2017 ANNUAL REPORT

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Contents

Message from the Medicaid Inspector General

It is my pleasure to submit the Office of the Medicaid Inspector General's (OMIG) 2017 Annual Report.

New York continues to lead the nation in identifying and preventing Medicaid fraud, waste, and abuse.

OMIG's comprehensive investigative, auditing and cost-avoidance efforts, extensive partnerships with law enforcement agencies, and wide range of compliance initiatives and provider education efforts, resulted in more than $2.6 billion in Medicaid recoveries and cost savings in calendar year 2017. The report that follows details the agency's efforts across all divisions and bureaus.

Going forward, as the health care landscape and the Medicaid program continues to evolve and change, OMIG will continue to aggressively protect the integrity of the program, which is a key component in sustaining New York State's (NYS) high-quality health care delivery system.

Sincerely,

Dennis Rosen
Medicaid Inspector General

OMIG's main office is in Albany with regional offices in New York City (NYC), White Plains, Hauppauge, Syracuse, Rochester, and Buffalo.

General Overview

History and Authority

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 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. Although OMIG remains a part of the 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 fight against fraud and abuse in the Medicaid program. To fulfill its mission, OMIG performs its own reviews of the Medicaid program, and works with other agencies that have regulatory oversight or law enforcement powers.

Mission Statement

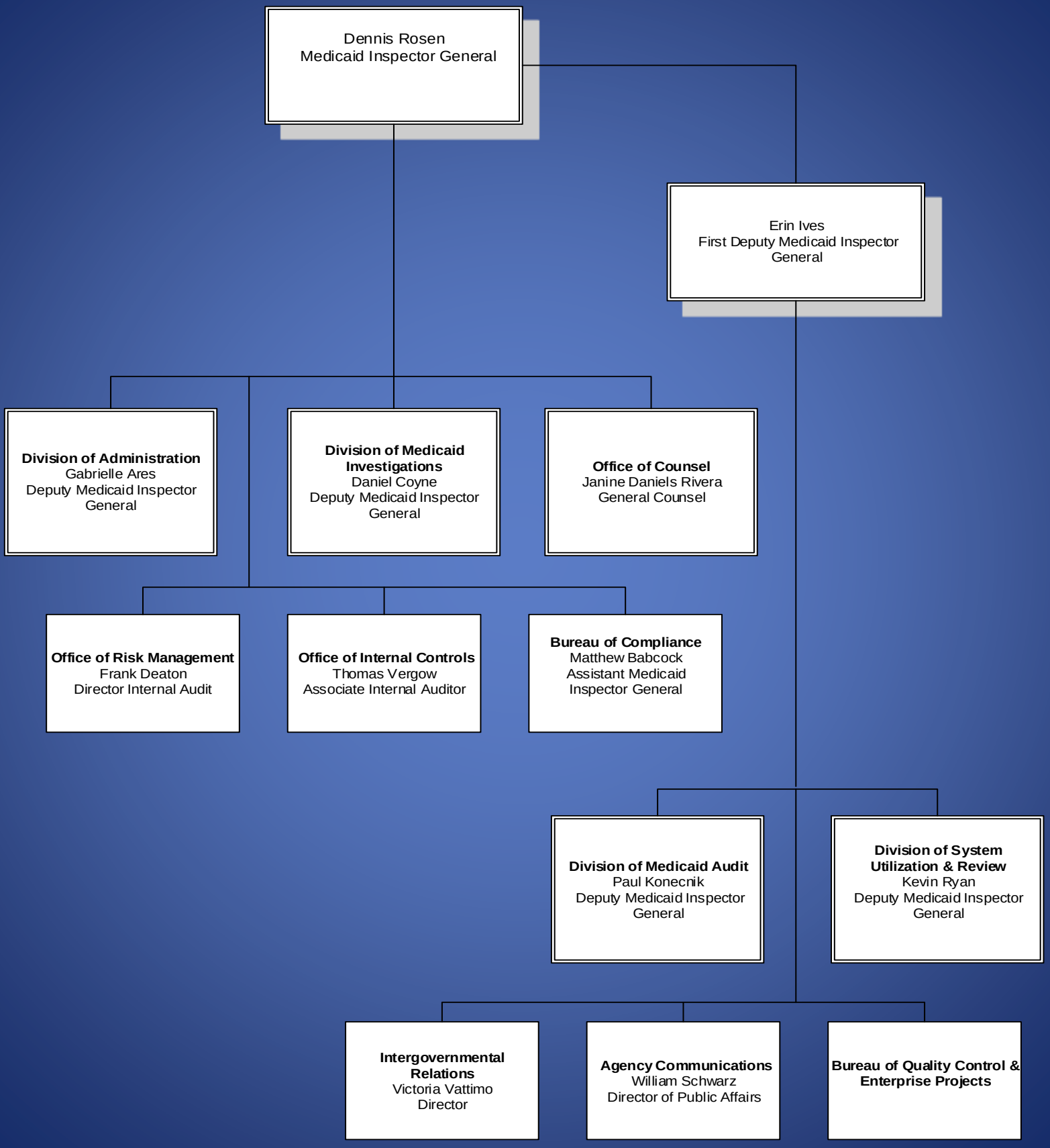
The mission of OMIG is to enhance the integrity of the NYS Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds, while promoting a high quality of patient care.

Annual Reporting

As required by NYS Public Health Law §35(1), OMIG must annually submit a report summarizing the activities of the agency for the prior calendar year. This Annual Report includes information about 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, and stipulations of settlement.

OMIG Organizational Chart



2017 Program Integrity Activities

OMIG conducts and oversees Medicaid program integrity activities that prevent, detect, and investigate instances of Medicaid fraud, waste, and abuse. OMIG coordinates such activities with a range of NYS agencies such as DOH, the Office for People with Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH), the Office of Temporary Disability Assistance, the Office of Children and Family Services, the Justice Center for the Protection of People with Special Needs (Justice Center), the NYS Education Department (NYSED), the fiscal agent employed to operate the Medicaid Management Information System, as well as local governments and entities.

OMIG receives and processes complaints of alleged Medicaid fraud, waste, and abuse. All allegations are reviewed and investigated, and if fraud is suspected, OMIG refers such cases to the NYS Attorney General's Medicaid Fraud Control Unit (MFCU), pursuant to applicable regulations and laws. The agency also works closely with local, state, and federal law enforcement entities as part of its efforts to protect the integrity of the state's Medicaid program.

Executive Initiatives

OMIG's Response to the Opioid Epidemic

The cost in lives and dollars due to the opioid epidemic - throughout New York State and the nation - is a recognized public health crisis. To combat opioid abuse, OMIG continues to collaborate across its divisions and with federal, state, and local law enforcement and other state regulatory agencies. OMIG staff meet monthly to discuss ongoing drug diversion investigations, findings, and future program integrity projects related to opioid abuse. OMIG's Division of Medicaid Investigations (DMI) and its Recipient Restriction Program (RRP) play major roles in the agency's efforts to address the crisis, and each continues to pursue additional avenues to fight the opioid epidemic. The RRP is an administrative mechanism whereby selected recipients with a demonstrated pattern of abusive utilization of Medicaid services are restricted to one primary medical provider, one primary pharmacy, and one designated inpatient hospital or clinic.

- Gabapentin, also known as Neurontin, is often used as an alternative for narcotics in pain treatment. Lack of controlled substance scheduling and generic availability of Gabapentin makes the drug more easily available and susceptible to overutilization, and this drug can be misused and abused alone or in combination with other legal or illicit drugs. To address this overutilization, OMIG's RRP pharmacy team performed additional exception processing. This resulted in RRP identifying recipients who appeared to be overutilizing pharmacy services to obtain an excess of this drug, and RRP uses this process to identify recipients for restriction.

Opioid Surveillance Task Force

OMIG participates in the Statewide Opioid Task Force created by the Governor's Office of Employee Relations (GOER). Multiple agencies collaborate to share ideas in the effort to combat the opioid

epidemic. Other agencies involved include OASAS, Bureau of Narcotic Enforcement, Division of Criminal Justice Services, and DOH's AIDS Institute.

OMIG Initiative to Combat Fraud in Home Health

In NYS, services provided by personal care aides (PCA) and home healthcare agencies (HHA) continues to increase as the population ages and as the managed care program moves away from hospitalization and long-term care placements. The need for oversight of the PCAs and HHAs providing these services to this vulnerable population is critical. This population often does not have the personal ability or family members available to advocate or to monitor and ensure that the services are necessary, are provided by qualified individuals, are provided as ordered, are provided at all, that the caregivers show up as assigned, and that the beneficiary is not at any risk.

OMIG is addressing the issue of fraud, waste, and abuse in the home health care sector by coordinating efforts statewide, and meeting monthly to discuss allegations and trends. However, a significant challenge to combating home health care fraud is the lack of an identifier for home health aides, personal care assistants, or individuals providing services under the Consumer Directed Assistance Program (CDPAP). While most providers receiving funds from the NYS Medicaid program have a National Provider Identifier (NPI), there is no such "unique" identifier to track the history and performance of individuals providing services. OMIG is reviewing solutions to address this issue, including requiring all home health caregivers to obtain an NPI, thereby enhancing OMIG's program integrity efforts through the ability to review individual caregiver services across all home health care providers.

OMIG staff collaborated with a Managed Care Organization (MCO) Special Investigation Unit (SIU) to identify consumer directed personal care aides who may be abusing the CDPAP by submitting timesheets for services not rendered or for services inappropriately billed during a recipient's inpatient admission. As a result of this collaboration, OMIG decided to review all allegations received since January 2016 that involved CDPAP aides and then used this information to create a watchlist. The watchlist has proven instrumental in identifying aides for whom OMIG has received more than one complaint and potentially colluding recipients. A required unique identifier would make it possible to systematically identify possible fraud, waste, and abuse by both PCAs and recipients.

Managed Care

In NYS, several different types of MCOs participate in Medicaid managed care, including mainstream managed care plans, health maintenance organizations, prepaid health service plans, managed long-term care (MLTC) plans, and Human Immunodeficiency Virus (HIV) Special Needs Plans. OMIG's program integrity initiatives in managed care include audits of MCOs' cost reports and related data, investigations of providers and enrollees, and regular meetings with the MCOs' SIU to identify targets and discuss cases.

Managed Care Audit Activities

OMIG's audit efforts include performing various match-based reviews utilizing data mining and analysis to identity potential audits. These audits lead to the recovery of inappropriate premium payments and identification of actions to address systemic and programmatic concerns. During 2017, these efforts resulted in 543 finalized audits with over $131 million in identified overpayments. Highlights of managed care audit activities are described below.

Foster Care

When a child is placed in agency-based foster care, that child loses eligibility for Medicaid Managed Care, and a per diem rate is paid to the foster care agency responsible for the child's care. Currently, there are separate upstate and downstate Welfare Management Systems. Due to the separate systems, a child may be issued a duplicate client identification number (CIN) which creates the possibility of duplicate payments being made.

After the child is placed in foster care, the New York State of Health (NYSoH), Local Departments of Social Services (LDSS), and New York City Human Resources Administration (NYC HRA) are responsible for retroactively adjusting the enrollee eligibility file, notifying OMIG of the retroactive disenrollment, and notifying the MCO to void the premium payments for any month where the MCO was not at risk to provide services for the foster care child.

During 2017, OMIG identified more than $17.1 million in inappropriate payments to MCOs for foster care children whose services were provided by the foster care agencies. This project was enhanced by a collaborative effort among OMIG and DOH's Office of Health Insurance Programs (OHIP) and NYS Office of Information Technology Services (ITS). OMIG utilizes information obtained from OHIP and ITS monthly reports (i.e., lack of social security numbers on eMedNY data files) to confirm instances where multiple CINs were created for a foster care child. OMIG continues to collaborate with the MCOs, NYSoH, LDSS, and NYC HRA to identify and resolve issues concerning timely eligibility updates for foster care children.

Retroactive Disenrollment

In most cases, when a member's Medicaid managed care eligibility changes, the adjustment is prospective. However, in some cases, the eligibility change is retroactive and may render one

or more capitation payments paid on behalf of the member inappropriate. OMIG recovers these inappropriate capitation payments from the MCO through the retroactive disenrollment process. This process requires a collaboration among OMIG, NYSoH, LDSS, and NYC HRA.

OMIG assists DOH in the development of new retroactive disenrollment reason codes, consults on MCO contract development, provides education and outreach to the LDSS, conducts analyses of retroactive disenrollment submissions, and distributes a semi-annual report to the MCOs of all LDSS-reported retroactively disenrolled individuals. Through the audit process, OMIG recovers any capitation payments the MCOs fail to void after receiving the semi-annual report. In 2017, more than $51 million in overpayments was identified due to retroactive disenrollments.

Managed Care Annual Deceased Enrollee Audit

OMIG continues to audit enrollment issues in several project areas, including Medicaid managed care monthly capitation payments made on behalf of deceased enrollees. OMIG compares data provided by NYS's Bureau of Vital Statistics and the NYC Bureau of Vital Statistics and individuals who are indicated as deceased on eMedNY against the monthly capitation payments paid to MCOs. OMIG's review identifies monthly capitation payments paid to the MCOs for months subsequent to the enrollee's month of death, that were not voided by the MCOs as part of the first-level enrollment reviews conducted by LDSS, NYC HRA, or NYSoH. OMIG's audit of deceased Medicaid managed care enrollees identified more than $23 million in overpayments.

OMIG Strengthens Partnerships with Managed Care Organizations

Throughout 2017, OMIG staff, including representatives from DMI, Division of Medicaid Audit (DMA), and Bureau of Business Intelligence (BBI), have visited several MCOs to discuss their program integrity operations. Topics include but are not limited to: SIU operations, claims processing and encounter validation, and subcontractor/vendor relations and oversight. Through its MCO on-site review process, OMIG continues to identify MCO best practices in an effort to enhance program integrity consistency throughout the industry. An example of a best practice identified through the on-site process, is one MCO's daily manual review of 15% of its paid claims, concurrent with its auto-adjudicated process. OMIG also noted that several plans conduct annual on-sites of contracted vendors in order to ensure Medicaid and contractual requirements are being met. It is processes such as these that OMIG is identifying and analyzing for potential inclusion in future contractual arrangements with MCOs.

OMIG has also undertaken an MCO liaison initiative to strengthen its working relationships with MCO SIUs. Each MCO has been assigned a designated OMIG liaison to work with their SIU representative. The appointed liaison meets with the SIU representative monthly to discuss fraud, waste, and abuse related referrals and general fraud trends. The liaison process was implemented in an effort to improve communication and increase referrals, so appropriate action can be taken to address overall program integrity. As a result of this initiative, OMIG has received positive feedback from the MCOs, and the agency has several ongoing investigations.

Managed Care Project Teams

OMIG has six project teams, each with a goal towards improving and expanding the agency's program integrity work in Medicaid managed care. OMIG staff across all divisions and offices participate on these teams and coordinate their efforts through the project management office.

OMIG's six project teams oversee the following focus areas:

- Data
- Managed Care Contract and Policy/Relationship Management (MCCPRM)
- Managed Care Plan Review
- Managed Care Network Provider Review
- Pharmacy
- Value Based Payments

Data

The Data Team assisted with creating a SharePoint tool entitled, "Report a Data Issue." This tool enables OMIG staff to submit issues and/or questions regarding any Medicaid processing system or database that is used in OMIG business operations. Another project identified all data elements that are available on the Medicaid Data Warehouse (MDW) for managed care encounters. This information was used to create a crosswalk between fields submitted on the post adjudicated claims data reporting (PACDR), the national encounter reporting standard adopted by DOH in September 2015, to those delivered to the MDW. Analysis of the crosswalk helped to identify fields being submitted on the PACDR encounter that are useful to OMIG program integrity efforts, but that are not currently populated in the MDW.

Managed Care Contract and Policy/Relationship Management

In 2017, the MCCPRM Team focused on developing model contract amendments to address new federal regulatory requirements. As part of this effort, MCCPRM proposed and negotiated amendments to the January 1, 2017 Managed Long-Term Care Partial Capitation Contract (Partial Capitation Contract). These amendments include updated fraud and abuse referral requirements, compliance programs, and the requirement that MCOs withhold payments from network providers who are the subject of a pending investigation of a credible allegation of fraud. In addition, program integrity changes made to the October 1, 2015 Medicaid Managed Care Model Contract were incorporated into the Partial Capitation Contract. All of these amendments will serve to strengthen OMIG's program integrity and oversight role in the managed long-term care program. In anticipation of the October 1, 2015 Model Contract being approved by Centers for Medicare and Medicaid Services (CMS), MCCPRM continued to coordinate the development of instructions and guidance for new program integrity requirements.

Managed Care Plan Review

The Managed Care Plan Review Team conducted Medicaid Managed Care Operating Report (MMCOR) audits utilizing detailed audit plans and processes. MMCORs are used by DOH to develop the capitation rates paid to MCOs. Costs and utilization reported on these MMCORs are reviewed to ensure accuracy of the reported data.

In addition, team members participated in on-site visits with seven MCOs to discuss program integrity related processes and procedures. These visits are part of a coordinated effort to gain a greater understanding of MCO business processes and to analyze their fraud, waste, and abuse activities.

Managed Care Network Provider Review

The Managed Care Network Provider Team finalized four audits of services provided by physicians who contracted with various MCOs. While conducting these reviews, OMIG auditors gained understanding of the complexities of reviewing network providers and ensuring the validity of encounter data. Team members are working on understanding data issues related to previously non-enrolled providers. Development has started on new audit plans and processes in the areas of outpatient chemical dependence services, opioid treatment programs, personal care services, and consumer directed personal care assistance. As these are developed the team will train audit staff throughout the agency to increase participation in program integrity efforts.

Pharmacy

While reviewing encounter data for pharmacy audits, the Pharmacy Team discovered that the encounter amounts paid were inconsistent with actual pharmacy reimbursements. Team members verified the submitted encounter field information directly with the MCOs, and by utilizing the Program Integrity Reports. The audit process was adjusted to obtain pharmacy reimbursement amounts directly from the pharmacies, and to use those amounts in the calculation of any recoveries. The Pharmacy Team continues to develop the practical application of audit processes to a managed care network pharmacy audit.

Value Based Payments

OMIG established a Value Based Payment (VBP) Team in August 2017. The team's mission is to determine how value based payment systems are being implemented, and to identify the rules and regulations that govern these payment structures. The team will identify potential program integrity weaknesses and make recommendations to help strengthen value based payment systems. Since its inception, VBP Team members have participated on the VBP Workgroup; a stakeholder group that meets regularly to support the development of the VBP Roadmap. The Workgroup is hosted by DOH and includes representatives from various regulatory oversight agencies and healthcare associations. VBP Team members have also participated on the VBP Program Integrity Workgroup and contributed to VBP program recommendations. Additionally, the team has expanded OMIG's knowledge base to prepare existing processes for the transition to the VBP system.

Audits

OMIG conducts audits of Medicaid services provided to beneficiaries. The objective of the audit is to assess providers' compliance with applicable federal and state laws, rules, and policies governing the NYS Medicaid program, and to verify that:

- Medicaid-reimbursable services were rendered for the dates billed;
- Appropriate rate or procedure codes were billed for services rendered;
- Patient-related records are maintained and contain the documentation required by regulations; and,
- Claims for payment were submitted in accordance with DOH regulations and the appropriate provider manuals.

In 2017, OMIG finalized 585 fee-for-service (FFS) audits which resulted in identified overpayments of more than $21 million. The most common audit findings identified by OMIG's FFS auditors were missing, late, or improperly authorized plan of care documentation. These care plans may have different titles across all categories of service which utilize them, however they form the fundamental basis for authorized Medicaid services. Errors of this nature resulted in identified overpayments and reinforced the importance of maintaining proper documentation. Auditors evaluate the required document set for accuracy in support of payment. The provider's ability to render services by licensed, certified, trained, and qualified caregivers is also evaluated via a review of the supporting documentation, which is required to be maintained. Health screenings, vaccinations, and lab test results documentation are reviewed to ensure that caregivers are providing service in a manner that will not endanger the patients. OMIG also performed audits in the following areas: rate-based providers, county demonstration, school districts and county preschools as required by the State Plan Amendment, and provider self-disclosures.

Personal Care

Throughout 2017, OMIG continued to audit various areas of personal care. OMIG finalized 21 audits with identified overpayments of more than $9 million. These audits reviewed certified home health agencies, personal care, and traumatic brain injury providers. The most common findings included:

- Billing Medicaid before services were authorized;
- Supervision visits not performed within the required timeframe;
- Failure to maximize third-party or Medicare benefits;
- Failure to document tasks;
- Personal care aide not present at nursing supervision visit;
- Missing plan of care;
- Missing documentation of service;
- Failure to complete health requirements; and,
- Failure to complete required training.

Minimum Data Set Reviews

A nursing home's Minimum Data Set (MDS) submission to DOH's Bureau of Long Term Care Reimbursement (BLTCR) is a representation of the level of care required for each Medicaid client residing in the facility. MDS submissions are used by BLTCR to calculate each facility's case mix index, which is used to determine the direct cost portion of each nursing home's Medicaid rate.

OMIG, in collaboration with BLTCR, reviews the MDS submissions to verify that the data submitted by the nursing home was an accurate representation of each resident's medical condition. These reviews have identified upcoding errors in the activities of daily living (i.e., bed mobility, transferring, eating, toileting) and the number of physician orders and visits. In addition, these reviews have identified instances where skilled therapy, including speech, occupational, and physical therapy, were not medically necessary. In 2017, OMIG finalized 364 reviews resulting in identified overpayments of more than $31.7 million.

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 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).

Base Year and Notice of Rate Change Audits

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 follows:

- Expense not related to patient care;
- Undocumented expense;
- Duplicated expense; and
- Non-allowable expense.

When a base year audit has resulted in adjustments to the base year's operating costs, these audit findings need to be integrated and carried forward into the rate calculation for subsequent rate years that use those base year costs as its basis. These projects are referred to as notice of rate changes because they carry forward the audit findings from a base year audit. During 2017, 46 base year and notice of rate change audits were finalized, with identified overpayments of more than $9 million.

Capital

The reported capital costs for RHCFs are used as a basis for the capital component of a 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 where improper expenses were included in the rate calculation are:

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

During 2017, 52 capital audits were finalized, resulting in identified overpayments of more than $18 million.

System Match and Recovery Projects

OMIG uses analytical tools and techniques to data mine Medicaid claims and identify improper claim conditions. The System Match and Recovery Unit finalized 144 reviews with identified overpayments of more than $3.1 million. The following reviews contributed to these findings:

Physician Services in OMH Clinics

This project sought recovery of paid claims for physician's services provided under an OMH Article 31 Licensed Outpatient Program for which only the licensed outpatient program is eligible for Medicaid reimbursement. Physicians engaged by the licensed OMH program may not seek separate Medicaid reimbursement for services provided by the OMH-licensed program. OMIG finalized 45 audits with identified overpayments of more than $750 thousand for this project.

CHHA – Improper Episodic Payments

Certified Home Health Agencies (CHHA) bill Episodic Payment System (EPS) claims, which are based on 60-day episodes of care, rather than fee-for-service claims, to reimburse CHHA's for home care services provided to Medicaid recipients. The EPS was designed to address the rapid growth in CHHA costs per patient by better aligning payments with needed services. By receiving services in the home, patients can avoid unnecessary and more costly placement in medical facilities, such as hospitals or rehabilitative centers. This project sought recovery of claims where Medicaid was inappropriately billed for:

- Improper episodic payments for recipients who were transferred into MLTC during a 60-day episode of care;
- Multiple episodic payments within 60 days; and

- Overpayments to a CHHA that improperly received full 60-day payments for recipients who subsequently obtained services from a different CHHA within 60 days of an episode of care.

This project finalized 54 audits with identified overpayments of more than $2 million.

Self-Disclosure

OMIG operates the statewide mandatory self-disclosure program, which is a way for all Medicaid providers to return self-identified overpayments, 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 the Federal Affordable Care Act and New York's Compliance Program obligations under Title 18 of the New York Codes, Rules and Regulations (NYCRR), require Medicare and Medicaid providers to self-disclose any overpayments within 60 days of identification by the provider. In 2017, OMIG's self-disclosure unit finalized 327 audits with identified overpayments of more than $26.9 million.

2017 Initiated Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	12	1	9	0	22
Managed Care	350	91	109	0	550
Medicaid in Education	3	4	3	0	10
Provider	479	110	121	8	718
Rate	50	100	218	0	368
Self-Disclosure	92	68	72	1	233
System Match Recovery	84	48	39	52	223
Total	1,070	422	571	61	2,124

2017 Finalized Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	9	2	2	0	13
Managed Care	349	98	94	2	543
Medicaid in Education	1	0	1	0	2
Provider	341	100	140	4	585
Rate	249	80	134	0	463
Self-Disclosure	135	104	85	3	327
System Match Recovery	73	30	26	15	144
Total	1,157	414	482	24	2,077

2017 Overpayments Identified for Recovery by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program*	$ 7,962,269	$ (59,686)	$ 53,160	$ 0	$ 7,955,744
Managed Care	93,720,744	28,886,742	7,853,353	1,486,135	131,946,975
Medicaid in Education	20,877	0	3,080	0	23,957
Provider	11,955,974	6,797,560	3,183,750	4,870	21,942,153
Rate	40,850,960	4,776,035	11,996,144	0	57,623,139
Self-Disclosure	21,508,469	2,408,099	2,656,173	392,089	26,964,830
System Match Recovery	2,082,219	454,368	333,176	259,874	3,129,637
Total	$ 178,101,512	$43,263,118	$26,078,836	$ 2,142,968	$249,586,435

2017 Overpayments Recovered by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	$ 2,373,646	$ 170,900	$ 183,655	$ 0	$ 2,728,202
Managed Care	90,939,579	28,846,628	7,788,257	1,486,135	129,060,599
Medicaid in Education	20,877	0	49,387	0	70,264
Provider	73,010,815	6,617,728	5,052,772	1,349,546	86,030,861
Rate	30,070,175	6,091,774	12,876,637	0	49,038,586
Self-Disclosure	19,192,800	2,444,201	2,439,992	433,625	24,510,618
System Match Recovery	2,794,330	412,193	365,089	214,305	3,785,916
Total	$218,402,222	$44,583,424	$28,755,789	$3,483,611	$295,225,046

*Audit Overpayments identified for recovery were lowered due to stipulations issued in 2017 related to final audit reports issued in prior reporting periods.

Data Mining and Technological Support

OMIG's BBI provides a comprehensive range of services and functions that drive agency initiatives through the optimum use of data.

BBI utilizes resources such as eMedNY, Salient, and MDW, to extract, organize, analyze, and report data. The data analyses cover a wide range of provider types and program areas, and support the operation of the other divisions within OMIG. In addition, BBI frequently processes data requests from several federal, state, and county government organizations.

In 2017, BBI processed the following requests:

1,520 data requests which consisted of Medicaid FFS and managed care data extraction and analysis in support of:

- DMA and DMI activities;
- System Match audits;
- CMS Payment Error Rate Measurement audit;
- CMS Healthcare Fraud Prevention Partnership Data Analysis and Review Committee (DARC);
- Office of the State Comptroller audits;
- U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) audits;
- Unified Program Integrity Contractor (UPIC) Audits;
- United States Department of Justice;
- District Attorney's Offices;
- Federal Bureau of Investigations (FBI); and
- Self-disclosure reviews.

163 statistical samples created for DMA audits and DMI investigations, including:

- County Demonstration audits;
- UPIC audits;
- Self-disclosure reviews;
- Medicaid Electronic Health Record Incentive Program audits; and
- Dental Provider reviews.

Positive Provider Reports

During the audit process, there are instances when OMIG determines that, for the audit period and objective reviewed, the provider has generally adhered to applicable Medicaid billing rules and regulations. In these cases, 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. These reports are also listed on the OMIG website as "Positive Reports."

Audit Summations	
Audit Department	2017
County Demonstration Program	10
Managed Care	5
Medicaid in Education	7
Provider	239
Rate	224
Total	485

Third-Party Liability

Medicaid is the payor of last resort; however, there are instances when Medicaid payments are made on claims for which third-party liability was not known at the time of service or Medicaid billing. OMIG recovered Medicaid overpayments for both FFS and managed care encounter claims. Recoveries were made from various third parties, including providers, commercial insurance carriers, Medicare, casualty settlements, and the estates of deceased Medicaid beneficiaries.

Medicaid Recovery Audit Contractor

Health Management Systems (HMS), the NYS Medicaid Recovery Audit Contractor (RAC), reviews claims that providers submit for services rendered to Medicaid beneficiaries, either through FFS or managed care, and identifies overpayments. HMS continued its reviews of long-term care facilities, assuring that proper patient liability amounts were used in Medicaid payment calculations, that other payor responsibilities were exhausted, and that service days reimbursed were appropriate. Throughout 2017, HMS had several successful reviews that utilized reverse engineering reviews. In reverse engineering, the cause of an overpayment is identified and then applied to a statewide algorithm based on policy and data to additional providers who may have made the same error. Examples include the duplicate comprehensive psychiatric emergency program (CPEP), CPEP inpatient overlap, intensive rehabilitation add-on, and intensity modulated radiotherapy unbundling. OMIG continues to facilitate the exchange of Medicare data with the CMS UPIC contractor to enhance the RAC's ability to identify potential overpayments that would likely not be identified by reviewing Medicaid claims data alone. In 2017, the RAC recovered more than $23.8 million in Medicaid overpayments.

2017 Third-Party Liability and RAC Recoveries		
Activity Area	**Amount**	
Third-Party Liability	**$**	**80,050,348**
Casualty & Estate		**97,015,027**
Recovery Audit Contractor		**23,897,090**
Home Health Care Demonstration Project		**3,644,274**
Self-Disclosed TP Health Insurance		**909,494**
Total	**$**	**205,516,233**

Investigations

OMIG investigates allegations of fraud and abuse within the Medicaid program. Enrolled and non-enrolled providers, entities, and recipients can all potentially be subjects of an investigation. Allegations are analyzed utilizing a variety of methods, including but not limited to, data mining, undercover operations, analyses of returned Explanation of Medicaid Benefits (EOMB) letters, and interviews of complainants and subjects. Investigations can lead to administrative actions, sanctions, and cash recoveries. Below are examples of OMIG's investigative activities.

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	278	325	151	157	2	1	431	483
Enrolled Recipient	70	74	31	29	7	5	108	108
Federal Agencies	91	89	6	8	1	3	98	100
Fiscal Agent Fraud Unit	9	6	1	0	0	0	10	6
General Public	228	239	154	154	3	3	385	396
Law Enforcement	0	3	0	0	0	0	0	3
Local Departments of Social Services	36	19	86	72	0	0	122	91
Managed Care Plans	317	315	180	109	34	35	531	459
Managed Long Term Care Plans	25	4	11	0	0	0	36	4
Non-Enrolled Provider	4	9	2	9	0	1	6	19
Non-Enrolled Recipient	9	7	8	6	0	0	17	13
Provider	69	92	64	68	3	6	136	166
State Agencies (including OMIG)	922	930	377	265	94	47	1,393	1,242
Total	2,058	2,112	1,071	877	144	101	3,273	3,090

OMIG Plays Critical Role in Multi-Agency Takedown of Massive $146M Health Care Fraud Scheme

OMIG assisted its partners in law enforcement to uncover a massive $146 million Medicaid and Medicare fraud, corruption, and money-laundering scheme that had been operating for more than three years out of Brooklyn. The details of the case and related arrests were announced at a December 5, 2017 joint press conference at the Brooklyn District Attorney's (DA's) office.

OMIG's investigative team in NYC assisted investigators and prosecutors from the Brooklyn DA's Office as well as HHS-OIG, NYC HRA's Office of Medicaid Provider Fraud and Abuse Investigation, DOH, NYS Department of Financial Services, the NYS Police, and the NYC Police Department (NYPD).

The multi-agency effort exposed an extensive, highly sophisticated network of physicians, clinic managers, recruiters, and others who are alleged to have conspired to fraudulently bill Medicare and Medicaid for thousands of unnecessary medical tests and services. Ultimately, 34 defendants – 20 individuals and 14 corporations, including four doctors (one, an NYPD surgeon) – were named in an 878-count indictment.

* Investigations completed may represent cases opened in prior periods.

At the press conference Medicaid Inspector General Dennis Rosen said, "This collaborative investigation and resulting indictment send an unmistakable message to those who seek personal gain by preying upon vulnerable New Yorkers and exploiting the Medicaid program: 'you will be identified and held fully accountable.' My office will continue to work closely with our partners in the Brooklyn District Attorney's Office, U.S. Health and Human Services Office of the Inspector General, NYC Human Resources Administration, NYS Department of Health, and other state and federal agencies to protect Medicaid recipients and save taxpayer dollars by rooting out fraud, waste and abuse in the Medicaid program."

Key elements of OMIG's support in this case included real-time, language-translation assistance during wiretapped phone conversations, as well as the use of data analytics and analyses to help identify fraudulent billing practices.

National Health Care Fraud Takedown

As a result of a Medicare Fraud Strike Force takedown in July 2017, ten individuals - including three doctors, a chiropractor, three licensed physical therapists, an occupational therapist, and two medical company owners - were charged for their alleged participation in multiple schemes that fraudulently billed the Medicare and Medicaid programs more than $125 million. These schemes, which took place in multiple NYC boroughs, included money laundering, falsifying millions of Medicaid claims for services that were not medically necessary or not rendered, and paying illegal bribes and kickbacks to patients to receive medically unnecessary services and diagnostic tests. OMIG provided claim and payment data as well as analysis that showed a network of Medicaid providers engaging in an extensive scheme that involved the payment of kickbacks for referrals of patients to their clinics who, in turn, subjected themselves to purported physical and occupational therapy and other services. Several of the indicted subjects, patients, and witnesses spoke Russian, OMIG staff assisted with interviews and language-translation.

OMIG Assists in $2.1 Million Medicaid and Medicare Fraud Scheme Takedown

Two managers of a Brooklyn-based occupational therapy medical clinic were charged in an indictment unsealed February 15, 2017 with allegedly partaking in a $2.1 million Medicaid and Medicare fraud and kickback scheme. OMIG's investigative team worked closely with the Department of Justice, HHS-OIG and the Internal Revenue Service Criminal Investigation (IRS-CI) throughout the investigation.

One manager was charged with one count of conspiracy to commit health care fraud, one count of conspiracy to commit money laundering, and three counts of money laundering. The second manager was charged with one count of conspiracy to commit money laundering and three counts of money laundering. Both indictments were filed in the Eastern District of New York.

Federal prosecutors charge in the indictment that through the Brooklyn-based occupational therapy services medical clinic the defendants paid patients to submit themselves to medically unnecessary therapy services provided by unlicensed aides. Prosecutors also allege that in order to conceal their

scheme the owners laundered the profits through shell companies using a skeleton crew of licensed occupational therapists that fabricated medical charts. The pair used ill-gotten cash to enrich themselves and to pay kickbacks to the beneficiaries.

OMIG assisted HHS-OIG and IRS-CI to investigate the case, which was brought as part of the Medicare Fraud Strike Force, under the supervision of the Criminal Division's Fraud Section and the U.S. Attorney's Office for the Eastern District of New York.

Patient Recruiting Investigation

On December 3, 2014, arrests and search warrants were executed pursuant to the unsealing of a Federal indictment obtained in the Southern District of New York. The indictment charged the ten individuals, involved in a $70 million health scheme, with conspiracy to commit health care fraud, wire fraud, and mail fraud, in addition to charging three of the ten with counts of Money Laundering. The scheme involved the operation of three clinics in Brooklyn and Queens where disadvantaged and homeless people insured by Medicaid and/or Medicare were recruited to undergo unnecessary medical tests, frequently performed by unlicensed personnel, in exchange for cash. Patient recruiters would locate these individuals in soup kitchens and local welfare offices, and then coach them on what to say on various medical forms, to make the procedures appear medically necessary. Medicaid and Medicare were then billed for these procedures. The clinic owners also enlisted a licensed physician to act as the nominal owner and/or physician to conceal their ownership, which goes against NYS law. Throughout the course of this investigation, OMIG assisted the law enforcement agencies by conducting surveillance, assisting in witness interviews, providing Medicaid data, and participating in the execution of search warrants.

The former owner of one of the three clinics implicated in this scheme, was sentenced to a prison term of 60 months and ordered to pay approximately $8 million in forfeiture and restitution. On August 13, 2016, the owner pleaded guilty to conspiracy to commit wire fraud, mail fraud, and health care fraud.

After pleading guilty to one count of conspiracy to commit wire fraud, mail fraud, and health care fraud, two other owners were sentenced. One owner was sentenced to imprisonment for 60 months, and supervised release for three years. The other owner was sentenced on May 19, 2017 to imprisonment for 40 months and supervised release for three years. They were both ordered to pay restitution of more than $13.7 million.

The physician of record for the health care clinics located in Queens and Brooklyn, falsely represented that he personally screened and conducted medical tests on patients at the three clinics, when in fact he was not present at two of them. The physician was sentenced to one month’s imprisonment and ordered to pay approximately $26 million in restitution, of which more than $15 million is to be paid to Medicaid.

The manager of the health care clinics located in Queens, involved in the payment of kickbacks to underprivileged individuals in exchange for their receipt of medically unnecessary services, was sentenced to 34 months imprisonment and ordered to pay approximately $13 million in restitution, of which more than $9.9 million is to be paid to Medicaid.

A nuclear medical technician at a diagnostic medical clinic in Jackson Heights, Queens, one of three clinics implicated in the scheme, was sentenced to a prison term of 18 months and ordered to pay approximately $3.6 million in restitution, of which more than $2.6 million is to be paid to Medicaid.

One of the patient recruiters was sentenced to a prison term of 24 months and ordered to pay approximately $5.6 million in restitution, of which more than $2.7 million is to be paid to Medicaid. Another patient recruiter, who had been remanded, was sentenced to time served, and ordered to attend an outpatient drug treatment program and pay approximately $3.9 million in restitution, of which more than $2.9 is to be paid to Medicaid. A third patient recruiter was sentenced to three years of probation with six months of home detention, and ordered to pay approximately $3.3 million in restitution, of which more than $2.4 million is to be paid to Medicaid.

All the individuals who were sentenced as a result of this investigation were excluded by OMIG from the NYS Medicaid program.

Home Care Referrals to MFCU

OMIG investigated allegations of fraud relating to home care. In one case, it was alleged a home health aide was providing CDPAP services and submitting documents stating she provided home health care to her mother, while her mother was out of the country. OMIG obtained passport documents, and the investigation verified that the home health aide did submit time sheets for a time period when the recipient was out of the country. OMIG referred the subject to MFCU for prosecution. The home health aide pleaded guilty in Orange County Court on March 9, 2017 to Grand Larceny in the 4th Degree, a class E Felony. On May 19, 2017, the home health aide was sentenced to five years of probation and 300 hours of community service, and had already repaid $75,812 in restitution to the Medicaid program.

In another case, OMIG received an anonymous complaint indicating that the mother of a recipient had enlisted her boyfriend as a PCA through Maxim of New York (Maxim) for her son, who is a Medicaid recipient. The anonymous complainant further indicated that the mother and her boyfriend were submitting false times sheets to Maxim indicating that her boyfriend was providing PCA services to her son when in fact he was not.

After OMIG determined that the recipient was participating in the CDPAP, and Maxim was billing the Medicaid program for PCA services, OMIG referred the matter to MFCU. MFCU ascertained that the PCA, who was a parolee, was wearing a GPS ankle monitoring device in accordance with his parole restrictions. Times and locations from the tracking device were compared against timesheets submitted to Maxim, showing that the PCA was not at the recipient's home providing services as reported, causing Maxim to inappropriately bill the Medicaid program for 251 hours of PCA services. On November 9, 2017, the Attorney General's office announced the sentencing of the PCA to one and a half to three years in state prison for stealing from and defrauding the Medicaid program.

Recipient Investigations

OMIG referred and coordinated the investigation with the Westchester County Police Department relating to a complaint alleging that a recipient's Medicaid card was presented to fill a forged prescription for Oxycodone. OMIG obtained a copy of the forged prescription and received verification documentation from the prescriber that the prescription was a forgery. On May 16, 2017, the Westchester County Police Department charged the recipient with three counts of Criminal Possession of a Forged Instrument in the 2nd degree in violation of NYS Penal Law 170.25, a class D felony.

Program Integrity Referrals to MFCU and Other Agencies

OMIG is required by law to refer suspected fraud and criminality to MFCU. OMIG also refers its findings to numerous other agencies including those responsible for oversight of professional licensure, specifically, the NYSED's Office of Professional Discipline (OPD) and DOH's Office of Professional Medical Conduct (OPMC). OPD and OPMC may take administrative action on individuals who hold professional licenses.

Referrals to MFCU	
Provider Type	2017
Billing Service Group/EMEVS	2
Capitation Provider	3
Consumer Directed Aide	2
Diagnostic and Treatment Center	5
Enrolled Provider	5
Enrolled Recipient	10
Home Health Agency	13
Home Health Aide	2
Hospital	1
Laboratory	1
Managed Long Term Care	2
Medical Appliance Dealer	1
Multi-Type	4
Multi-Type Group	10
Non-Enrolled Provider	68
Nurse	7
Optician	5
Optometrist	3
Personal Care Aide	1
Pharmacy	50
Physician	48
Physicians Group	17
Podiatrist	1
Service Bureau	4
Social Adult Day Care	3
Therapist	3
Therapist Group	2
Transportation	14
Total	287

Referrals to Other Agencies	
Agency	2017
AG - Not MFCU	3
CMS - UPIC	34
Law Enforcement Agency	114
Local Departments of Social Services	47
Local District Attorney	4
NYC Department of Buildings	1
NYC Department of Health	2
NYC HRA Bureau of Client Fraud Investigations	154
NYC Office of the Special Narcotics Prosecutor	8
NYS Bureau of Narcotic Enforcement	12
NYS Department of Environmental Conservation	4
NYS Department of Financial Services	1
NYS Department of Health	99
NYS Department of Justice	4
NYS DOH Office of Professional Medical Conduct	12
NYS Education Department – Not Professional Discipline	23
NYS Education Department – Office of Professional Discipline	89
Office for People with Developmental Disabilities	3
Out of State	1
US Health and Human Services (HHS-OIG)	14
Total	629

2017 Recoveries

The recoveries outlined in the chart below include OMIG's audits and investigations, third-party payments recovered from other insurers, Medicaid RAC activities, and estate and casualty recovery projects. The recoveries represent both the Federal and State share of funds and equal the actual dollars recouped by OMIG. The recoveries reflect cash deposits and voids resulting from OMIG and contractor audits, less any refunds paid to providers.

2017 Recoveries	
Activity Area	**Amount**
Third-Party Liability	$ 80,050,348
Managed Care	129,060,599
Casualty & Estate	97,015,027
Provider	86,030,861
Recovery Audit Contractor	23,897,090
Rate	49,038,586
Home Health Care Demonstration Project	3,644,274
Self-Disclosure	24,510,618
System Match Recovery	3,785,916
Investigation Financial Activities	761,342
County Demonstration Program	2,728,202
Self-Disclosed TP Health Insurance	909,494
Medicaid in Education	70,264
Total	$ 501,502,621

Cost Savings

Cost savings activities prevent inappropriate, duplicate, or erroneous Medicaid payments from being made. OMIG's cost savings are calculated as estimates based on historical and current Medicaid claims data. Cost savings amounts are not monetary recoveries. Cost savings initiatives are intended to save taxpayer dollars proactively and protect the integrity of the Medicaid program. 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 improper Medicaid payments from being made; those denied claims represent cost savings. In another example, when OMIG has an interaction with a provider, the agency will subsequently compare billing patterns prior to the interaction with those after to determine the cost savings attributable to OMIG's actions.

OMIG utilizes an internal workgroup of cross-divisional staff to develop, review, and approve its cost savings methodologies. This team reviews all cost savings initiatives on an ongoing basis to identify and assess variations in the savings amounts reported. Variations can occur naturally over time for any of OMIG's initiatives, and the workgroup ensures that methodologies are being reviewed on a timely basis, and updated as needed.

Throughout 2017, OMIG saved NYS taxpayers more than $2.1 billion as a result of these proactive efforts. Some examples of these activities are outlined below.

Pre-Payment Insurance Verification

OMIG's third-party liability vendor, HMS, obtains rosters of insured individuals from insurance carriers across the country. HMS matches this identified coverage against Medicaid beneficiaries enrolled in NYS to identify those beneficiaries who have additional insurance coverage. Once identified, this information is added to eMedNY so that medical services are first billed to the other insurance, establishing Medicaid as the payor of last resort. This pre-payment insurance verification resulted in cost savings of over $1.9 billion in 2017.

Enrollment Screening Activities

In coordination with OHIP's Provider Enrollment Unit, OMIG performs secondary reviews of enrollment applications determined to require additional evaluation based on specific categories of service, or high-risk providers that require additional scrutiny, and determines an appropriate course of action. OMIG's Enrollment and Reinstatement Unit (EAR) also assists OHIP in coordinating and conducting on-site visits of enrolled Medicaid providers that are in the process of revalidating their enrollment.

In 2017, EAR reviewed 1,394 new enrollment and reinstatement applications. These reviews resulted in 256 applications being denied, the cost savings associated with these denials was more than $34 million. Below are examples of enrollment denials:

Pharmacy Enrollment Denials

OMIG staff conducted an on-site inspection of a pharmacy located in the Bronx, that applied for enrollment in the NYS Medicaid program, and found eleven expired medications in the inventory. The pharmacy also did not have hot running water in the dispensing area and was not equipped with the proper graduates as required by the Board of Pharmacy. Violations of Board of Pharmacy regulations are cause for denial of Medicaid enrollment, and the pharmacy's application for enrollment was denied.

During an on-site inspection of a different pharmacy seeking to enroll in the NYS Medicaid program, OMIG staff found that the pharmacy had ten expired medications on the shelves and had a refrigerator with temperatures that were warmer than those required by Board of Pharmacy regulations. Due to these violations and the pharmacy's inability to provide safe, high-quality care to recipients, the pharmacy's application for enrollment was denied.

Dental Group Enrollment Denial

During the on-site inspection of a dental group located in Queens, that applied for enrollment in the NYS Medicaid program, OMIG staff found that the group failed to have proper spore testing conducted to assure that the autoclave was properly sterilizing dental instruments. The failure by the group to conduct testing required by state regulations is a potential safety hazard, and was cause for denial.

2017 Cost Savings Activities	
Activity Area	**Amount**
Clinic License Verification	$ 1,680,779
Corporate Integrity Agreement Sentinel Effect	2,025,090
Dental Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	1,144,495
Duplicate Claim included in Inpatient Coverage – Edit 760	272,705
Enrollment and Reinstatement Denials	34,381,847
Exclusions/Terminations – Internal	7,511,831
Exclusions/Terminations – External	7,791,732
Managed Care Locator Code	8,867,281
Medical Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	1,110,738
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	26,809,139
Ordering Provider Excluded Prior to Order Date – Edit 939	1,303,300
Ordering/Referring Provider Number Missing – Edit 903	790,125
Order/Servicing/Referring Provider Number Verification – Edit 1236/1238	1,022,436
Pharmacies License Verification	2,467,443
Pre-Payment Insurance Verification Commercial	1,494,323,892
Pre-Payment Insurance Verification Medicare	418,344,948
Pre-Payment Review Sentinel Effect – Edit 1141	2,758,916
Prescription Serial Number Missing, Lost, Stolen, Altered	10,182,954
Provider ID/Service ID are the same – Edit 1357	306,444
Recipient Medicaid MC Benefits - Case Closures for False Information	339,843
Recipient Restriction	94,038,001
Service Date prior to Birth Date – Edit 102	261,969
Transportations Claims-Modifier Invalid for Submitted Procedure Code – Edit 927	970,899
Transportation Claims-Procedure Code Modifier Missing – Edit 1344	4,125
Transportation Service Billed for During Inpatient Stay – Edit 02062	11,094
Total	**$ 2,118,722,025**

Compliance Initiatives

Medicaid providers with compliance programs are better positioned to identify, correct, and prevent billing mistakes and fraud. NYS Social Services Law §363-d and 18 NYCRR Part 521 (Part 521) establish New York's requirements for what must be included in compliance programs. Medicaid providers who must maintain an effective compliance program are those who are subject to the provisions of Public Health Law Article 28 or 36; or those who are subject to the provisions of Mental Hygiene Law Article 16 or 31; or those for whom Medicaid is a substantial portion of their business operations. What constitutes a substantial portion of business operations is if the Medicaid provider claims, orders, receives payment, or submits bills for others for Medicaid care, services, or supplies in an amount of at least $500,000 in any consecutive 12-month period.

The Deficit Reduction Act of 2005 (DRA) instituted a requirement for health care entities receiving or making $5 million or more in direct Medicaid payments during any FFY to establish written policies and procedures informing their employees, contractors, and agents about federal and state False Claims Acts and whistleblower protections. If an entity furnishes items or services at more than a single location, under more than one contractual or other payment arrangement, or uses more than one provider or tax identification number, the aggregate of all payments to that entity is used to determine if the entity reached the $5 million annual threshold. Direct Medicaid payments involve payment directly by New York's Medicaid program to the payee.

Certification and Review

Part 521 requires Medicaid providers subject to NYS's mandatory compliance program obligation to certify that they have a compliance program in place that meets the requirements of Part 521. The certification is required at the time of enrollment into the Medicaid program and a subsequent annual certification is required each December. The certification is a self-reporting requirement that is used by OMIG to help identify Medicaid providers who may not be meeting the mandatory compliance program obligation.

Annually OMIG develops a universe of providers who are subject to the mandatory compliance program obligation. The universe includes FFS and MCO supplied encounter data. It should be noted that the mandatory compliance program and the certification obligations apply to MCOs, as well as those that are direct providers of Medicaid care, services, or supplies. In 2017, OMIG issued two notices of agency action for failure to meet the compliance certification obligation. This was the first time an enforcement action was taken for such failures.

There is also an annual certification requirement for those providers who are subject to the DRA obligation. The DRA certification is to be completed in December each year and it applies based upon payments received by the Medicaid provider during the FFY that ended immediately prior to December. OMIG manages the DRA certification process by making a DRA Certification form available on OMIG's website. Medicaid direct payment data is used to establish the universe of providers who must annually complete a DRA Certification.

Compliance Program Reviews

OMIG conducts compliance program reviews of Medicaid providers subject to the mandatory compliance program obligation. These reviews include compliance program assessments of MCOs, as well as providers of Medicaid care, services, or supplies. The desk review and on-site review process gives providers and OMIG an opportunity to discuss what specific

requirements are not being met, and guidance is provided either through direct conversations or through reference to resources posted on OMIG's website. OMIG conducts follow-up reviews of providers' compliance programs when OMIG determines, on an initial review, that providers' compliance programs fail to meet a significant number of requirements. The compliance unit referred six providers to DMI due to significant insufficiencies identified during the compliance program review process.

Corporate Integrity Agreements

Corporate Integrity Agreements (CIA) are monitoring agreements entered into with Medicaid providers who have been determined to have engaged in one or more unacceptable practices that would otherwise warrant exclusion as a provider in New York's Medicaid program. CIAs are for a five-year term and involve a heightened level of monitoring by OMIG. A large part of the monitoring of providers under a CIA is conducted by an Independent Review Organization (IRO). The IRO is engaged by the provider, at the provider's expense, and with OMIG's approval, to report on specific areas related to the unacceptable practice that gave rise to the need for a CIA, as well as other issues specified in the CIA. Additionally, the CIA establishes significant additional reporting requirements for a provider beyond the typical reporting required of all Medicaid providers.

Failure to meet any term of the CIA, including a reporting requirement, can result in OMIG determining that a breach of the CIA has occurred for which OMIG can assess penalties. In 2017, OMIG received $25,000 in payments for penalties assessed due to breaches of CIAs. If OMIG determines that the provider materially breached the CIA, the CIA can be terminated and the provider can be excluded.

Education and Outreach

Since 2010, OMIG has taken extensive steps to educate and provide tools to providers subject to the mandatory compliance program and certification obligations so that they know what is expected and can develop effective compliance programs. In 2017, OMIG provided 14 compliance-related presentations and webinars that addressed specific questions raised by those subject to the compliance obligation, and focused much attention on the *Compliance Program Review Guidance* that was published by OMIG in 2016. The education programs were supplemented by compliance publications on OMIG's website and in the *Medicaid Updates* posted on DOH's website.

OMIG's outreach activities went beyond presentations at educational programs and conferences. OMIG received over 1,150 telephone calls and 325 email contacts to its dedicated compliance phone lines and compliance email box, respectively, where providers asked more specific questions about the compliance requirements and how they may relate to their compliance programs.

In an attempt to accomplish provider specific notice and reminders of their compliance and certification requirements, OMIG mailed more than 1,100 letters and sent more than 9,500 email reminding providers of the December 2017 certification obligation. All outreach was initiated to maximize notice of the compliance and certification obligations and to provide notice of compliance resources that are available to help providers meet those obligations. OMIG's website includes a compliance tab that includes links to forms, guidance, alerts, and other resources. During 2017, there were nearly 100,000 hits on the compliance tab.

Collaborative Activities

Collaboration with St. Lawrence County Drug Task Force

While OMIG has extensive administrative powers, investigators work collaboratively with local, state, and federal law enforcement to seek punitive action against recipients who have committed fraud against the Medicaid program. On May 31, 2017, OMIG staff met with the St. Lawrence County Drug Task Force to discuss ongoing investigations. The task force consists of law enforcement from multiple city police departments in the county, the County Sheriff's Office, State Police, Drug Enforcement Administration, and Homeland Security. OMIG began working with the task force following the arrests of Medicaid recipients for illegal distribution of prescription medications that involved Medicaid recipients.

OMIG discussed their findings related to upstate recipients travelling to NYC to obtain Buprenorphine prescriptions, a drug used to treat opioid addiction, and discussed OMIG's investigative efforts related to opioid prescriptions and the prescribers. Specific recipient targets were also discussed and investigative plans were coordinated to prevent duplication. OMIG and the St. Lawrence County Task Force continue to work together on this initiative.

Pre-Payment Reviews Lead to Investigation Referrals

Medical and dental pre-payment review (PPR) staff continue to have several successful collaborations within OMIG, including an ongoing transportation project with DMI. Staff meet periodically to discuss joint cases and providers of concern for transportation services. As a result of these meetings, DMI referred nine transportation providers for pre-payment claims review. PPR staff referred eight private duty nursing providers to DMI for further investigation. PPR and DMI also collaborate to monitor providers with limited enrollments to ensure providers submit only those claims allowed under the limited enrollment agreement, and monitor billings for providers slated for exclusion until the enrollment status change is processed. This was initiated to prevent payments from being made to excluded providers. PPR staff referred four individual dentists along with two dental groups to DMI for further investigation. PPR staff also assisted DMI staff on multiple site visits. Additionally, PPR staff works joint cases with external entities including MFCU, CMS, SGS, General Dynamics Information Technology, and OHIP. PPR staff also work closely with DOH policy staff and statewide stakeholder associations as needed.

Encounter Reimbursement Process

In recent years, several situations of duplicate or overlapping Medicaid payments made on behalf of Medicaid managed care enrollees had been identified during audits. This includes situations where the enrollee is in foster care, has multiple CINs, is retroactively enrolled, or where the enrollee has permanent residency in an institution and is not eligible for managed care. In these scenarios, OMIG would not be able to recover the capitation payment due to encounter payments made by the MCO. OMIG and DOH worked jointly to address the issue; and in May 2017, OMIG and DOH finalized and announced the CMS approved Encounter Reimbursement Process. This new process gives OMIG the ability to recover capitation payments that were paid for an enrollee in specific scenarios, inclusive of months with encounters. DOH will then reimburse the MCO for the cost of services rendered. The announcement of the finalized process allowed OMIG to issue a number of final audit reports that had been on hold.

OMIG Collaboration Regarding Transportation

Claims for Medicaid ambulette services require a driver's license to be entered on the Medicaid claim for the driver who transported the Medicaid recipient on the date of service. For transportation providers to receive payment, drivers must be authorized and certified by the NYS Department of Motor Vehicles (DMV) under 19-A of the NYS Vehicle and Traffic Law, which requires a special class license, a clean driving record, an annual physical, and an annual road test to maintain the 19-A qualification. OMIG staff collaborated with DMV to gain access to the data for 19-A qualified driver records. OMIG staff used the information from DMV and created a database of 19-A qualified/disqualified driver information. This database is used to match against paid Medicaid claims data for ambulette services and will be used for future transportation projects.

Healthcare Fraud Prevention Partnership

In April 2017, OMIG staff attended the Healthcare Fraud Prevention Partnership (HFPP) information sharing meeting at the Medicaid Integrity Institute in South Carolina. The HFPP is a voluntary, public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations to identify and reduce fraud, waste, and abuse across the healthcare sector. HFPP partners regularly collaborate, share information and data, and conduct cross-payer studies to achieve these objectives. Much of the April sharing session focused on current investigations being conducted by health plans. However, HHS-OIG gave a presentation related to their efforts to investigate opioid related cases followed by a presentation by the FBI. This presentation consisted of a briefing on an opioid conviction from start to finish and what is needed to prove the crime for prosecution. The HFPP also conducts in-depth studies using data from other states and insurance companies to identify trends and patterns that should be investigated. This information was also shared at this session. In attendance were Federal and State program integrity representatives, as well as representatives from some of the major managed care plans from across the country. The HHS-OIG as well as the FBI gave presentations related to healthcare fraud investigations and initiatives. After the presentations, small breakout groups discussed ongoing investigations, trends, and ideas with the whole group. Other states and OMIG shared best practices relating to opioid investigations and identifying targets through recipient data and RRP successes. Many of the trends had been identified by other managed care plans, and the breakout groups facilitated the sharing of the various methods used to achieve positive outcomes in investigations.

New York Welfare Fraud Investigators Association Conference

In June 2017, OMIG staff attended the 34th Annual New York Welfare Fraud Investigators Association Training Conference. The conference had 240 participants representing LDSS staff, law enforcement agencies, district attorney offices, and other state agencies that oversee benefit programs. Breakout and general sessions were conducted, covering regulatory changes, current fraud trends, and techniques designed to detect and investigate welfare fraud. OMIG staff spoke about its efforts in investigating Medicaid eligibility fraud and discussed trends that had been discovered through investigations.

Recipient Investigations Unit Collaboration with LDSS Offices

During 2017, the Recipient Investigations Unit facilitated meetings with LDSS offices to discuss ongoing investigative activities and the RRP. The meetings included the investigations units and Medicaid personnel to discuss and review the referral process, and resolve outstanding OMIG fraud allegation complaints. The meetings also provided LDSS staff with a RRP overview and administrative training to those assigned to RRP functions. An updated RRP resource file is used that identifies and describes each step of the local district implementation process. Specific cases for each RRP district function (FFS, Managed Care, and NYSoH) were used to demonstrate the step-by-step enrollee and provider notification process.

2017 visits were as follows:

- January - Broome County
- February - Erie County, Cayuga County, and Westchester County
- March - Onondaga County
- May - Greene County
- June - Clinton County
- August - Franklin County and Hamilton County
- September - Albany County and Steuben County
- October - NYC HRA, Courtland County, Wayne County, Orleans County, Chautauqua County, and Allegany County
- November - St. Lawrence County

Administrative Actions

Sanctions – Exclusions

Sanctions that can be imposed on a provider by OMIG include censure, exclusion, or conditional or limited participation in the Medicaid program (18 NYCRR §515). In 2017, OMIG conducted investigations and imposed administrative actions based upon:

- Investigations, audits, or reviews that identified unacceptable practices as defined by 18 NYCRR § 515.2 and/or determined that the provider represented an imminent danger to the public health or welfare;
- NYSED actions, such as license surrender, suspension, or revocation, for Medicaid and non-Medicaid providers;
- Actions taken by DOH's OPMC involving professional misconduct and physician disciplinary actions, including suspensions, revocations, surrenders, and consent agreements;
- Felony indictments and convictions of crimes relating to the furnishing or billing for medical care, services, or supplies;
- Federal HHS-OIG exclusion actions; and/or
- Ownership information and affiliations of excluded providers.

OMIG issued 990 exclusions and 175 censures in 2017. The NYS Medicaid Exclusion List contains 6,681 Medicaid and non-Medicaid provider exclusions. This list is updated daily (except holidays and weekends) and is available to the public on OMIG's website, www.omig.ny.gov.

Exclusions	
Reasons for Exclusions	Number of Actions
Affiliations – 18 NYCRR 504.1(d)(1)	90
Unacceptable Practice – 18 NYCRR 515.2	16
Indictments – 18 NYCRR 515.7(b)	163
Convictions – 18 NYCRR 515.7(c)	232
Imminent Danger – 18 NYCRR 515.7(d)	4
Professional Misconduct – 18 NYCRR 515.7(e)	155
Mandatory Exclusion – 18 NYCRR 515.8	330
Grand Total	990

Conclusion

OMIG appreciates the opportunity to share the results of its Medicaid program integrity activities for 2017. Across all sectors of the Medicaid program, OMIG's provider education and outreach programs, coupled with its comprehensive investigative efforts and success in identifying and recovering inappropriate Medicaid payments, play a vital role in preventing and detecting Medicaid fraud and abuse, while promoting the delivery of high-quality care to millions of New Yorkers. OMIG's commitment to preventing, detecting, and rooting out fraud and abuse in the Medicaid program remains unwavering.

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