
TBI	0	0	0	8,641
Total	80	27	$ 9,889,680	$ 5,299,249

Table 2.2				
2013 Downstate Region Fee-for-Service Audits				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
ALP	0	6	$ 46,485	$ 46,485
Ambulatory Surgery	0	0	0	39,733
Certified Home Health Agency (CHHA)	0	1	66,186,318	0
Diagnostic and Treatment Center	0	0	(531,638)	(2,898,033)
DME and Orthopedic Shoe Vendor	0	0	(1,490,917)	137,804
Duplicate Clinic Match	0	32	205,948	123,979
EPOGEN Clinic Review	0	23	2,885,628	2,885,628
High Ordering Providers	0	0	0	68,965
Hospital Inpatient	1	0	0	0
Laboratories	0	1	14,693	14,693
Medicaid EHR Incentive Program	126	0	0	0
Medicare Crossover	4	7	467,571	547,019
MRT 154-8	35	17	147,408	266,903
OASAS	0	1	(9,731,111)	725,719
OB/GYN Services	0	0	0	13,137
OMH	0	0	0	406,539
OMH – Outpatient	0	0	0	59,905
OMH-Rehabilitation	3	0	0	0
OMH-COPS Recon Project	0	39	34,644,254	18,596,751
OPWDD - Day Hab	5	0	0	0
OPWDD – IRA Res Hab	11	2	174,069	190,626
OPWDD – MSC	1	1	646,671	14,546
PERM	0	2	28,871	28,871
Pharmacies	0	11	165,725	534,618
Physician Reviews	0	0	0	(1,297)
Radiology	0	0	0	(99,298)
Total	186	143	$ 93,859,975	$ 21,703,293

Table 2.3				
2013 Western Region Fee-for-Service Audits				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
ALP	0	3	$ 31,567	$ 31,567
Certified Home Health Agency	0	2	42,174	41,238
Diagnostic and Treatment Center	0	1	83,799	0
DME and Orthopedic Shoe Vendor	0	0	0	10,153
Duplicate Clinic Match	0	2	3,737	4,352
EPOGEN Clinic Review	0	3	249,222	249,222
Hospital Outpatient Department	1	0	0	0
Medicaid EHR Incentive Program	35	1	7,083	0
Medicare Crossover	4	2	22,649	538
MRT 154-8	5	5	22,248	36,782
OASAS	0	0	0	23,946
OMH Rehabilitation	5	0	0	0
OMH-COPS Recon Project	0	1	432,613	192,356
OPWDD – Day Habilitation	7	0	0	0
OPWDD – Day Treatment	1	0	0	0
OPWDD-Ira Res Hab	8	0	0	0
Pharmacies	4	4	187,699	(22,048)
Physician Reviews	1	0	0	0
TBI	0	0	0	34,457
Total	71	24	$ 1,082,791	$ 602,563

Table 2.4				
2013 Out-of-State Fee-for-Service Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Laboratories	0	0	$ (105,785)	$ 14,195
Medicaid EHR Incentive Program	2	0	0	0
Medicare Crossover	1	1	28,855	28,855
MRT 154-8	1	1	5,628	23,732
Total	4	2	$ (71,302)	$ 66,782

Table 2.5				
2013 Statewide Fee-for-Service Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
ALP	0	10	$ 89,495	$ 93,023
Ambulatory Surgery	0	0	0	39,733
Certified Home Health Agency	0	3	66,228,492	41,238
Diagnostic and Treatment Center	0	2	(456,478)	(2,857,140)
DME and Orthopedic Shoe Vendor	0	0	(1,490,917)	147,957
Duplicate Clinic Match	0	37	217,947	140,605
EPOGEN Clinic Reviews	0	32	3,290,144	3,290,144
High Ordering Providers	0	0	0	68,965
Hospital Inpatient	1	0	0	0
Hospital Outpatient Department	1	0	0	0
Laboratories	0	1	(91,092)	28,888
Medicaid EHR Incentive Program	218	1	7,083	0
Medicare Crossover	11	11	519,074	732,134
MRT 154-8	46	25	197,014	331,386
OASAS	0	1	(9,731,111)	938,604
OASAS – Inpatient	0	1	950,729	950,729
Ob/Gyn Services	0	0	0	13,137
OMH	0	0	0	406,539
OMH Outpatient	0	0	0	59,905
OMH Rehabilitation	8	1	260,821	0
OMH-COPS Recon Project	0	41	35,507,710	20,948,360
OPWDD – Day Habilitation	21	0	0	0
OPWDD – Day Treatment	1	3	6,601,665	406,810
OPWDD – IRA Res Hab	28	4	631,007	647,564
OPWDD – MSC	1	3	965,138	75,918
PERM	0	3	28,871	28,871
Pharmacies	4	17	1,035,552	1,194,699
Physician Reviews	1	0	0	18
Radiology	0	0	0	(99,298)
TBI	0	0	0	43,098
Total	341	196	$ 104,761,144	$ 27,671,887

County Demonstration Program

The Medicaid Fraud, Waste, and Abuse County Demonstration Program (County Demonstration Program) was implemented in 2006 and is a partnership between OMIG and NYS counties and NYC to detect Medicaid provider fraud, waste and abuse and recoup any identified overpayments. The number of participating counties has fluctuated since implementation. In 2013, seven counties and NYC were participating in the program. Under the County Demonstration Program, the counties, with OMIG oversight, perform audits of pharmacy, transportation, and DME providers. In 2014, the County Demonstration Program will also audit assisted living providers.

During the past year, in accordance with provisions of the 2013-14 Executive Budget, OMIG began holding quarterly meetings with the participating counties. The purpose of these meetings is to improve communication between OMIG and the counties and to foster communication among the participating counties. Additionally, OMIG provided guidance to participating county audit staff concerning targeting new audit areas and applying updated audit protocols to audits. An example of one of the County Demonstration projects is highlighted below.

$4 Million Ambulette Audit

OMIG issued a final report identifying overpayments of over $4 million as a result of an ambulette audit. The ambulette company, based in Brooklyn, received $5,238,370 for 89,847 services rendered to 6,993 Medicaid enrollees during the review period. The audit assessed this provider's compliance with the laws, rules, and regulations of the Medicaid program. This audit was conducted in conjunction with NYC HRA as part of the County Demonstration Program.

Results of all County Demonstration Program audits for 2013 are in tables 3.1 – 3.4.

Table 3.1				
2013 Upstate Region County Demonstration Program Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Pharmacies	0	3	$ (507,571)	$ 125,516
Total	0	3	$ (507,571)	$ 125,516

Table 3.2				
2013 Downstate Region County Demonstration Program Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
DME and Orthopedic Shoe Vendors	0	0	$ (9,837)	$ 5,635
Pharmacies	0	50	(632,601)	800,534
Transportation	0	5	8,358,030	203,395
Total	0	55	$ 7,715,592	$ 1,009,564

Table 3.3				
2013 Western Region County Demonstration Program Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Pharmacies	10	4	$ 24,128	$ 10,710
Transportation	1	0	0	0
Total	11	4	$ 24,128	$ 10,710

Table 3.4				
2013 Statewide County Demonstration Program Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
DME and Orthopedic Shoe Vendors	0	0	$ (9,837)	$ 5,635
Pharmacies	10	57	(1,116,044)	936,760
Transportation	1	5	8,358,030	203,395
Total	11	62	$ 7,232,149	$ 1,145,790

School Supportive and Preschool Supported Health Services Programs

In 2013, OMIG auditors continued to audit school districts and county preschool programs as required by the Compliance Agreement between NYS and the federal government. Many of the audits completed in 2013 were audits of paid claims under NYS's new State Plan Amendment. The majority of these audits were closed with no findings – see Table 7.0 on page 57. These results can be attributed to the extensive training and guidance provided by OHIP and the NYSED – Medicaid Unit, as required by the Compliance Agreement, to business officials, special education directors, Medicaid billing clerks, compliance officers and clinicians within the school districts and county preschools. The tables below summarize the OMIG school supportive audit activities for 2013.

Table 4.1
2013 Upstate Region Medicaid in Education Audits

Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
PSHSP	1	6	$ 140,283	$ 134,005
SSHSP	1	5	499,829	464,742
Total	2	11	$ 640,112	$ 598,747

Table 4.2
2013 Downstate Region Medicaid in Education Audits

Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
PSHSP	0	1	$ 75,943	$ 75,943
SSHSP	0	4	2,133,937	2,341,380
Total	0	5	$ 2,209,880	$ 2,417,323

Table 4.3
2013 Western Region Medicaid in Education Audits

Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
PSHSP	0	4	$ 118,285	$ 123,046
SSHSP	0	8	169,071	390,115
Total	0	12	$ 287,356	$ 513,161

Table 4.4
2013 Statewide Medicaid in Education Totals

Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
PSHSP	1	11	$ 334,511	$ 332,994
SSHSP	1	17	2,802,837	3,196,236
Total	2	28	$ 3,137,348	$ 3,529,230

Rate Based Audit Activities

Certain Medicaid providers are reimbursed for covered services to eligible beneficiaries based on prospectively determined rates. These rates are calculated based on cost reports that are submitted annually by the provider to DOH's Bureau of Long Term Care Reimbursement (BLTCR). BLTCR uses these cost reports as the basis to promulgate a daily rate for each provider. An example of a rate based provider reimbursed using this method is a residential health care facility (RHCF).

Capital

The reported capital costs for RHCFs are used as a basis for the capital component of the nursing facility's Medicaid rate. OMIG audits the capital costs to examine the underlying costs that determine the capital component of the rate. Some examples of findings from capital audits are as follows:

- Working capital interest expense disallowances;
- Equity disallowances;
- Sales tax disallowances;
- Mortgage expense disallowances; and,
- Depreciation disallowances.

During 2013, 50 capital audits were finalized, resulting in identification of overpayments of $7.3 million. An example of one of the capital projects is highlighted below.

Findings of Nearly Half Million Dollars for Long Island Rehabilitation Center

An audit of Medicaid rates paid to a Long Island rehabilitation facility identified overpayments in the amount of $470,367. OMIG's audit disclosed variances between audited mortgage interest expense and that included in the rate along with expenses that could not be verified. Auditors also disallowed costs associated with luxury automobiles as well as other vehicles that were deemed unrelated to patient care but were instead for the personal use of the facility's management.

Base Year

OMIG examines the costs reported in a nursing facility's base year. The reported base year costs are trended forward by an inflation factor and used by BLTCR to calculate the operating portion of the rate for subsequent years until a new base year is established. Examples of the base year audit findings are as follow:

- Expense not related to patient care;

- Undocumented expense;
- Duplicated expense; and,
- Non-allowable expense.

During 2013, 25 base year audits were finalized, with identified overpayments in the amount of $19.9 million. An example of one of the base year projects is highlighted below.

Auditors Identify $1 Million in Overpayments

An audit of Medicaid rates paid to a long-term care center in Westchester County found overpayments in the amount of $1,054,909. Major disallowances found in this audit were miscalculation of sales tax and automobile expenses.

Rollover

Base year operating costs are used by BLTCR as a basis for rate calculations for a facility in subsequent years. When a base year audit has resulted in adjustments to the base year operating costs, these audit findings are integrated and carried forward into the rate calculation for subsequent rate years that use those base year costs as its basis. These audits are referred to as rollover audits because they roll forward audit findings from a base year audit. During 2013, 36 rollover audits were completed, resulting in identification of overpayments of $1.7 million.

Dropped Services

Medicaid rates for RHCFs include various ancillary services as contained in the facility's base year costs. Dropped services audits consist of an examination of ancillary services included in the RHCF's Medicaid per diem rate and any changes in billing that may have occurred. The audit identifies RHCFs that have elected to change the method of billing regarding ancillary services – for example, an outside FFS provider bills Medicaid directly for the ancillary services as opposed to the RHCF being reimbursed the cost of these services in their rate. Where Medicaid is paying the outside FFS provider in addition to the RHCF for the same ancillary services, duplicate reimbursement occurs. During 2013, three dropped service audits were completed identifying overpayments of $1 million.

Rate Appeals

RHCFs may file rate appeals with DOH to contest their Medicaid rates. OMIG reviews rate appeals that have been approved by DOH and, where appropriate, audits underlying costs associated with those appeals to determine the appropriateness of each appeal issue. Appeals findings are the same types of findings identified in an operating or capital rate audit. During 2013, OMIG completed reviews of two rate appeals, which identified overpayments of $5.3 million.

Long-Term Home Health Care Program and Certified Home Health Agency

OMIG conducts audits of Long-Term Home Health Care Program (LTHHCP) and CHHA cost reports to verify per-visit and hourly rates calculated for the various ancillary services provided, with an emphasis on both high Medicaid utilization and rate capitations. OMIG also audits rate add-ons including funds dedicated to worker recruitment, training, and retention. During 2013, two LTHHCP audits were completed, which identified overpayments of $1.1 million; and one CHHA audit was completed, identifying overpayments of $1.7 million.

Bed Reserve

Under Medicaid program requirements, RHCFs are reimbursed for reserving a Medicaid beneficiary's bed if that beneficiary leaves the facility on a temporary hospital or therapeutic leave of absence and certain conditions are met. OMIG continues to review bed reserve payments to assure that RHCFs are in compliance with Title 18 NYCRR §505.9(d), which addresses the eligibility and requirements to bill Medicaid for a reserved bed day. In 2013, OMIG finalized 23 audits that identified $1.5 million in overpayments. In addition, OMIG began the development of an expanded bed reserve audit scope that incorporates the additional billing requirements set forth in NYS Public Health Law §2808(25). Reimbursement for a facility's bed reserve days for each individual Medicaid beneficiary within the facility will be limited to a maximum of 14 days in a 12-month period for hospitalizations, and ten days in a 12-month calendar period for non-hospital therapeutic leaves of absence.

Rate audit activity outcomes are in Tables 5.1–5.4.

2013 Rate Audits by Type and Region

Table 5.1 2013 Upstate Region Rate Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Adult Day Care	0	1	$ 163,544	$ 163,544
Bed Reserve	4	1	0	0
Data Warehouse	0	0	0	203,808
MDS	129	0	0	0
Medicare Part B	1	0	0	0
PRI	0	2	114,677	797,437
Skilled Nursing – Base Year	4	8	4,058,083	1,106,023
Skilled Nursing – Dropped Services	0	0	0	7,308
Skilled Nursing – Capital	11	7	713,873	(1,055,253)
Skilled Nursing – PRI/MDS	1	0	(1,006,879)	(1,040,831)
Skilled Nursing – Rollovers	10	9	85,729	849,335
Total	160	28	$ 4,129,027	$ 1,031,371

Table 5.2 2013 Downstate Region Rate Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Bed Reserve	25	22	$ 1,475,676	$ 2,703,029
Data Warehouse	0	0	0	29,536
Home Health Care	1	1	1,663,180	1,685,116
Home Health Care – Long Term	0	1	61,358	0
Hospital Inpatient	0	1	537,896	537,896
MDS	187	0	0	0
Medicare Part B	4	0	0	0
PRI	0	3	(68,481)	249,315
Rollover – Sales Tax	1	2	6,449	6,435
Skilled Nursing – Base Year	2	14	13,531,831	11,801,767
Skilled Nursing – Dropped Services	0	3	1,064,453	850,816
Skilled Nursing – Capital	9	29	3,915,568	5,371,350
Skilled Nursing – Rollovers	28	23	1,579,303	1,924,625
Total	257	99	$ 23,767,233	$ 25,159,885

Table 5.3				
2013 Western Region Rate Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Home Health Care – Long Term	0	1	$ 1,063,981	$ 476,075
MDS	180	0	0	0
Medicare Part B	3	0	0	0
Skilled Nursing – Base Year	8	3	2,291,312	2,828,493
Skilled Nursing – Dropped Services	3	0	(32,712)	(32,712)
Skilled Nursing – Capital	6	14	2,658,498	4,806,784
Skilled Nursing – PRI/MDS	1	0	0	0
Skilled Nursing – Rate Appeal	0	2	5,295,213	4,917,300
Skilled Nursing - Rollovers	6	4	51,230	632,599
Total	207	24	$ 11,327,522	$ 13,628,539

Table 5.4				
2013 Statewide Rate Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Adult Day Care	0	1	$ 163,544	$ 163,544
Bed Reserve	29	23	1,475,676	2,703,029
Data Warehouse	0	0	0	233,345
Home Health Care	1	1	1,663,180	1,685,116
Home Health Care – Long Term	0	2	1,125,339	476,075
Hospital Inpatient	0	1	537,896	537,896
MDS	496	0	0	0
Medicare Part B	8	0	0	0
PRI	0	5	46,196	1,046,752
Rollover – Sales Tax	1	2	6,449	6,435
Skilled Nursing – Base Year	14	25	19,881,226	15,736,283
Skilled Nursing – Dropped Services	3	3	1,031,741	825,413
Skilled Nursing – Capital	26	50	7,287,939	9,122,882
Skilled Nursing – PRI/MDS	2	0	(1,006,879)	(1,040,831)
Skilled Nursing – Rate Appeal	0	2	5,295,213	4,917,300
Skilled Nursing - Rollovers	44	36	1,716,262	3,406,558
Total	624	151	$ 39,223,782	$ 39,819,797

Managed Care Audit Activities

As a result of MRT proposals, DOH established a goal to move most Medicaid populations into a care management system by April 2016. This system includes comprehensive managed care (MC) plans, HIV/AIDS special needs plans, and various long-term care plans, as well as, new plans that will need to be tailored to meet the needs of other transitioning populations, such as those with mental health and/or substance abuse issues.

OMIG currently performs various eligibility/enrollment based reviews and audits of MC plans to recover overpayments and correct system and program errors. OMIG's MC activities have primarily focused on MC enrollment and eligibility; however, OMIG's activities are expanding because of the MRT goal to transition added services to MC.

In 2013, NYS continued to transition the FFS Medicaid population with long-term care needs into managed long-term care plans. This transition is expected to continue over the next several years. Over this period, OMIG will continue to move audit resources from traditional FFS and rate audits to monitoring payments made to the MCOs, and reviewing the network provider costs used to determine MC rates. To accomplish this, OMIG is coordinating program integrity activities with DOH and the MFCU, which includes updating regulations and MC model contract language, as appropriate. Highlights of MC audit activities are described below.

Capitation Payments for Retroactive Disenrollment Transactions

Retroactive disenrollment audits are conducted when an inappropriate capitation payment is made on behalf of an enrollee who has multiple client identification numbers, deceased and incarcerated enrollees, enrollees permanently placed in an institutional facility, enrollees covered by commercial health insurance, enrolled in a federal waiver program, or enrollees that are no longer a resident of the state. These retroactive disenrollment situations are identified by the LDSS and/or NYC HRA, or through reports generated by OMIG, which list retroactive disenrollments not initially identified. When a capitation payment is inappropriately made due to eligibility errors or untimely eligibility file updates, LDSS and/or NYC HRA retroactively adjust the enrollee eligibility file and instruct the MCO to void the premium payments received for any month where the MCO was not at risk to provide services.

Over the course of 2013, DOH and OMIG worked collaboratively to transition the responsibility for the data management and receipt of reported retroactive disenrollment transactions from DOH to OMIG. The transition was completed April 1, 2014. Changes to the former process will include moving from a paper to an electronic notification system, thereby enhancing accuracy and efficiency. In 2013, OMIG in concert with DOH, LDSS, and NYC HRA, were successful in recovering $15.7 million through retroactive disenrollments and subsequent repayments.

Managed Care Institutional

The LDSS or NYC HRA is responsible for determining the eligibility of Medicaid MC enrollees. Medicaid enrollees placed in foster care or a long term care facility are no longer eligible for Medicaid MC because these medical services are provided in foster care or by the facility. In these cases, the LDSS or NYC HRA retroactively adjusts the enrollee eligibility file, and instructs the MCO to void the premium payments for any month where the MCO was not at risk to provide services. OMIG audits and recovers the premiums when the MCO fails to submit the voids in a timely manner. In 2013, 38 MC institutionalized audits were finalized, resulting in $9.9 million in identified overpayments.

Family Planning Chargeback Services

MCOs may include family planning and reproductive services in the benefit package offered to enrollees. Federal rules state that MC enrollees may receive these services from any FFS Medicaid provider, without referral or prior approval of the MCO. According to provisions in the NYS MC Model Contract, if a MCO includes these services in their benefit package and an enrollee chooses to go outside the MCO network, the servicing provider is compensated by Medicaid, and the MCO agrees to reimburse Medicaid for the payments made to the non-network provider. OMIG recovers those payments not reimbursed to the Medicaid program by the MCO. In 2013, OMIG finalized 26 audits and identified overpayments of $9.9 million.

Capitation Payments for Deceased Managed Care Enrollees (Death Match)

OMIG receives files from both the NYS and NYC Bureaus of Vital Statistics and annually matches this data against premiums paid to MCOs. OMIG uses this information to identify payments made for individuals who were deceased for an entire payment month and were not identified during the LDSS and NYC HRA retroactive disenrollment process. In 2013, OMIG finalized 38 audits with identified overpayments of $4.9 million.

Capitation Payments for Incarcerated Managed Care Enrollees (Prison Match)

OMIG receives files from DOH that matches Medicaid enrollees to the prison rosters maintained by the NYS Department of Corrections and Community Supervision (State Prisons) and NYS Division of Criminal Justice Services (County Jails). On an annual basis OMIG matches this data against the premiums paid to MCOs in order to identify payments made for individuals who were incarcerated for an entire payment month and were not identified during the LDSS and NYC HRA retroactive disenrollment process. In 2013, OMIG finalized 28 audits with identified overpayments of $3.2 million.

Managed care audit activity outcomes are in Tables 6.1–6.5.

2013 Managed Care and Provider Review Audits by Type and Region

Table 6.1				
2013 Upstate Region Managed Care and Provider Review Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
FQHC FFS/MC Crossover	4	4	$ 53,335	$ 50,740
Death Match	7	8	959,086	959,086
Dental	4	4	14,553	14,553
Family Plan Chargeback/MCO	5	6	752,819	728,229
Institutionalized	15	9	1,429,480	1,429,480
MLTC Eligibility	1	0	0	0
Newborn FFS-MC Crossover	0	8	143,739	143,739
No Reported Encounter Data	10	1	0	551
Prison Match	8	7	938,985	938,984
Retro Disenrollments	34	41	3,653,444	3,650,320
Total	88	88	$ 7,945,441	$ 7,915,682

Table 6.2				
2013 Downstate Region Managed Care and Provider Review Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Clinic – FQHC	0	0	$ (182,955)	$ (182,955)
FFS-GME Crossover	0	0	0	22,327
FQHC FFS/MC Crossover	10	9	477,195	473,465
Death Match	32	24	3,541,803	3,541,803
Dental	119	113	321,406	262,367
Family Plan Chargeback/FFS	11	11	293,994	244,608
Family Plan Chargeback/MCO	13	14	8,900,410	7,216,214
Institutionalized	39	20	9,742,271	8,469,846
Misclassified Patient Discharges	0	6	831,379	775,101
MLTC Eligibility	11	0	0	0
Newborn FFS-MC Crossover	0	24	450,258	442,125
No Reported Encounter Data	12	5	374,955	1,434,083
Prior DOB Payments	0	0	0	378
Prison Match	15	16	1,913,208	2,315,129
Retroactive Disenrollments	65	72	5,613,723	5,354,062
Total	327	314	$ 32,277,647	$ 30,368,553

Table 6.3				
2013 Western Region Managed Care and Provider Review Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Death Match	7	6	$ 362,914	$ 362,914
Dental	1	1	16,032	16,032
Family Plan Chargeback/FFS	2	2	1,551	1,551
Family Plan Chargeback/MCO	5	6	245,051	245,051
FQHC FFS/MC Crossover	3	4	20,290	20,290
Institutionalized	14	9	61,287	61,287
Misclassified Patient Discharges	0	1	0	0
MLTC Eligibility	1	0	0	0
Newborn FFS-MC Crossover	0	7	33,971	17,121
No Reported Encounter Data	5	0	0	94
Prior DOB Payments	0	0	0	138
Prison Match	5	5	329,812	333,075
Retroactive Disenrollments	26	29	6,437,090	6,434,588
Total	69	70	$ 7,507,998	$ 7,492,141

Table 6.4				
2013 Out-of-State Managed Care and Provider Review Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Newborn FFS-MC Crossover	0	2	$ 7,640	$ 7,526
Total	0	2	$ 7,640	$ 7,526

Table 6.5				
2013 Statewide Managed Care and Provider Review Audit Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Clinic – FQHC	0	0	$ (182,955)	$ (182,955)
Death Match	46	38	4,863,803	4,863,803
Dental	124	118	351,991	292,952
Family Plan Chargeback/FFS	13	13	295,546	246,159
Family Plan Chargeback/MCO	23	26	9,898,279	8,189,493
FFS-GME Crossover	0	0	0	22,327
FQHC FFS/MC Crossover	17	17	550,820	544,495
Institutionalized	68	38	11,233,038	9,960,612
Misclassified Patient Discharges	0	7	831,379	775,101
MLTC Eligibility	13	0	0	0
Newborn FFS-MC Crossover	0	41	635,607	610,511
No Reported Encounter Data	27	6	374,955	1,434,728
Prior to DOB Payments	0	0	0	517
Prison Match	28	28	3,182,005	3,587,188
Retroactive Disenrollments	125	142	15,704,258	15,438,969
Total	484	474	$ 47,738,726	$ 45,783,900

Other Audit Initiatives

Minimum Data Set

Minimum Data Set (MDS) is an important tool that nursing homes use to evaluate each resident and develop a plan to provide the services that best meet the resident's needs. MDS data submissions to BLTCR are used to calculate each facility's Case Mix Index (CMI) which is used to determine the direct cost portion of each facilities' Medicaid rate.

OMIG, in collaboration with BLTCR, initiated reviews of the accuracy of nursing home MDS submissions. The objective of these reviews was to verify that the MDS information submitted by the nursing home was an accurate representation of each resident's medical condition, functional abilities, and care needs. OMIG plans to perform 250 audits for every six month census period.

BLTCR used MDS submissions from the January 25, 2012 census date to determine the CMI for Medicaid rates for the period July 2012 through December 2012, and from their July 25, 2012 census date to determine CMI for Medicaid rates for the period January 2013 through June 2013.

In 2013, the OMIG Nursing Review Unit initiated 496 MDS reviews covering both the January and July 2012 census dates. OMIG anticipates completing the first series of audits in 2014.

New York State Medicaid Electronic Health Records Incentive Program

In 2009, the United States Congress included provisions in the American Recovery and Reinvestment Act allocating approximately $19 billion to provide incentives for the adoption of electronic health information technology (HIT) among Medicaid and Medicare providers. This federally funded project will continue to pay incentives through 2021. During this time, OMIG will audit the CMS prescribed adoption, implementation, upgrade (AIU), and meaningful use (MU) phases of certified electronic health records (EHR) to identify and/or prevent improper Medicaid EHR Incentive payments, and monitor for potential fraud, waste, and abuse.

Through the Medicaid EHR Incentive Program, eligible hospitals and health care practitioners in NYS apply for financial incentives by moving from a paper-based system of maintaining patient records to a certified EHR. As part of their AIU attestations in the first year of participation in the Medicaid EHR Incentive Program, providers are required to supply documentation that, at a minimum, demonstrates either a binding financial commitment (such as a contract) or actual expenditures for AIU activities to a certified EHR technology. Each system must be certified by the Office of National Coordinator for HIT as meeting required standards and specifications.

During 2013, OMIG initiated 218 audits. A risk assessment for the 2011 incentive payment year was completed, and one was started for the 2012 payment year. AIU audits were finalized for the first year of the program for individual eligible providers and eligible hospitals. The majority of the AIU audits of NYS providers found them to be in compliance with the requirements of the program. The results of these audits, which can be found in Table 7.0, are consistent with other states' findings. Also in 2013, audits of eligible providers attesting as groups were initiated for the first time, and a process was developed for MU audits. The first MU audits are scheduled to begin in 2014.

Managed Long Term Care Eligibility and Care Management Audits

MLTC is a program that streamlines the delivery of long-term care services to people who are chronically ill or disabled and who wish to stay in their homes and communities. These services, such as home care or adult day care, are provided through MLTC plans that are approved by DOH. In 2013, OMIG conducted audits to ensure MLTC plans properly determined the eligibility of a selected group of Medicaid beneficiaries for enrollment into the MLTC program. In addition, when it has been determined that a selected beneficiary was properly enrolled, the MLTC plan's care management of that beneficiary is reviewed to ensure the care received complied with the beneficiary's plan of care. In 2013, OMIG initiated 13 MLTC eligibility and care management audits.

Medicare Coordination of Benefits where Providers Submitted Duplicate Claims

OMIG conducts reviews of claims approved and paid by Medicare for dual-eligible beneficiaries (i.e., beneficiaries with both Medicare and Medicaid coverage), that are also submitted to Medicaid for payment. Potential duplicate claims are reviewed for possible edit enhancements, and recoveries are made when appropriate.

Effective December 2009, the NYS Medicaid program implemented an automated Medicare crossover process so that providers will no longer have to bill Medicaid separately for the Medicare deductible, coinsurance, or co-pay amounts for dual-eligible Medicare/Medicaid beneficiaries covered by Medicare Parts A and B. These types of claims are now sent directly by Medicare to NYS Medicaid for processing and payment. In certain instances under this automated process both the provider submitted claim and the crossover claim can be

reimbursed, if a separate claim is submitted directly by the provider to NYS Medicaid for a dual-eligible beneficiary. This is a problem because only one of the claims should be paid.

In 2010, OMIG started monitoring claims to observe how the new system was operating and if sufficient claim system edits were in place to catch any duplicate or questionable claims. OMIG identified a large volume of duplicate claims, and determined that providers were still submitting claims for dual-eligible beneficiaries directly to Medicaid. In 2011, OMIG submitted an MRT proposal which focused on eliminating and/or reducing the number of provider submitted claims associated with the automated Medicare crossover system. OMIG worked with DOH to modify claim system edits that identify and deny duplicate claims.

During 2013, the savings associated with the edit modifications suggested by OMIG resulted in $174.4 million in estimated cost savings. OMIG continues to monitor the crossover system for duplicate Medicaid claims to identify and recover inappropriately paid claims from providers.

Positive Reports

In the process of an audit there are times when OMIG finds that, for the scope period and objective reviewed, the provider has generally adhered to applicable Medicaid billing rules and regulations. In these instances OMIG will issue an audit summation letter advising the provider that pursuant to 18 NYCRR 517.3(h) the audit was concluded and no further action is required on their part. However, in these cases, OMIG reserves the right to conduct further reviews of the provider's participation in the Medicaid program, take action where appropriate, and recover any associated overpayments that may be identified. These reports are also listed on the OMIG website as "Positive Reports". Please see Table 7.0 for a breakdown of audit summation letters issued by each program area.

Table 7.0

Audit Department	Audit Summations
Fee-for-Service Audit	172
Rate Audit	18
Managed Care	0
Medicaid in Education	16
County Demonstration Program	27
Total	233

System Utilization and Review Activities

OMIG system utilization and review activities focus on using technology, including data matches, and front-end payment controls, in order to improve program integrity. Below are highlights of these activities from 2013, and detailed data can be found in Tables 8.1 – 10.1.

Due to the transition in the Medicaid program from FFS to a MC environment, the Division of System Utilization and Review (DSUR) continues to evolve. As a result of this shift in the program, DSUR established project teams and is cross training staff to expand the resources available to develop new approaches to detect fraudulent activities.

DSUR will continue to develop projects, both within the Division and collaboratively with other OMIG program areas, to further OMIG's mission of enhancing the integrity of the NYS Medicaid program.

Pre-payment Review

Pre-payment Review (PPR) affords OMIG the opportunity to review provider submitted Medicaid claims before they are paid or denied. PPR uses Edit 1141 in the eMedNY system as a tool to detect, monitor, and deter the submission of inappropriate claims by enrolled Medicaid providers that demonstrate possible unacceptable or inappropriate billing practices. Once a provider is placed on PPR, claims transactions are manually reviewed prior to any payment being made. In conjunction with this review, staff will contact providers and request information necessary to support the submitted claims. Based on the review of the provider's documentation, claims will be paid or denied. As a result of these in-depth pre-payment reviews, providers can be referred for further investigation and/or administrative action.

For 2013, cost savings for pre-payment reviews totaled just over $24 million. Most of the savings were realized from DSUR's activities of reviewing claims submitted by transportation and private duty nursing providers. The PPR Unit selected a total of 41 nurses for a detailed review of their medical records. Records were reviewed for a three month period and resulted in 11 referrals to DMI for further action. In addition, the unit prevented numerous payments to six other providers that were referred to PPR by other OMIG units.

DSUR also played a significant role in collaborating with other OMIG program areas and external partners to educate providers in order to prevent and recover monies erroneously paid by Medicaid.

PPR worked with BNE to update the eMedNY claim payment system with lost or stolen prescription serial numbers thereby preventing payment for claims associated with the lost or stolen prescription information.

When DMI conducted its OMIG/TLC 19-A Stop Operations, PPR pended claims for the targeted transportation providers. In addition, future claims for a number of transportation providers were set to deny, thereby preventing erroneous payments.

PPR worked with OMIG's Self-Disclosure unit and prevented payment of transportation services included in the hospital diagnostic related group (DRG) payments. In conjunction with the System Match and Recovery Unit (SMR), PPR pended targeted transportation claims while SMR recovered the overpayments for the incorrectly billed and paid claims. PPR prevented an additional $162,713 from being erroneously paid.

Additionally, the PPR unit manager participated in a CMS Educational Advisory Focus Group to train providers about fighting fraud. This group developed educational materials that are now available on the CMS website under *Fighting Medicaid Fraud, Waste and Abuse Through Education*: *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html*

Medicaid Systems Controls Review

During 2013, Medicaid Systems Controls Review (MSCR) was involved in a number of activities that resulted in substantial estimated cost savings as well as improvements of the Medicaid claims processing system and Data Warehouse.

Cost Savings

During 2013 the MSCR edit improvements on the Medicaid FFS claims payment system resulted in estimated savings of approximately $70.9 million. These savings are the net result of claims that where denied by the edit improvements recommended by this unit and not resubmitted to Medicaid within the 90 day allowed resubmission period. Some examples of the edits that attributed to these savings are Clinic License Verification, Pharmacy Verification and Serialized Prescription.

Clinic License Verification and Pharmacy Verification edits confirm that a valid service provider is listed on the clinic claim, valid prescribing provider is listed on the pharmacy claim, that the provider is not excluded from providing services to Medicaid clients, and that the provider has a license in good standing with NYSED. The Serialized Prescription cost savings initiative utilizes a series of prescription serial number edits to verify that a prescription serial number is included on a pharmacy claim and that the serial number has not been reported as missing or stolen. One particular edit in this series denies any claim adjustments where the prescription serial number has been altered.

Evolution Project Process

MSCR continues to be involved with OHIP, Computer Science Corporation (CSC) and CMA Consulting Services staff to implement evolution projects (EP) proposed by OMIG. These projects can range from system changes to enhance and streamline work activities, to implementing front-end system controls including edits to reduce inappropriate Medicaid payments. For any system enhancement, a strict EP process must be followed. The EP process has many phases including, but not limited to, the submission and approval of the Evolution Project Request, the creation and approval of a Functional Requirement Document, and the Project Design Document. This leads to the User Acceptance Testing and implementation of the project. MSCR determines the viability of projects and guides each EP through this process.

During 2013 four evolution projects initiated by MSCR were implemented in the Medicaid Data Warehouse (MDW) and/or eMedNY, three are in various phases of completion and six projects are in the queue awaiting eMedNY and MDW staff resources.

System Match and Recovery

System Match and Recovery (SMR) uses analytical tools and techniques, as well as knowledge of Medicaid program rules, to identify and recover inappropriate FFS Medicaid expenditures. Staff matches Medicaid claim details to the services provided to identify improper claim conditions. SMR also creates audit parameters, requests and reviews claim data related to potential audit criteria, and plans future recovery projects, based on current Medicaid fraud trends. Efforts of the SMR Unit in 2013 identified Medicaid overpayments of $7.8 million.

Transportation

SMR conducted reviews of Medicaid payments for transportation services. Findings included transportation services provided to inpatient beneficiaries, services provided by unqualified or disqualified drivers, services submitted with an invalid DMV driver's license number, and services submitted with an invalid DMV license plate number. Additionally, SMR reviewed Medicaid ambulette transportation claims where the driver's license was disqualified on the date of service. For 2013, SMR issued 91 final reports to transportation providers totaling $5.4 million in Medicaid overpayments.

Dental

Throughout 2013, SMR reviewed Medicaid payments made for dental services. Staff reviewed claim information and had findings for inappropriate billing for edentulous patients, inappropriate billing for various denture services or procedures, dental services billed as FFS when the beneficiary was in a skilled nursing facility (SNF), and consultation

procedures that were inappropriately billed. For 2013, SMR issued 38 final reports identifying $689,385 in overpayments.

Clinic APG

Beginning in 2009, clinic based providers adapted a new methodology for billing the Medicaid program. This new methodology, called Ambulatory Patient Groups (APG), categorizes the amount and type of resources used in various ambulatory visits. The APG methodology provides higher reimbursement for high intensity services and less reimbursement for low intensity services. In 2013, SMR reviewed FFS payments made for ordered ambulatory services that were also included in a clinic's APG payment rate. SMR issued 54 final reports that identified $518,515 in overpayments.

DME Crossover

The purpose of this project was to compare the amounts paid and approved by Medicare Part B for DME services, as well as the coinsurance and deductible amounts, with the amounts reported on the Medicaid claims. Staff found instances where Medicaid overpayments were made due to misreporting or failure to report correct Medicare payments. For 2013, SMR issued 34 final reports identifying $686,983 in overpayments.

Home Health Inpatient Skilled Nursing Facility Audit Project

Staff reviewed Medicaid claims to identify potential overpayments paid for home health services and/or personal care services for beneficiaries that resided in a SNF, or received inpatient hospital services on the date of the home health service and/or personal care service. For 2013, SMR issued 69 final reports identifying $199,219 in overpayments.

SMR activity outcomes are in Tables 8.1-8.5.

2013 Systems Match Recoveries by Type and Region

Table 8.1 2013 Upstate Region Systems Match Recovery Audits				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
DME Crossover – Medicaid with Medicare Detail	0	9	$ 100,414	$ 87,242
Dental	0	4	24,020	24,020
General Clinic	0	11	58,977	55,236
Home Health	5	10	23,560	54,558
Inpatient Crossover/Clinic/ER	0	0	0	13,157
OB/Gyn	0	0	0	483
Partial Hospitalization	0	0	(36,839)	(34,914)
Physician – Place of Service	0	0	0	5,451
Physician Services in OMH Clinics	0	3	8,284	16,391
Transportation	0	19	289,926	80,768
Total	5	56	$ 468,342	$ 302,392

Table 8.2 2013 Downstate Region Systems Match and Recovery Audits				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
DME Crossover – Medicaid with Medicare Detail	0	5	$ 233,594	$ 152,252
Dental	0	17	291,899	280,795
General Clinic	0	21	163,099	248,125
Home Health	21	45	155,527	218,433
Inpatient Crossover/Clinic/ER	0	1	17,303	19,596
OB/Gyn	0	1	16,602	2,248
Partial Hospitalization	0	0	(10,220)	(10,220)
Physician – Place of Service	0	0	0	(481)
Physician Services in OMH Clinics	0	2	66,108	644,718
Transportation	1	46	4,577,723	472,532
Total	22	138	$ 5,511,635	$ 2,027,998

Table 8.3 2013 Western Region Systems Match Recovery Audits				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
ALP	0	2	$ 21,805	$ 21,805
DME Crossover – Medicaid with Medicare Detail	0	12	192,640	263,101
Dental	0	4	55,025	47,035
General Clinic	1	22	296,439	325,438
Home Health	7	14	20,132	31,929
Inpatient Crossover/Clinic/ER	0	0	0	14,750
NAMI	0	0	81,966	81,966
Ob/Gyn	0	0	0	(215)
Physician – Place of Service	6	12	91,754	419,410
Physician Services in OMH Clinics	0	0	0	100,548
Transportation	0	13	15,320	14,063
Total	14	79	$ 775,081	$ 1,319,830

Table 8.4 2013 Out-of-State Systems Match Recovery Audits				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
DME Crossover – Medicaid with Medicare Detail	0	8	$ 160,335	$ 105,483
Dental	0	13	318,441	274,991
OB/Gyn	0	0	0	584
Physician Services in OMH Clinics	0	1	1,553	3,240
Transportation	0	13	531,341	22,201
Total	0	35	$ 1,011,670	$ 406,499

Table 8.5 2013 System Match and Recovery Statewide Totals				
Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
ALP	0	2	$ 21,805	$ 21,805
DME Crossover – Medicaid with Medicare Detail	0	34	686,983	608,078
Dental	0	38	689,385	626,841
General Clinic	1	54	518,515	628,800
Home Health	33	69	199,219	304,920
Inpatient Crossover/Clinic/ER	0	1	17,303	47,502
NAMI	0	0	81,966	81,966
Ob/Gyn	0	1	16,602	3,101
Partial Hospitalization	0	0	(47,059)	(45,134)
Physician – Place of Service	6	12	91,754	424,379
Physician Services in OMH Clinics	0	6	75,945	764,897
Transportation	1	91	5,414,309	589,563
Total	41	308	$ 7,766,726	$ 4,056,718

Provider Self-Disclosures

OMIG operates the statewide mandatory self-disclosure program for all Medicaid providers regardless of the types of services provided to beneficiaries. OMIG encourages providers to investigate and identify possible fraud, waste, abuse, or inappropriate payments through self-review, compliance programs, and internal controls. Section 6402(a) of ACA and New York's Compliance Program obligations under 18 NYCRR §521, require Medicare and Medicaid providers to self-disclose any overpayments within 60 days of identification by the provider.

OMIG's self-disclosure unit, in concert with its vendor, HMS, provides efficient, user-friendly methods for providers to refund Medicaid payments to DOH. OMIG created a process for submissions to include disclosure reasons, financial impact to the Medicaid program, and corrective measures undertaken to prevent the error from reoccurring. Providers can either disclose directly to OMIG staff, or they can utilize the OMIG/HMS Provider Overpayment Reporting Terminal (PORTal), which was developed as a single point of entry for all OMIG/HMS reviews. HMS developed the PORTal to assist in the overpayment recovery process. OMIG's self-disclosure activities identified overpayments of $16.3 million in 2013. The following tables summarize self-disclosure activity for 2013.

Table 9.1

2013 Upstate Region Self Disclosure Audits

Provider Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Billing Service Group/EMEVS	1	1	$ 108,530	$ 108,530
Child Care Institution	2	1	8,162	8,162
Diagnostic and Treatment Center	11	12	266,035	277,086
Home Health Agency	25	23	1,215,417	1,067,709
Hospital	6	10	452,614	523,893
Long Term Care Facility	6	6	58,827	14,074
Medical Appliance Dealer	1	0	0	7,152
Multi-Type	10	14	198,137	471,744
Nurse	1	2	15,381	14,625
Pharmacy	1	0	0	0
Physicians Group	2	2	37,649	37,649
Transportation	1	1	56,827	56,827
Total	67	72	$ 2,417,579	$ 2,587,451

Table 9.2				
2013 Downstate Region Self Disclosure Audits				
Provider Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Capitation Provider	2	1	$ 23,418	$ 23,418
Child Care Institution	3	2	79,908	13,421
Dentist	1	0	0	0
Diagnostic and Treatment Center	26	21	1,382,471	2,573,716
Home Health Agency	27	30	3,451,747	2,609,887
Hospital	16	15	1,086,579	917,490
Laboratory	2	0	0	757
Long Term Care Facility	7	5	1,447,366	1,375,896
Multi-Type	23	26	2,556,450	2,547,829
Multi-Type Group	0	5	148,336	5,049
Pharmacy	1	1	214,504	98,314
Physicians	9	9	10,773	10,773
Physicians Group	7	13	81,643	99,679
Transportation	2	0	0	0
Total	126	128	$ 10,483,195	$ 10,276,229

Table 9.3				
2013 Western Region Self Disclosure Audits				
Provider Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Diagnostic and Treatment Center	13	11	$ 738,523	$ 770,508
Home Health Agency	20	20	706,930	816,561
Hospital	3	7	46,372	41,430
Long Term Care Facility	4	5	195,487	207,469
Medical Appliance Dealer	1	0	0	0
Multi-Type	11	19	993,948	770,640
Nurse	0	0	0	8,770
Pharmacy	3	4	408,010	316,350
Physicians Group	1	1	530	530
Transportation	1	1	1,768	7,464
Total	57	68	$ 3,091,568	$ 2,939,721

Table 9.4				
2013 Out-of-State Self Disclosure Audits				
Provider Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Hospital	1	2	$ 19,632	$ 0
Laboratory	1	1	111,341	111,437
Medical Appliance Dealer	0	1	69,573	69,573
Multi-Type	0	1	90	0
Total	2	5	$ 200,636	$ 181,010

Table 9.5				
2013 Statewide Self Disclosure Audits				
Provider Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
Billing Service Group/EMEVS	1	1	$ 108,530	$ 108,530
Capitation Provider	2	1	23,418	23,418
Child Care Institution	5	3	88,070	21,582
Dentist	1	0	0	0
Diagnostic and Treatment Center	50	44	2,387,029	3,621,310
Home Health Agency	72	73	5,374,094	4,494,156
Hospital	26	34	1,605,198	1,482,813
Laboratory	3	1	111,341	112,193
Long Term Care Facility	17	16	1,701,680	1,597,438
Medical Appliance Dealer	2	1	69,573	76,726
Multi-Type	44	60	3,748,625	3,790,213
Multi-Type Group	0	5	148,336	5,049
Nurse	1	2	15,381	23,396
Pharmacy	5	5	622,514	414,664
Physician	9	9	10,773	10,773
Physicians Group	10	16	119,822	137,858
Transportation	4	2	58,595	64,291
Total	252	273	$ 16,192,978	$ 15,984,411

Third-Party Insurance Review Activities

Medicaid is the payer of last resort; however, providers often do not bill the responsible third-party insurer before billing Medicaid. A significant amount of the State's Medicaid recoveries are the result of OMIG's efforts to obtain payments from private insurers responsible for services inappropriately reimbursed by Medicaid funds. Other insurance coverage, including Medicare and/or commercial insurance, should be identified during the enrollee's intake process at the LDSS.

Pre-Payment Insurance Verification Cost Savings Activities

The NYS third-party liability vendor, HMS, obtains rosters of insured individuals from many insurance carriers across the country. HMS matches these rosters against Medicaid beneficiaries enrolled in NYS in an effort to identify those beneficiaries that have additional insurance coverage. Once identified, this information is added to eMedNY so that medical services are first billed to the other insurance, leaving Medicaid as the payer of last resort. In 2013, these pre-payment insurance verification activities resulted in estimated cost savings to the State's Medicaid program of approximately $1.3 billion, as shown in Table 11.1.

Third-Party Recovery Activities

OMIG, through its vendor, HMS, maximizes the reimbursement of Medicaid expenditures through recovery of funds from third-party insurers. HMS recoveries can come from providers that adjust their claims to include third-party monies, or they can come directly from the insurance companies through direct billing of the Medicaid claims. HMS also seeks recovery of encounter based claims for MC enrollees. These recoveries are pursued directly from the third-party insurer. In 2013, OMIG initiated 3,443 third-party reviews, with recoveries of more than $112 million, as shown in Table 10.1.

Home Health Care Demonstration Project

Under the Home Health Care Demonstration project's initial phases, beginning in 2000, the traditional approach had been to examine each questionable dual-eligible claim on a claim-by-claim basis. This became overwhelmingly cumbersome. CMS agreed to allow OMIG and their vendor, the University of Massachusetts Medical School (UMass), to employ a 200 case 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 Medicaid. Following the establishment of the sampling methodology, OMIG and UMass staff applied an extrapolation technique to calculate payments that Medicaid had made that should instead have first been made by Medicare first.

In October 2013 under this project, $496 million in erroneous Medicaid payments were identified and $211 million was recovered from the federal government for errors relating to home care recipients that are dually-eligible for both Medicare and Medicaid funds during 2007 - 2010. This represents the "largest single monetary recovery in OMIG's history." This demonstration project has not been extended beyond the large settlement in October 2013.

CMS did not approve the continuation of the demonstration project for review periods of 2011 and later. Therefore, OMIG will return to the traditional, more labor intensive approach of individually reviewing claims from home health agencies on a case-by-case basis for every dual-eligible Medicaid claim the State has possibly paid in error. In this traditional approach, the cases are sent through a five level appeals process in the HHS Office of Medicare Hearings and Appeals (OMHA). Utilizing this approach, OMIG recovered an additional $5.7 million in 2013, far less than had been recovered in prior periods utilizing the sampling approach.

In July 2013, OMHA suspended the assignment of Administrative Law Judge hearings, the third level of appeal, due to the massive increase of requests for hearings. HHS OMHA office hosted a forum in February 2014 to inform interested parties on the status of the scheduling backlog. Four OMIG staff members attended the forum, and were able to express their concern on the troubling delays of the review process and suggested some initiatives to remedy the backlog.

Additional information on this demonstration project and OMIG's record setting recoveries is available on OMIG's website at: http://www.omig.ny.gov/latest-news/697-496-million

Estate & Casualty Recovery

MRT #102 calls for the centralization of responsibility for the management and reporting of Medicaid casualty and estate recovery amounts and gave OMIG statewide responsibility for making these recoveries. NYS may recover from the estates of deceased beneficiaries, as well as from personal injury awards and settlements, for the cost of medical care covered by Medicaid. This proposal enables OMIG to manage a central recovery process through their vendor HMS, as well as implement best practices for making these recoveries.

In 2013, 26 counties were trained in the use of HMS's Maestro Case Management System, which is a web based case management system that supports the entire casualty and estate recovery project. Another 12 local districts are currently in the process of learning this system. OMIG offers the counties a menu of options to customize the implementation of their recovery programs. These options all contain usage of the HMS Maestro System. Options range from full outsourcing to HMS of all cases, to the use of Maestro only to manage the LDSS cases. Recoveries in 2013 for the Casualty and Estate project were $83.1 million.

Medicaid Recovery Audit Contractor

Pursuant to ACA, Medicaid agencies are required to contract with a Recovery Audit Contractor (RAC) to identify and recover Medicaid overpayments. The Medicaid RAC Program is modeled after CMS's Medicare RAC program, but provides significant discretion to states to tailor activities to meet its unique Medicaid program. In NYS, HMS has been designated as the Medicaid RAC.

HMS performs data mining algorithms on the Medicaid database to identify potential areas of recovery. They then develop an Improper Payment Scenario Development Request (IPSDR) for each initiative. This document includes the overpayment scenario, methodology used to identify the finding, and any pertinent State and federal regulations. The IPSDR is approved by OMIG staff prior to implementation.

Overpayments associated with these projects can be tracked and reported through the PORTal that was developed by HMS. This process allows for validation of the overpayment at the time of data mining and notifies providers of such via mail and electronically via the PORTal. This process places more emphasis on provider compliance and program oversight as each overpayment is reviewed at the claim level.

During 2013, HMS identified and recovered approximately $41.8 million in inappropriate Medicaid expenditures. The bulk of these recoveries were from payment integrity reviews resulting from analysis of the Medicaid paid claims data. Some of the RAC projects undertaken by HMS were reviews of hospital based credit balances, long-term care bed holds, net available monthly income (NAMI), MC premium same plan overlaps, Medicare Part B coinsurance, and changing alcohol detox to medically managed detoxification.

The table below summarizes the recoveries related to the above described Third Party Liability and RAC activities.

Table 10.1

2013 Third Party Liability and RAC Recoveries

Activity Area	Amount
HMS – Third Party Liability	$ 112,966,129
HMS – Casualty & Estate	83,097,213
HMS – RAC	41,744,362
UMASS	502,312,784
Self-Disclosed TP Health Insurance	916,990
Total	$ 741,037,478

Cost Savings Activities

Cost savings activities prevent inappropriate, duplicate, or erroneous Medicaid payments from being made. OMIG's cost savings initiatives are calculated as estimates based on historical and current Medicaid claims data. Cost savings amounts are not cash recoveries. Cost savings initiatives are proactive actions all states can implement to save taxpayer dollars and protect the integrity of its Medicaid program. In this way, they help OMIG to achieve its mission to enhance the integrity of the Medicaid program by saving taxpayer dollars.

In 2013, OMIG has employed various cost savings initiatives. Each OMIG action or initiative has its own methodology for calculating program costs that are avoided. For example, OMIG utilizes program edits in the Medicaid billing system that deny provider claims, thereby preventing Medicaid payments from being made; those denied claims represent cost savings. In another example, when OMIG has an intervention with a provider, the agency will compare billing patterns prior to the intervention with those after to determine the cost savings attributable to the agency's actions.

OMIG puts great effort into developing, reviewing and approving its cost savings methodologies including utilizing internal workgroups consisting of cross functional teams. Teams will review all cost savings initiatives on an ongoing basis to identify and assess fluctuations in the savings amounts reported. Fluctuations can occur naturally over time for any of OMIG's actions or initiatives and the workgroup ensures that methodologies are being reviewed on a timely basis.

Throughout 2013, OMIG estimates it saved NYS taxpayers more than $2 billion as a result of these proactive efforts. These initiatives are displayed in Table 11.1.

Cost Savings Activities

Table 11.1 2013 Cost Savings Activities	
Activity Area	Estimated Savings
Card Swipe Program/ Post & Clear Program	$ 13,479,631
CIA Sentinel Effect	55,903,773
Clinic License Verification	14,917,157
Dental System Match	3,663,785
Edit 102 – Service Date prior to Birth Date	150,034
Edit 1141 – Dental Activities	444,740
Edit 1141 – Medical Activities	242,955
Edit 1141 – Monitored (0-12 Months)	88,623
Edit 1141 – Monitored (12-24 Months)	153,357
Edit 1141 – Sentinel	23,418,913
Edit 1236/1238 - Order/Servicing/Referring Provider #	5,665,257
Edit 1344 – Transportation Claims	58,669
Edit 1357 – Provider ID/Service ID are the same	2,604,490
Edit 760 – Suspected Duplicate, Covered by Inpatient	1,814,886
Edit 903 – Ordering/Referring Provider Number Missing	4,919,731
Edit 927 – Transportations Claims	3,476,754
Edit 939 - Ordering Provider Excluded Prior to Order Date	4,465,421
Enrollment and Reinstatement	32,843,021
Exception and Conflict Report	17,780
Exclusions/Terminations – Internal	8,964,049
Exclusions/Terminations – External	11,467,547
High Ordering Physicians	160,301,706
Managed Care Locator Code	19,380,446
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	174,398,467
Pharmacies License Verification	8,229,049
Pre-Payment Insurance Verification Commercial	1,326,064,364
Pre-Payment Insurance Verification Medicare	16,393,164
Recipient Restriction	150,554,571
Serialized Prescription Program Edits	24,581,270
Transportation Crossover Edit	44,420
Total	$ 2,068,708,030

Conclusion

OMIG appreciates the opportunity to share the results of its Medicaid program integrity activities for 2013. OMIG's work this year demonstrates that NYS remains the national leader in promoting and protecting the integrity of the Medicaid program. As OMIG ends another year of operation and reports on its varied achievements and accomplishments, the agency recognizes that much remains to be done. OMIG looks forward to strengthening its partnerships with other state agencies, expanding provider compliance education efforts, and increasing the level of transparency in the agency's operations.

Appendix

2013

Acronym List

ACA – Affordable Care Act

AIU – Adoption, Implementation and Upgrade

APG – Ambulatory Patient Groups

ARU – Administrative Remedies Unit

BLTCR – Bureau of Long Term Care Reimbursement

BMFA – Bureau of Medicaid Fraud Allegations

BNE – Bureau of Narcotic Enforcement

BOC – Bureau of Compliance

CAF – Credible Allegation of Fraud

CFA – Comprehensive Functional Assessment

CHHA – Certified Home Health Agency

CHIP – Children's Health Insurance Program

CIA – Corporate Integrity Agreement

CMI – Case Mix Index

CMS – Centers for Medicare and Medicaid Services

COPS – Comprehensive Outpatient Programs

CSC – Computer Sciences Corporation

CSP – Community Support Programs

CVR – Credential Verification Reviews

D&TC – Diagnostic and Treatment Center

DME – Durable Medical Equipment

DMI – Division of Medicaid Investigations

DMV – Department of Motor Vehicles

DOH – Department of Health

DOT – Department of Transportation

DRG – Diagnostic Related Group

DSUR – Division of Systems Utilization and Review

EAR – Enrollment and Reinstatement Unit

EHR – Electronic Health Records

EOMB – Explanation of Medical Benefits

EP – Evolution Project

FFS – Fee-for-Service

HHA – Home Health Care Agencies

HHS OIG – United States Department of Health and Human Services Office of the Inspector General

HIT – Health Information Technology

IPSDR – Improper Payment Scenario Development Request

IRA – Individualized Residential Alternative

ISP – Individualized Service Plan

LDSS – Local Department of Social Services

LTHHCP – Long-term Home Health Care Program

MC – Managed Care

MCO – Managed Care Organization

MDS – Minimum Data Set

MDW – Medicaid Data Warehouse

MFCU – Medicaid Fraud Control Unit

MLTC – Managed Long Term Care

MRT – Medicaid Redesign Team

MSC – Medicaid Service Coordinator

MSCR – Medicaid Systems Controls Review

MU – Meaningful Use

MWBE – Minority and Women Business Enterprise

NYC – New York City

NYC HRA – New York City Human Resources Administration

NYCRR – New York Codes, Rules and Regulations

NYS – New York State

NYSED – NYS Education Department

NYSOFA – New York State Office for the Aging

OHIP – Office of Health Insurance Programs

OMH – Office of Mental Health

OMHA – Office of Medicare Hearings and Appeals

OMIG – Office of the Medicaid Inspector General

OPD – Office of Professional Discipline

OPMC – Office of Professional Medical Conduct

OPWDD – Office for People With Developmental Disabilities

PCA – Personal Care Agency

PORTal – Provider Overpayment Reporting Terminal

PPR – Prepayment Review

PSHSP – Pre-School Supportive Health Services Program

RAC – Recovery Audit Contractor

RHCF – Residential Health Care Facility

RRP – Recipient Restriction Program

SADC – Social Adult Day Care

SIU – Special Investigation Unit

SMR – System Match and Recovery

SNF – Skilled Nursing Facility

SSHSP – School Supportive Health Services Program

TLC – Taxi and Limousine Commission

UMass – University of Massachusetts Medical School

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