New York State
Office of the Medicaid Inspector General

Annual Report
Calendar Year 2011

Andrew M. Cuomo
Governor

James C. Cox
Medicaid Inspector General

Fighting Fraud. Improving Integrity and Quality. Saving Taxpayer Dollars

STATE OF NEW YORK

OFFICE OF THE MEDICAID INSPECTOR GENERAL

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In 2006, New York demonstrated its commitment to fighting fraud through the establishment of the Office of the Medicaid Inspector General (OMIG) as an independent entity within the Department of Health. The intent behind OMIG's creation was to coordinate fraud and abuse detection activities among various state agencies, as well as other entities that play a vital role in the Medicaid program. This Annual Report is OMIG's chance to brief government leaders and the public about the outcomes of our efforts to safeguard the Medicaid program.

One thing we have discovered is that the right approach to protecting Medicaid from fraud and abuse requires accuracy, precision, and transparency. Over the last year, New York State implemented Medicaid program reforms that will change the system from a largely fee-for-service program to one that focuses on managed care. Efficiently fighting Medicaid fraud is essential in order to support the State's goal to contain taxpayer costs, while improving health care access and quality.

We do believe that, by working with providers, managed care plans, beneficiaries, policymakers, and law enforcement, we will continue to make great strides in protecting the Medicaid program for those who need it.

Sincerely,

James C. Cox
Medicaid Inspector General

Executive Summary

In 2011, New York State (NYS) achieved significant results in several areas of Medicaid program integrity. Some of the highlights include:

- **Avoiding over $2.5 billion in costs –** OMIG succeeded in avoiding inappropriate costs of $2.5 billion through various initiatives, including the restricted recipient program, pre-payment reviews and use of card swipe terminals at points of service (e.g., pharmacies, transportation providers, etc.).

- **Identifying more than $220 million in inappropriate payments –** OMIG identified $220,494,749 in improperly expended Medicaid payments.

- **Collaborating with other agencies –** OMIG worked with the NYS Attorney General's Medicaid Fraud Control Unit (MFCU) and other local, state, and federal agencies on the Medicare Fraud Strike Force led by the United States Department of Justice (DOJ). These efforts led to 14 arrests, two complaints, and four indictments of individuals alleged to have committed health care fraud against the Medicare and/or Medicaid programs. This work also led to improvements in coordination with state agency partners.

- **Ending program participation for more than 700 providers who placed beneficiaries or the program at risk –** OMIG excluded 766 providers from participating in the Medicaid program. These providers can no longer work in Medicaid-funded positions in health care-oriented businesses and organizations. OMIG also referred 87 providers to the NYS Attorney General for potential criminal prosecution.

- **Improving review processes by better understanding the Medicaid program –** OMIG developed a working group comprised of representatives of provider and consumer groups, as well as other state agency partners, to discuss Medicaid program issues and to discuss policies and procedures related to OMIG audits and investigations. OMIG also started work with regulating agencies to ensure a better understanding of Medicaid regulations and guidelines and to develop audit protocols that clarify audit criteria for providers of Medicaid services.

- **Assisting Providers with Compliance Issues –** OMIG's Bureau of Compliance's (BoC), first created in 2010, continued its work to develop and refine its process to monitor and assess providers' success in meeting their mandatory compliance obligations. As the BoC developed new assessment processes and forms, they were shared with the provider community through publication on OMIG's website and during various presentations provided across the State. In order to facilitate provider outreach and the BoC's response to provider and public questions, OMIG initiated a bureau-dedicated e-mail box (compliance@omig.ny.gov). Interaction with the MFCU and the United States Department of Health and Human Services Office of the Inspector General (HHS OIG) on providers who would benefit from an OMIG Corporate Integrity Agreement (CIA) has been positive.

- **Conducting Provider Education –** OMIG held 10 webinars during 2011 with more than 6,500 registrants. OMIG also improved its outreach and coordination with providers regarding changes in federal health care law as it pertains to payment suspensions and credible allegations of fraud, as well as mandatory compliance program obligations.

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OMIG Background

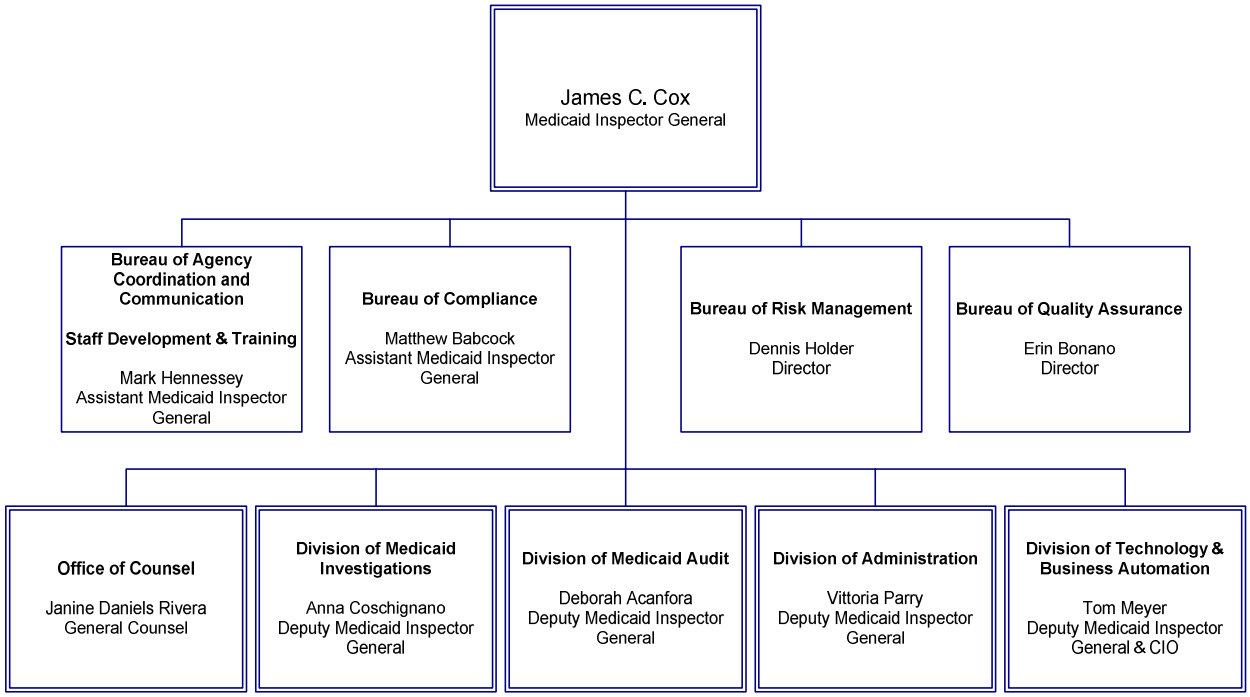
On July 26, 2006, Chapter 442 of the Laws of 2006 was enacted, establishing OMIG as a formal state agency. The legislation amended the Executive, Social Services, Insurance and Penal laws to create OMIG and institute the reforms needed to effectively fight fraud, waste, and abuse in the State's Medicaid system. 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 NYS 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. OMIG's mission requires that the agency perform 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 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.

OMIG Organizational Chart



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.

Executive Initiatives

OMIG Working Group

In order to improve agency operations, OMIG analyzed overall program integrity efforts, agency work products and standards. As part of this process, the Medicaid Inspector General spent time working with individual health care providers and beneficiaries to gather further input.

At the direction of the Governor, OMIG convened a working group of individuals who represent stakeholders such as health care providers, local government, and beneficiaries to discuss ways to improve OMIG's policies and procedures. The group convened three times, starting in November 2011. One additional subgroup meeting took place in December 2011 to discuss issues and concerns raised by representatives of Medicaid beneficiaries.

During these sessions, conversations took place about the importance of improving overall integrity and focusing efforts on areas where the most need existed. What resulted from those conversations were a set of observations about how OMIG could improve its processes. Towards the end of 2011, OMIG began to implement some of these improvements and plans to implement more during 2012.

Task Force Formation

During 2011, three task forces were created to focus efforts on three key areas of engagement: pharmacy, transportation, and managed care. These task forces tested the concept of a multidisciplinary approach that brought together clinicians, auditors, investigators, data miners, compliance reviewers, and legal staff. OMIG's task forces established stronger working relationships with regulating agencies in order to enhance OMIG's understanding of regulations and guidance while also coordinating actions taken to enhance program integrity. The results of this work were streamlined protocols and more accurate and informed findings.

After testing the efficacy of this approach in 2011, OMIG launched Business Line Teams (BLTs) in 2012. A BLT is a group of executives, managers/supervisors, and employees with multidisciplinary backgrounds that evaluate program integrity within specific categories of service. The BLTs will enable OMIG to better coordinate efforts, thereby enhancing the accuracy, completeness, and overall effectiveness with which OMIG can achieve its mission.

NYS 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 adoption of electronic health information technology (HIT) among Medicaid and Medicare providers. This is a federally funded project that will be underway for five years. During that time, OMIG will have to oversee the implementation of Electronic Health Records (EHR).

Through the Medicaid EHR Incentive Program, eligible hospitals and health care practitioners in NYS can qualify for financial incentives to move from a paper-based system of maintaining patient records to an EHR. Providers can choose the type of EHR they wish to implement; but, the chosen system must be certified by the Office of National Coordination for HIT as meeting required standards and specifications.

In 2011, OMIG began developing an audit plan and protocols to ensure that those providers that received financial incentives met all eligibility requirements of the program, with the goal of initiating audits in the spring of 2012. Starting in year two of the program – which can be either 2012 or 2013 depending on when the provider began participating in the program – OMIG will also verify that the provider is meeting meaningful use standards of the certified EHR systems.

Medicaid Redesign Team

NYS spends more than $50 billion annually to provide health care to almost five million people in need of health insurance coverage. In 2011, to find ways to reduce costs and increase quality and efficiency in the Medicaid program, Governor Andrew Cuomo established the Medicaid Redesign Team (MRT). The purpose of the MRT was to develop recommendations for significant structural reforms to reduce costs and improve quality in the Medicaid program.

In Phase 1, the MRT provided a blueprint for lowering Medicaid spending in State Fiscal Year 2011-12 by $2.2 billion. In February 2011, the MRT submitted an initial report to meet the Governor's Medicaid spending target contained in the 2011-12 Executive Budget. The initial report included 79 recommendations to redesign and restructure the Medicaid program to be more cost effective and get better results for patients. Seventy-eight recommendations were approved by the Legislature as part of the 2011-12 enacted Budget and are in the process of being implemented. More information on the MRT, including its Phase 2 efforts and measures included in the 2012-13 enacted Budget, can be found at www.health.ny.gov/health_care/medicaid/redesign.

OMIG is responsible for the establishment and administration of two of the enacted Phase 1 proposals, MRT 102 (Centralize Responsibility for Medicaid Personal Injury and Estate Recovery), and MRT 154 (Enhance and Improve the State's Medicaid Program Integrity Efforts). These initiatives generated cost savings of $369 million in 2011. Cost savings are identified in Table 8.2 of the Operational Statistics portion of the Appendix at the end of this report

MRT 102, Centralize Responsibility for Personal Injury and Medicaid Estate Recovery Process

MRT 102 gave OMIG statewide responsibility for making Medicaid recoveries from the estates of deceased beneficiaries as well as personal injury awards and settlements for all NYS Medicaid beneficiaries. The proposal enables OMIG to develop a State-centralized recovery process as well as implementation of best practices statewide.

In 2011, OMIG began centralizing the recovery process through voluntary participation with certain counties. The process included the use of standardized correspondence and procedures including: mailing of lien notices, questionnaires, asset research methods, lien filings, negotiations and hardship determinations. Enhancement of the process will result in an increased overall recovery rate of State Medicaid funds.

MRT 154, Enhance and Improve the State's Medicaid Program Integrity Efforts

MRT 154 was originally composed of eight sub-proposals, four of which are proceeding to implementation. Below is a brief summary of the current active OMIG initiatives.

Exception and Conflict Report

Chapter 59 of the Laws of 2011 enacted as part of the 2011-12 budget, which amended NYS Social Services Law § 2(38) and Social Services Law § 363-e, required certified home health agencies (CHHA), long term home health care programs (LTHHCP) and personal care providers whose Medicaid reimbursement exceed $15 million per calendar year to procure and utilize a verification organization to produce exception and conflict report data that allows confirmation that a service was actually provided in the patient's home, the length of the visit, the provider's credentials, the location of the service provided, and the scheduled visits. The legislation defines a verification organization as an entity that uses electronic means to verify the services performed in a recipient's home and that those services are consistent with what was scheduled and billed to the Medicaid program.

OMIG was charged with implementing this project in collaboration with the DOH Office of Health Insurance Programs (OHIP). As part of the preparation for this project, OMIG undertook a number of initiatives to better understand and monitor the home health arena, and educate providers on their responsibilities under the new law. Some of the efforts carried out in 2011 were:

- OMIG presented a webinar on May 25, 2011, focusing on program implementation and reporting requirements.
- OMIG developed and sent a questionnaire to providers asking questions about their existing electronic visit verification (EVV) software and related experiences and practices.
- OMIG conducted on-site visits to providers to educate them on program requirements and to help OMIG better understand each provider's processes and policies.
- OMIG issued a *Compliance Alert* advising providers that compliance plans must include use of a point of service verification vendor.
- OMIG staff conducted pre-payment reviews of selected home health claim submissions to determine what practices and documentation are in place for properly clearing conditions where EVV software detected exception conditions.
- OMIG met several times with home health provider associations to understand issues and concerns regarding the project and its implementation.

OMIG developed detailed specifications for identifying the providers covered by the law. All identified providers were notified that they were covered by the program as well as the major milestones that were involved in the project rollout. This included developing detailed project goals, which the providers and prospective verification organizations were allowed to review and comment on prior to finalization.

Once the requirements were established, authorized verification organizations were also finalized, and agencies were provided with a schedule by which to choose a verification organization from the qualified vendor list.

During 2012, OMIG expects providers to choose their verification vendors and that those vendors will upgrade their software and audit their clients' processes to ensure all project requirements will be met. Initial implementation of the full verification organization concept is expected in early fall of 2012.

Require Signature for Home Delivery and Receipt of Prescriptions at Pharmacies

Effective October 1, 2011, new Medicaid policy requirements took effect requiring beneficiaries, or their designee, to sign for home delivery and receipt of prescriptions from pharmacies. During 2011, OMIG worked on developing audit protocols related to the signature requirement in conjunction with stakeholders.

Medicare Coordination of Benefits with Provider 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), which are also submitted to Medicaid for payment. Potential duplicate claims are reviewed and recoveries made when appropriate. In 2011, OMIG proposed an MRT project to focus on claims associated with the automated Medicare crossover system – Medicare/Medicaid Coordination of Benefits Agreement (COBA) – which started in December 2009. Before the automated system, providers who rendered services to dual-eligible beneficiaries were required to submit one claim to Medicare and one to Medicaid which showed the amount that Medicaid had paid for the service. The Medicaid payment was calculated based on what Medicare approved and paid. The COBA system was designed to have the provider submit the claim to Medicare. Medicare processes the claim and then submits it to Medicaid for adjudication. This helps ensure that the Medicare payment information is correct and reduces the opportunity for Medicaid overpayments.

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. The MRT project focused on eliminating and/or reducing the number of provider submitted claims when there is an associated Medicare claim that was paid by the COBA system. OMIG worked with DOH to modify claim system edits that identify and deny duplicate claims. OMIG also recovered inappropriately paid claims from providers. OMIG continues this monitoring and recovery process as duplicate claims are identified.

Compliance Activities

Adoption and implementation of an effective compliance program, meeting the requirements of Social Services Law § 363-d and Title 18 of the New York Codes, Rules and Regulations (NYCRR) Part 521, is required for certain providers to be eligible to receive Medicaid payments or submit claims for Medicaid services. Because of this requirement, the BoC's approach when conducting reviews of providers' mandatory compliance programs is to take all reasonable steps to work with providers to assist them in meeting these compliance obligations. If providers are not meeting specific compliance requirements, the BoC identifies the specific statutory or regulatory insufficiency, suggests resolutions, and monitors the providers' progress in resolving the insufficiency. The BoC reserves the right to conduct unannounced follow-up reviews to confirm correction of the insufficiencies.

Providers who are required to have and maintain reasonably effective compliance programs must annually certify the effectiveness of their compliance programs. OMIG actively oversees providers' performance through the certification obligation, use of computer databases, and direct outreach to providers who appear to have failed to meet the annual certification requirement. In 2011, the BoC commenced compliance program assessments of 24 providers. Those reviews were a mixture of desk reviews and on-site reviews. Some were initiated based upon BoC metrics and others were initiated on referral from other OMIG divisions or other NYS agencies.

Effectiveness Reviews

When conducting reviews of providers' compliance programs, the BoC's goals are to:

- determine if specific providers are satisfying the mandatory compliance program requirement
- identify best practices in compliance that can be shared with other Medicaid providers
- recommend enhancements to providers' compliance programs where appropriate
- provide the results of the effectiveness reviews to other appropriate NYS agencies with responsibility for program oversight of the provider

In 2011, the BoC initiated 17 on-site reviews and 6 desk reviews of providers' compliance programs. Additionally, OMIG met with the NYS Office for People With Developmental Disabilities (OPWDD) to learn about its compliance activities and assess how they align with the requirements of Social Services Law § 363-d. The on-site reviews were of varying length and included hospitals, pharmacies, physicians, and other providers. Desk reviews were initiated based primarily on referrals within OMIG and from other state agencies.

The BoC determined that one provider did not to have a compliance program meeting the requirements of the law and regulation. The BoC's appraisal of the compliance program was issued with that finding and referred to DOH. Subsequently OMIG and DOH took action to exclude that provider from the Medicaid program, and to terminate the entity's contract with Medicaid.

The remaining providers were determined to either have a compliance program meeting the requirements or had minor issues that were being addressed by the providers to bring their programs into conformity with the mandatory compliance requirements.

Corporate Integrity Agreements

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 provider 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 program if there is a material breach of the CIA's terms. In 2011, as part of a multi-million dollar federal and NYS settlement for irregularities in completing multi-year consolidated fiscal reports, OMIG imposed a CIA on an OPWDD provider.

During 2011, OMIG continued to monitor seven providers who have CIAs. Providers are monitored to assess adherence to the terms of the CIA, which are contracts between the affected Medicaid providers and NYS. Since providers who have entered into a CIA have engaged in conduct that is in some way contrary to the requirements of the Medicaid program, CIA providers' plans of correction must be monitored to ensure that the corrective action is appropriate and implemented. Additionally, CIA providers' compliance programs are monitored to assess whether those programs are promoting Medicaid program integrity within the providers' operations.

OMIG Guidance to Providers on Compliance

In 2011, OMIG expanded its outreach, training, and guidance regarding the requirement set forth in Social Services Law § 363-d that providers maintain compliance programs. OMIG's goal was to collaborate with the provider community in order to promote greater program integrity on the front end of the Medicaid program. OMIG's outreach efforts included the following:

- Publication on OMIG's website of *Compliance Alerts*, forms, and other guidance and explanatory information in a Compliance Library;
- Contributions to DOH's *Medicaid Update* on compliance matters;
- Provision of webinars, which remain available on the OMIG website;
- Presentations to industry and trade association groups, educational institutions, other state agencies and the public; and
- Communication with the Centers for Medicare and Medicaid Services (CMS), HHS OIG and other states' government agencies.

OMIG continues to be involved in information sharing and collaborative initiatives with CMS. The focus of this collaboration has been on NYS's Medicaid and CMS's Medicare compliance initiatives to assist both agencies' compliance oversight obligations. CMS has adopted OMIG's Self-Assessment Tool (published on OMIG's website as *Compliance Alert 2010-02*) as the basis for its self-assessment tool for Medicare providers. Best practices in oversight are continually being discussed. Additionally, CMS often refers other states to OMIG when they request information on developing a Medicaid CIA.

Outreach and Educational Activities

Part of OMIG's statutorily-defined work is to educate health care providers about the Medicaid program. As a segment of that work, in 2011 OMIG made educational presentations to a variety of outside consumer and professional trade association groups. These groups included:

- Health Care Compliance Association
- Home Care Association of New York State
- Healthcare Association of New York State
- Greater New York Hospital Association
- LeadingAge New York
- United Cerebral Palsy Association
- Community Health Care Association of New York State
- New York State Association of Health Care Providers
- Long Term Care Community Coalition
- New York State Association of County Health Officials

OMIG also presented webinars to members of the general public, offered free of charge, with just under 6,500 participants. All webinars are posted on the OMIG website for later viewing and listening. These educational presentations help providers learn Medicaid program requirements and also provide an opportunity for providers to ask questions about the program. FAQs are posted on OMIG's website after every webinar based on questions submitted by participants.

Investigative Activities

OMIG uses an investigative review process to detect and deter potential instances of fraud, waste, and abuse in the Medicaid program. This process includes activities which deter improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billings and services, and cooperating with other agencies to enhance enforcement opportunities.

Cases involving providers conducting suspected fraud or other illegal activities are forwarded to MFCU, the United States Attorney, or local district attorneys for pursuit of appropriate civil or criminal prosecutions.

Enrollment and Reinstatement Investigations

Enrollment and reinstatement investigators screen providers prior to enrollment to enhance quality and regulatory adherence to the Medicaid program. Reviews of enrollment and reinstatement applications are conducted to identify unqualified, fraudulent, or abusive practitioners and businesses, as well as those providers whose poor quality of care would present a danger to Medicaid beneficiaries. Based on these investigations, OMIG may deny enrollment or reinstatement to those parties. On-site inspections and undercover operations are performed as part of the review, when necessary.

In 2011, OMIG added reviews of individual dentist applications to the list of provider types that were already reviewed prior to enrollment, which included pharmacies, medical equipment providers, and several others. OMIG also intensified efforts to identify owners of businesses applying to be Medicaid providers who were also Medicaid recipients and had not reported the ownership on Medicaid eligibility applications. In addition, OMIG addressed new requirements of the federal Affordable Care Act (ACA), which mandate denial of enrollment of all providers convicted of certain Medicaid-related offenses and required site visits for providers in high-risk categories. In 2011, denials of enrollment and reinstatement applications resulted in $70.2 million in Medicaid cost savings. Cost avoidance occurs when a provider's application for enrollment or reinstatement in the Medicaid program is denied. The cost avoidance is considered to be the amount that is saved in a fiscal year by not enrolling an applicant into the provider type they are requesting. Cost avoidance for each denial is calculated at the average Medicaid reimbursement for the previous fiscal year in the particular provider category denied. This can be seen in Table 8.2 within the Appendix.

Pharmacy Investigations

Pharmacy investigations identify kickback schemes, false claims, and quality of care issues. OMIG investigators also review early refills, black box medications (those medications that have a federal Food and Drug Administration black warning box indicating the potential for severe side effects and suggesting caution when using) and off-label use of prescriptions. These investigations identify aberrant pharmacy and prescription practices. These practices include billing for services not rendered, inaccurate data submissions on claims, duplicate

billings, rendering unnecessary services, unlicensed or excluded providers rendering services, as well as quality of care issues.

In 2011, OMIG began implementing an initiative to conduct medication inventory reviews of pharmacies. During the review process, payments made for prescriptions billed to NYS Medicaid are compared with pharmacy inventory purchases to determine whether the pharmacy had purchased enough medications to fill the prescriptions that were claimed. The results of this initiative will be reported in the 2012 Annual Report.

Recipient Investigations

Detecting eligibility fraud is challenging but integral to ensuring those receiving Medicaid benefits meet enrollment criteria. OMIG, in concert with its law enforcement partners, initiates investigations which result in civil actions, criminal prosecution, and restitution from recipients who fraudulently enroll and receive Medicaid benefits.

In 2011, OMIG launched new initiatives to expand its efforts to detect and investigate fraud committed by recipients. OMIG strengthened its established liaisons throughout the State with local law enforcement and district attorney (DA) offices and fostered new relationships with additional law enforcement agencies to prosecute cases of fraud and abuse against the NYS Medicaid program. OMIG completed 2,319 investigations involving enrolled recipients, as set forth in Table 1.3 within the Appendix. Additionally, 1,764 referrals to law enforcement and other state and federal agencies were made in 2011. The list of referrals made is shown in Table 1.9 within the Appendix.

Recipient Underreporting Income Made to Pay Back Money to Medicaid

In January 2011, OMIG received a complaint alleging a Medicaid recipient and alleged owner/operator of a daycare center was substantially underreporting her income. After the initial investigation found supporting evidence to pursue the matter, OMIG forwarded the investigation to the Orange County Local Department of Social Services' (LDSS) Special Investigations Unit for further investigation. Orange County LDSS determined this recipient was ineligible to receive Medicaid benefits. As a result, the recipient entered into a voluntary repayment agreement with Orange County LDSS and paid the full Medicaid overpayment of $7,192.

Interagency Collaboration Leads to Medicaid Recoupment

OMIG investigators spearheaded collaborative efforts with Orange County LDSS and the Orange County Sheriff's Department by presenting four cases of alleged recipient fraud involving large Medicaid overpayments that had not yet been prosecuted in Orange County. As a result of this meeting, the Orange County LDSS and the Sheriff's Department agreed to look into the cases.

One of the four cases involved a Medicaid recipient who was arrested and charged with three felonies, which included Grand Larceny in the Second Degree, Offering a False Instrument, and Welfare Fraud. Orange County LDSS calculated this recipient had received public assistance benefits totaling $219,361, with $188,830 being an overpayment of Medicaid benefits. In September 2011, the recipient pled guilty to one count of Grand Larceny in the Third Degree, and one count of Offering a False Instrument. As a result, the recipient was sentenced to six months in the Orange County Jail and was also ordered to pay restitution in the amount of $104,570.

Restricted Recipient Program

In cases where OMIG's team of physicians, nurses, and pharmacists identify recipients that have received Medicaid funded care and services that are duplicative, excessive, or contraindicated, the recipient may be restricting to one primary care provider, and one pharmacy. Local districts implement the restrictions to primary providers. In 2011, OMIG conducted 5,633 reviews leading to 4,931 recommendations for restriction. In 2011, the average monthly number of restricted recipients was more than 10,000. These restrictions resulted in improved quality of care for recipients, and a cost savings to the Medicaid program of more than $165 million. Savings associated with this project are found in the Cost Savings Activities in Table 8.2 within the Appendix under "Recipient Restriction".

With the onset of recipients moving into managed care plans, OMIG has had to increase its cooperative efforts with those organizations. DOH has mandated that each plan implement restriction criteria to control recipient abuse and fraud. Plans working with the Restricted Recipient Program are able to implement and maintain restrictions while promoting the integrity of the NYS Medicaid program, and providing quality care to its enrollees.

Prescription Fraud

Forged prescriptions can lead to thousands of illegal pills and other drugs being unsafely disbursed into the community. Under DOH regulations, doctors are responsible for reporting to Medicaid and BNE when prescription pads are lost or stolen. Pharmacies can unknowingly fill an altered or forged prescription when not reported. Pharmacy providers are required to question such documents and contact the purported physician and appropriate authorities when they suspect fraud. When pharmacies or physicians fail to report or question suspect prescriptions, Medicaid may unwittingly pay for drugs dispensed to recipients who in turn may sell these drugs for cash or use them incorrectly.

Collaborative efforts between OMIG and BNE have allowed access to lost or stolen prescription pad reports. These reports, coupled with data mining techniques, use prescription serial numbers to reveal potentially forged prescriptions and dispensing discrepancies by pharmacies. Detecting forgeries early prevents additional prescriptions from being filled, keeps illicit drugs out of the community, and saves taxpayers money. In 2011, OMIG initiated 832 forgery investigations. A breakdown of the forgery investigations can be found in Table 1.6 within the Appendix. Additionally, 855 referrals were made to law enforcement

and other state and federal agencies. The referrals made to law enforcement and other state and federal agencies are listed in Table 1.10 within the Appendix.

Shutdown on Forgery Refills for Atripla Saves More than $104,000

Atripla, an HIV medication costing $1,367 for a 30-day supply, was one of the medications figuring most predominantly in prescription forgery schemes in 2011. OMIG is diligently working to verify fraudulent prescriptions quickly in order to prevent fraudulent refills. Forgeries are identified through reviewing a recipient's pharmacy claims and then identifying prescriptions that are inconsistent with medical billings and encounter data. Once a prescription is verified as a forgery, the serial number of the prescription pad and prescriber data is analyzed to detect additional suspect claims and recipients. OMIG shuts down the serial numbers associated with the pad on which forged prescriptions are being written. The serial number shutdown leads to a hard edit in the eMedNY/Medicaid claims payment system with no override option at the point of service. The pharmacist receives a denial-edit notifying them in real time that the prescription has been reported lost/stolen and hence payment is denied. It was estimated this shutdown process saved the taxpayers more than $104,000.

Collaboration between OMIG, Wyoming County LDSS Fraud Unit and District Attorney Results in Recipient Prosecution

The Wyoming County Fraud Unit contacted OMIG for assistance in pursuing the investigation of a Medicaid recipient who had been arrested for allegedly selling Diazepam (generic Valium) and Suboxone. OMIG subsequently reviewed pharmacy claims and identified numerous claims for both Suboxone and Diazepam at five different pharmacies. OMIG's review of the files from these five pharmacies also showed that on multiple occasions the recipient in question paid cash for Diazepam. When Medicaid recipients pay cash for prescriptions it allows the recipient to circumvent Medicaid program safe guards. Such actions can be an indication of fraud, possible diversion of prescription medications, and could cause quality of care issues for the recipient. Copies of the case files outlining these cash payments from the five identified pharmacies were then sent to Wyoming County LDSS. Subsequently, the Wyoming County Assistant DA accepted the case. This cooperative investigative effort yielded a positive outcome as the recipient pled guilty to Welfare Fraud, was sentenced to five years on probation and was required to pay NYS Medicaid restitution in the amount of $1,986.

Collaborations with Other Agencies

Medicaid Fraud Control Unit

The statute that established OMIG states "the inspector shall refer suspected fraud or criminality to the deputy attorney general as required or contemplated by federal law."

OMIG refers allegations of suspected fraud or criminality to MFCU for possible criminal prosecution. In 2011, preliminary findings from OMIG investigations led to 87 referrals to MFCU. While the majority of those referrals involved Medicaid providers, OMIG also referred 16 non-enrolled providers, which can be seen in Table 1.7 within the Appendix. Additionally, OMIG excluded 126 individuals and entities from the Medicaid program as a direct result of MFCU prosecutorial activity. The summary of excluded providers can be found in Table 1.15 within the Appendix.

Referrals to Other Agencies

OMIG also works in close collaboration with the NYC Human Resources Administration Bureau of Client Fraud Investigation (NYC HRA) and other LDSSs on recipient referrals.

OMIG shares its findings with agencies such as the NYS Education Department's Office of Professional Discipline, DOH Office of Professional Medical Conduct (OPMC) and other legally authorized law enforcement agencies.

Table 1.8 within the Appendix shows there were 1,933 referrals to outside agencies in 2011. That total is made up of 1,078 referrals to NYC HRA, 405 referred to the LDSSs, and 450 cases referred to other agencies.

Federal Health Care Strike Force

During 2011, OMIG's participation with the DOJ's Medicare Fraud Strike Force led to 14 arrests, four indictments, and two complaints for individuals alleged to have committed health care fraud against the Medicare and/or Medicaid programs. Additionally in 2011, seven individuals pled guilty to health care fraud related charges and another two individuals were found guilty after trial for their role in schemes to defraud the programs.

OMIG's participation included conducting interviews, analyzing documents, surveillance, translating, and assisting in the execution of search warrants. Additionally, OMIG conducted various undercover operations to assist the DOJ Medicare Fraud Strike Force in furthering several of its cases. Significant cases include those highlighted below:

- Seven individuals were charged in connection with a $56.9 million scheme to fraudulently bill the Medicaid and Medicare health care programs for physical therapy and diagnostic tests, while also paying kickbacks to Medicaid and Medicare recipients for their participation in the scheme. The individuals were charged with health care fraud, conspiracy to commit health care fraud, and conspiracy to pay health care kickbacks.
- A NYS licensed proctologist was indicted on health care fraud related charges in connection with a $22.5 million scheme to defraud Medicare and private insurance carriers by submitting fraudulent claims for hemorrhoidectomy services.

- A NYS licensed physical therapist was arrested and pled guilty to five counts of health care fraud in connection with an $11.9 million scheme to fraudulently bill the Medicare program for physical therapy services.
- OMIG assisted HHS OIG agents in a criminal investigation which resulted in the execution of four arrest warrants for Medicaid/Medicare recipients who allegedly participated in a kickback and solicitation scheme to defraud the Medicaid and Medicare health care programs.
- Two individuals, the owner and the director of customer service of a durable medical equipment (DME) dealer, pled guilty to health care fraud charges in federal court for their participation in a scheme to defraud Medicare by submitting fraudulent claims for medically unnecessary orthotics and shoes.
- Three employees of a physical therapy practice each pled guilty to one count of conspiracy to commit health care fraud for their participation in a scheme to defraud Medicare by paying cash kickbacks to Medicare beneficiaries to induce them to visit the facility to receive medically unnecessary physician services, physical therapy, and diagnostic tests.
- Two doctors of a physical therapy practice were indicted for health care fraud for their participation in a scheme to defraud Medicare by paying cash kickbacks to Medicare beneficiaries to induce them to visit the facility to receive medically unnecessary physician services, physical therapy, and diagnostic tests.
- Two NYS licensed podiatrists were found guilty of committing health care fraud in federal court. After a two-week trial, a jury found the podiatrists guilty of a total of seven counts of health care fraud against the Medicaid and Medicare health care programs for their participation in submitting claims for services that were not provided and not medically necessary.
- Lastly, an employee of a DME company pled guilty to health care fraud charges for submitting false claims to the programs for DME supplies that were not provided or not medically necessary.

New York City Human Resources Administration

An internist practicing in NYC was referred to OMIG by an emergency room physician. OMIG conducted a medical record review which found multiple instances of fabricated documents that were used to support a diagnosis of HIV/AIDS in order to prescribe HIV/AIDS medications to recipients who did not suffer from the disease. In 2008, this provider had ordered over $700,000 in medications to treat HIV/AIDS. He also created false records for his purported treatment of the patients, even though in most cases these individuals did not visit his office more than once. The defendant charged Medicaid for the initial patient visits and for the subsequent visits that did not take place.

Subsequently, OMIG entered into a joint investigation resulting in prosecution by the New York County DA's Office. In April 2011, the provider was indicted on several counts of Grand Larceny and Falsifying Business Records. On June 2, 2011, members of OMIG's investigative team accompanied the NYPD during the arrest of the provider and the execution of a search warrant of the provider's office. Based on OMIG's investigation and

the criminal indictment, on July 27, 2011, OMIG issued an Immediate Notice of Agency Action to exclude the provider from the Medicaid program. In December 2011, this provider was convicted of Grand Larceny in the Second Degree, 11 counts of Falsifying Business Records in the First Degree, and petit larceny.

New York City Office of the Special Narcotics Prosecutor

In November 2011, a Medicaid provider with a specialty in anesthesiology, who operated a pain management clinic, was indicted in New York County following a yearlong investigation by the NYC Office of the Special Narcotics Prosecutor (OSNP). OMIG opened its investigation of this provider in November 2010, and in July 2011, OMIG met with OSNP regarding this provider and agreed to conduct a collaborative investigation.

Search warrants were executed at the provider's residence and at his place of business in NYC where he was arrested. Subsequently, he was charged with 15 felony counts of Criminal Sale of a Prescription for a Controlled Substance and five counts of Reckless Endangerment in the Second Degree.

OMIG and NYC Taxi and Limousine Commission Discuss Collaboration

OMIG and the New York City Taxi and Limousine Commission (NYC TLC) developed a framework to share information. NYC TLC provided examples of the transportation trip sheet records utilized by the transportation providers which contain pertinent information such as the TLC provider license number, vehicle plate number, and pick-up and drop-off date and time for each passenger. Through this exchange, OMIG was able to identify 12 Westchester and Nassau County transportation providers operating exclusively within NYC, without possessing the required TLC license. OMIG initiated new investigations into these companies. Information provided by OMIG enabled NYC TLC to seize one ambulette in the Bronx for operating without the required NYC TLC license.

NYC TLC and OMIG are now working together on a joint project regarding transportation providers within NYC.

Managed Care Organizations

During 2011, OMIG convened three meetings with managed care organizations (MCOs). The purpose of these meetings was to establish a collaborative approach between OMIG and the MCOs to identify, investigate, and refer for appropriate administrative, civil, and criminal action those providers who would attempt to defraud the Medicaid program. Additionally, these meetings were used as forums to advise the MCO community of new rules and regulations affecting their programs.

The first meeting took place in January 2011, at OMIG's NYC regional office. Representatives from the Compliance and Special Investigation Units of 10 MCOs attended. The Assistant Medicaid Inspector General for Compliance provided a presentation on the responsibilities of MCOs under ACA.

The second meeting took place in March 2011, again at OMIG's NYC regional office. Representatives from 11 MCOs attended. Representatives from OMIG reviewed OMIG's role and the function of investigations into fraud, mismanagement and abuse in the Medicaid program and responsibilities of both OMIG and the MCOs under ACA. This ACA presentation focused on the MCOs' responsibility to report overpayments to OMIG.

In September 2011 the meeting concentrated on the MCO pharmacy benefits packages as of October 1, 2011 as well as the progress of the enrollment of the restricted recipients initiated in July 2011.

Immediate Exclusions

Section 515.7 of 18 NYCRR provides that "upon determining that the public health or the health or welfare of a recipient would be imminently endangered by the continued participation of any person in the program, the department may immediately exclude the person and any affiliates until the conditions giving rise to the exclusion have been corrected or a further investigation determines that there is insufficient evidence to support a continued exclusion." Examples of situations in which OMIG protected the health and welfare of NYS residents are highlighted below.

Immediate Exclusion of Provider due to Imminent Danger

As a result of a referral from the NYS Office of Alcoholism and Substance Abuse Services (OASAS), OMIG initiated an investigation of an OASAS facility providing mental health services to Medicaid recipients located in Orange County. The on-site investigation was conducted in unison with the Deer Park Police Department and the Orange County Mental Health Department.

OASAS suspended the operating certificate for this facility for immediate health and safety issues, including the absence of any medical staff on-site despite the requirement to have medical staff present 24 hours a day, seven days a week; no mental health services for patients needing them; case record deficiencies; and women being forced to shower in the men's facility due to an absence of hot water, soap, and towels in the women's facility.

Subsequent to the OASAS action, OMIG conducted an on-site investigation in July 2011. In addition to confirming OASAS' findings, investigators found no medical staff present on the facility premises. Investigators also interviewed the Executive Director who informed them a doctor came to the facility to see residents approximately every 10 days. OMIG's review of the records at the facility revealed the treatment plans of 10 residents were blank, but appeared to be signed by the doctor with no resident signatures. Also lacking were notes in the records regarding team meetings, and complete psychosocial histories of the residents. At the culmination of the on-site investigation, OMIG issued an Immediate Notice of Agency Action to the Executive Director and the owner of the facility excluding the facility from the

Medicaid program under 18 NYCRR §515.7(d) because the continued operation of the facility posed an imminent danger to the health and welfare of Medicaid recipients.

Unsafe Medical Practices Leads to Immediate Exclusion

Initial clinical review analysis led to the immediate exclusion of an otolaryngologist located in Brooklyn whose practices were not only fraudulent, but also put his patients at risk. OMIG noted possible excessive services and a high number of ordered home health services that were unusual for an otolaryngologist.

OMIG's review found OPMC had previously penalized this provider for numerous unacceptable practices such as failing to document adequate histories, inappropriately performing nasal endoscopies, laryngoscopies, cauterization of nasal turbinates, sinus irrigations, and vestibular function testing, as well as unbundling services. In April 2011, OMIG obtained medical records, which indicated this provider was engaged in the same inappropriate practices.

In June 2011, OMIG and the NYC Department of Health and Mental Hygiene conducted a credential verification review which revealed the provider was practicing medicine in an unsafe manner. Investigators took photos noting the provider was performing invasive procedures with unsterilized instruments. Additionally, outdated medication vials and crash cart supplies were discovered.

OMIG issued an immediate exclusion upon determining that the provider's continued participation in the Medicaid program would pose an imminent danger to the health and welfare of the public, including Medicaid recipients.

Audit Activities

Audits of Medicaid providers are conducted with the goal of ascertaining whether providers adhere to applicable federal and state laws, regulations, rules, and policies pertaining to the Medicaid program.

During 2011, OMIG's Division of Medicaid Audit and Office of Counsel (OC) began a process to review all fee-for-service (FFS) audit protocols. Audit protocols had been developed for each category of service, or program, audited by OMIG. The established review process includes the oversight agency responsible for the respective program. Subsequently, the audit protocols are shared with applicable provider associations 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 OMIG's website.

Fee-for-Service Audit Activities

OMIG conducts billing audits of provider services rendered to eligible beneficiaries paid on a FFS basis. Examples of these audits include home health agencies, personal care agencies, diagnostic and treatment centers, hospitals, pharmacies, and other health care providers.

Certain FFS audit activities are highlighted below. Results of all FFS audit activities are listed in Tables 2.2 – 2.6 within the Appendix.

Comprehensive Outpatient Programs and Community Support Programs

OMIG audits payments to Comprehensive Outpatient Programs (COPS) and Community Support Programs (CSP) certified by the NYS Office of Mental Health (OMH). COPS overpayments are calculated from the amount of COPS reimbursement in excess of yearly threshold amounts set by OMH. These overpayments are subject to recoupment. Similarly, CSP payments in excess of a formulated reimbursement rate are also subject to recovery. OMIG is the agency responsible for issuing audit reports for recoveries based on OMH's calculations. OMIG is also responsible for collecting recoveries of any identified overpayments. In 2011, OMIG and OMH finalized 76 COPS/CSP audits, with total findings of $53.7 million and recoveries totaling $38.6 million.

Outpatient Chemical Dependence Providers

OMIG audits OASAS outpatient chemical dependence services provided in hospital-based or free-standing clinic settings. These audits involve determining provider adherence to billing and documentation requirements set forth in 14 NYCRR Part 822. Audit findings typically involve non-compliance with documentation requirements for evaluations, treatment planning, and progress notes. Additionally, OMIG performs quality of care reviews of certain chemical dependence providers to determine the level of clinical care. In 2011, OMIG finalized six audits identifying $6.2 million in overpayments.

Programs Certified by OPWDD

OMIG conducts audits related to services authorized by OPWDD in its residential habilitation, Medicaid service coordination, and day treatment services programs. These audits involved determining provider adherence to billing and documentation requirements set forth in 14 NYCRR Parts 635, 671, 690 and the *Medicaid Service Coordination Vendor Manual*. Audit findings typically involve non-compliance with documentation requirements for evaluations, service and treatment planning, service and progress notes (monthly and daily), and correct reimbursement based on proper rate code usage depending on the beneficiary's program attendance. OMIG worked closely with OPWDD program staff to continue developing standard audit protocols for each of the programs audited. In 2011, OMIG finalized two audits for OPWDD and Medicaid Service Coordination services identifying overpayments of $827,311.

Diagnostic and Treatment Centers

A diagnostic and treatment center is a medical facility with one or more health services which is not part of an inpatient hospital facility or vocational rehabilitation center. It is primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician or dentist, for the prevention, diagnosis, or treatment of human disease, pain, injury, deformity, or physical condition. A diagnostic and treatment center is certified in accordance with Article 28 of the NYS Public Health Law and/or Article 31 of the Mental Hygiene Law to provide such services on an outpatient basis.

During 2011, OMIG finalized 17 diagnostic and treatment center audits. Audit staff reviewed case record documentation to assess adherence to applicable laws, regulations, rules, and policies of the Medicaid program. Audit findings typically involve missing entries in patient medical records and progress notes, as well as unlicensed/unregistered practitioners. The total overpayments identified for recovery amounted to $6.6 million in 2011.

Home Health Services

OMIG reviews FFS payments for home health and personal care aide services, nursing, and, physical, speech, and occupational therapy as part of the agency's CHHA audits. As of the end of 2011, 47 active audits had been opened in these programs.

In addition, during 2011, OMIG focused on outreach to DOH, the associations representing the providers in this industry, CMS, and the providers themselves to have open discussions related to preliminary findings on OMIG audits of CHHAs, personal care agencies, LTHHCPs, and Licensed Home Health Care agencies.

Traumatic Brain Injury

Traumatic Brain Injury (TBI) services fall within the Home and Community Based Services Medicaid Waiver Program (HCBS). The waiver program is a federally approved initiative

that allows for specific services that are not included in the State Medicaid Plan to be provided to individuals with TBI that meet the eligibility criteria. There are 12 specifically designated TBI waiver services that meet the standards established by DOH; and TBI service providers must be approved to participate in the HCBS/TBI waiver program for each distinct waiver service provided. The waiver service standards and service provider requirements are maintained in a DOH HCBS/TBI Medicaid Waiver Program Manual.

OMIG has worked in collaboration with DOH in order to appropriately revise audit standards and protocols as necessary to address updates and service clarifications to the HCBS/TBI Waiver Program Manual. In 2011, OMIG finalized eight TBI audits, identifying overpayments totaling $1.6 million. The most common findings include billing more hours than documented, no documentation of service, partial service hours not billed correctly, and insufficient staff training.

School Supportive and Preschool Supported Health Services Programs

As part of a 2009 compliance agreement entered into between NYS and CMS, OMIG was required in calendar year 2011 to audit every school district and county preschool provider that received at least $1 million in Medicaid reimbursement in calendar year 2010. There were seven providers who met this criterion. OMIG was also required to audit 30 additional school districts and county preschool providers with total paid claims of less than $1 million in calendar year 2010.

In 2011, OMIG initiated 37 new audits of school districts, county preschool programs and schools defined under §4201 of the NYS Education Law (state supported schools for the blind, visually handicapped and/or hearing impaired). OMIG finalized 38 audits in 2011 identifying $1.4 million in overpayments, which are shown in Tables 5.1 – 5.4 within the Appendix.

Rate Based Audit Activities

Certain Medicaid providers are reimbursed for covered services to eligible beneficiaries based on prospectively determined rates which are based on cost reports submitted by the provider. Residential health care facilities (RHCFs) are rate-based entities.

Rate audit activities are described below, and the outcomes of those activities are demonstrated in Tables 3.1 – 3.4 within the Appendix.

Capital Audits

The reported capital costs for RHCFs are used as a basis for the capital component of the nursing facility's Medicaid rate. Capital audits result in a large variety of findings. Examples of capital audit findings include:

- Working capital interest expense disallowances

- Equity disallowances
- Sales tax disallowances
- Mortgage expense disallowances
- Depreciation disallowances

During 2011, 37 capital audits were completed resulting in the identification of $17.5 million in overpayments.

Base Year Audits

Base year audits examine the costs reported in the provider's base year. The reported base year costs are trended forward by an inflation factor and used as the basis for 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
- Non-allowable expense

During 2011, 13 base year audits were completed identifying overpayments of $6.6 million.

Rollover Audits

Base year operating costs are used as a basis for rate calculations for 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 the base year costs as its basis. Fifty four rollover audits were completed in 2011 resulting in identification of $1.4 million in overpayments.

Dropped Services Audits

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 costs 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 2011, 20 dropped services audits were completed identifying overpayments of $3.8 million.

Medicaid Rate Part B Carve Out

Medicaid rates for RHCFs include billable rates for Medicaid patients who are not eligible for Medicare Part B service reimbursement, as well as rates for those who are Medicare Part B eligible. The difference between the non-eligible and eligible rates is called the "Medicare Part B Offset". In conjunction with DOH, OMIG developed and implemented the Medicare Part B Offset audit protocol. During 2011, OMIG initiated three Part B carve out probe audits to determine the propriety of the Part B offset. In addition, OMIG assisted DOH with their processing of several Medicare Part B Offset appeals. OMIG plans to initiate additional Medicare Part B Offset audits in 2012.

Managed Care Audit Activities

Managed care plans coordinate the provision, quality, and cost of care for enrolled members. In NYS, several different types of MCOs participate in Medicaid managed care, including health maintenance organizations, prepaid health service plans, managed long-term care plans, primary care partial capitation providers, and HIV special need plans.

One of the major reforms instituted on the recommendation of the MRT was an initiative to enroll almost all of the Medicaid population into Medicaid managed care, as well as transitioning services previously delivered through Medicaid FFS to the responsibility of the MCOs. Total transitioning of the population and services into managed care is expected to be completed by April 2013. At full implementation of the MRT proposals, it is estimated that more than 90 percent of the NYS Medicaid population will be enrolled in managed care.

As services and the Medicaid population are transitioned into managed care, it is imperative OMIG also transition its focus and resources from a FFS provider environment to the MCOs and their network of providers. To do so requires reorganization of business lines, coordination with other agencies, and development of a work plan that will effectively monitor and ensure program integrity.

OMIG currently performs various match-based targeted reviews and audits of MCOs, recovers overpayments, and submits/implements corrective action procedures that address system and programmatic errors.

Highlights of managed care audit activities are described below, and the results of all such activities can be found in the Tables 4.1 – 4.5 within the Appendix.

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

OMIG annually matches the NYS Medicaid database with vital statistics for NYS and NYC. This match generates a list of Medicaid payments made on behalf of MCO enrollees who remained enrolled in Medicaid following the date of their death. As part of the contract between NYS and the MCOs, any capitation payments made on behalf of deceased enrollees are recoverable from the MCO. OMIG informs the local district to take appropriate action on

behalf of any of the active cases/enrollees that are identified. In 2011, OMIG finalized 43 audits that identified $3.8 million in overpayments.

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

Matching the NYS Medicaid database with files from the NYS Department of Corrections and Community Supervision and the NYS Division of Criminal Justice Services, OMIG generates a list of inappropriate payments made to MCOs that the local districts failed to identify and recover for managed care enrollees while they were incarcerated. In 2011, OMIG finalized 29 audits, with identified overpayments of $2.25 million.

Recovery of Capitation Payments for Retroactive Disenrollment Transactions

Local districts and/or the NYC HRA instruct MCOs to void premium claims for any month where a managed care member is retroactively disenrolled and the MCO was not at risk to provide services to the member during that time. Retroactive disenrollments include inappropriate capitated payments made on behalf of a single enrollee who receives multiple client identification numbers, deceased and incarcerated enrollees, enrollees permanently placed in an institutional facility, or enrollees who moved out of state. These retroactive-disenrollment situations are identified by the local district/NYC HRA or through reports generated by OMIG which list retroactive-disenrollments not initially identified. In 2011, through the combined efforts of OMIG, DOH, and the local districts, including NYC HRA, 148 audits were finalized, identifying $13 million in overpayments.

Family Planning Services

Under federal rules, managed care enrollees are entitled to receive family planning and reproductive health services from a FFS Medicaid provider outside of their MCO's provider network. If an enrollee receives the service outside of their plan's provider network, the servicing provider is compensated by Medicaid and the MCO is responsible for repaying Medicaid for the FFS payment made to the out-of-network provider. In 2011, OMIG finalized 31 audits and identified $9.2 million in overpayments for family planning services billed directly to Medicaid.

Incorrect Locator Code Designations

Each managed care enrollee is assigned a number that identifies the enrollee's county of residence which has fiscal responsibility for that person. The county determines the level of payment a managed care plan receives for insuring each enrollee. OMIG identified instances where managed care plans were receiving higher than appropriate capitation and supplemental payments due to billing at a locator code other than the one for the enrollee's county of fiscal responsibility. In 2011, OMIG finalized 10 audits that identified $1.6 million in overpayments.

Newborn FFS/Managed Care Crossover

OMIG identified instances where a hospital inappropriately received a FFS Medicaid payment for a newborn enrolled in managed care whereas the managed care plan was responsible for the cost of the newborn's birth. In 2011, OMIG finalized five audits identifying $1.2 million in overpayments.

Nursing Home – Bed Reserve Audits

The Medicaid program reimburses RHCFs for reserving a Medicaid beneficiary's bed when that person must leave the facility on temporary hospital or therapeutic leave of absence if certain conditions are met. OMIG continues to review bed reserve payments to assure that a RHCF is in compliance with Title 18 NYCRR §505.9(d), which addresses the eligibility and requirements to bill Medicaid for a reserved bed day. In 2011, OMIG finalized 11 audits that identified $1.1 million in overpayments.

Provider Self-Disclosures

OMIG is responsible for operating the statewide mandatory self-disclosure program for all Medicaid FFS providers, regardless of the types of services provided to beneficiaries. OMIG's BoC is further promoting the self-disclosure process through presentations to the provider community and effectiveness reviews.

OMIG recognizes that many improper payments are discovered during the course of a provider's internal review process. While providers who identify they have received inappropriate payments from the Medicaid program are obligated to return the overpayments[1], OMIG appreciates it is essential to develop and maintain a fair, reasonable process that will be mutually beneficial for both NYS and the provider involved.

OMIG's self-disclosure unit's goal is to provide the most efficient, user-friendly methods for providers to refund Medicaid payments to DOH. OMIG created a process, promoted by providers and attorneys, for submissions to include disclosure reasons, financial impact to the Medicaid program, and corrective measures undertaken to prevent the error from reoccurring. Through this self-disclosure approach, OMIG's overall efforts to eliminate fraud, waste, and abuse will be enhanced. Disclosures submitted to OMIG are reviewed for necessary facts and data, including any statistical sampling and extrapolation of overpayments, and analyzed for reasonableness and credibility, along with verification of claim data to determine the amount of overpayment.

In 2011, the number of self-disclosure cases received increased to 554 cases from the 227 cases received in 2010. Overpayments of resolved cases totaled $2.7 million for 2011. Results of all self-disclosure activities are listed in Tables 2.2 – 2.6 within the Appendix.

[1] See 18 NYCRR §515.2.

County Demonstration Program Activities

The purpose of OMIG's Medicaid Fraud, Waste, and Abuse County Demonstration Program (County Demonstration Program) is to partner with counties and NYC in an effort to detect fraud, waste, and abuse conducted by providers in the Medicaid program and recoup overpayments. Currently, 16 jurisdictions have an executed Memorandum of Understanding in place with the State; of which 11 counties and NYC are actively participating in the County Demonstration Program. In 2011, the County Demonstration Program focused on audits of pharmacy and transportation services providers, as well as evaluating other areas of focus including reviews of home health services. This evaluation was started because of requests from participating counties to review additional service types. In 2011, OMIG finalized 90 audits that identified $11.9 million in overpayments.

County Demonstration Program activities are shown in Tables 6.1-6.4 within the Appendix.

Medicaid Payment Monitoring and Recovery Activities

OMIG payment monitoring and recovery activities focus on using technology, including data matches, and front-end payment controls, to leverage state activities to improve program integrity. Below are highlights of these activities from 2011, and detailed data can be found in Tables 7.1 – 8.2 within the Appendix.

Third-Party Insurance Review Activities

Medicaid is the payer of last resort, but 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 local districts.

Pre-Payment Insurance Verification Cost Savings Activities

NYS has been successful in identifying other insurers who should have paid for services instead of Medicaid. These pre-payment insurance verification activities have resulted in cost savings to the state's Medicaid program of approximately $1.2 billion.

Third-Party Recovery Activities

FFS Third-Party Recovery – The primary objective is to identify and maximize private insurance and Medicare coverage. This enables the state to recover Medicaid funds.

Managed Care Third-Party Recovery – The State and managed care plans now share responsibility for the collection of third-party revenues, pursuant to respective managed care contracts. This is generating additional cash recoveries.

During the past year, OMIG, through its vendor HMS, initiated 6,158 third-party reviews, with recoveries of more than $222 million.

Home Health Care Demonstration Project

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

This demonstration project replaces previous third-party-liability audit activities of individually gathering Medicare claims from home health agencies for every dual eligible Medicaid claim the State has possibly paid in error. This is an administrative savings in

resources for the home health agencies, as well as the regional home health intermediary and for the participating states. During 2011, this project recovered $22.8 million.

Medicaid Recovery Audit Contractor

HMS was designated as the NYS Medicaid Recovery Audit Contractor with CMS's approval of State Plan Amendment #10-43. The scope of work will draw heavily on the payment integrity portion of the HMS scope of work.

Payment integrity reviews play a crucial role in OMIG's ability to effectively leverage data mining capabilities as well as improve the enforcement of NYS Medicaid billing and reimbursement policies. OMIG continues to expand its work with commercial carriers and pharmaceutical benefit managers on suspected misreported and duplicate payment reviews using the carrier claim information as our source data. This e-Review initiative analyzes paid claims data from third-party payers and other external data. This process allows for validation of overpayment at the time of data mining and notifies providers via mail and electronically via the OMIG/HMS Provider Overpayment Reporting Terminal (PORTal). The OMIG PORTal is a web-based application that will allow providers a single point of entry for multiple OMIG reviews.

The PORTal will be designed to accommodate multiple functionalities including:

- Third-Party Reviews
- Payment Integrity Reviews
- Provider Self-Disclosures
- Medicaid credit balance reporting.

This process places more emphasis on provider compliance and program oversight as each overpayment is reviewed at the claim level.

Business Intelligence Activities

The Bureau of Business Intelligence (BBI) uses analytical tools and techniques, as well as knowledge of Medicaid program rules, to mine Medicaid claims data and identify improper claim conditions.

Dental Match

The Systems Match Recovery Unit initiated 232 dental match audits in 2011. Included in these reviews were combinations of procedure codes which should never happen, claims for residents of a skilled nursing facility that bears the responsibility for these claims, as well as consultations which did not follow Medicaid requirements when submitted. In 2011, 126 audits were finalized which identified overpayments of $2.8 million for recovery.

Products of Ambulatory Care

Products of Ambulatory Care (PAC) clinic rates are all-inclusive clinic reimbursement rates associated with procedures, diagnosis, and beneficiary age. General clinic visits are not allowable when PAC codes are submitted for payment. Also, ancillary testing and physician services are included in the all-inclusive rate. In 2011, OMIG identified $1.5 million for services inappropriately claimed in association with a PAC visit.

Pharmacy Claims – Credits for Drugs Never Picked Up

BBI staff analyzed all pharmacy claims for a one year period and calculated the average rate of pharmacy voids. A pharmacy should void a claim when a beneficiary does not pick up an ordered drug. Staff identified providers who were statistically below the normal range for voided claims. OMIG took steps to notify these providers that appeared to void at a very low rate. These actions resulted in a dramatic increase in the number of pharmacy voids and resulted in a decrease in Medicaid billings of over $170 million. Savings associated with this project are found in the Cost Savings Activities in Table 8.2 within the Appendix under "Pharmacy Claims – Credit for Prescriptions".

Salient Interactive Miner - Controlled Substances and HIV Medications

In conjunction with OMIG's Division of Medicaid Investigations (DMI), BBI staff provided data analysis and data mining services using the Salient Interactive Miner. This solution assisted staff in preparing analysis directed at potential abuse of certain high cost medications. The analysis looked at analgesics, narcotics, and HIV medication; and, focused on both the providers ordering the drugs as well as the pharmacies dispensing the drugs. The resulting data was used to support the efforts of a multi-governmental task force.

The Salient solution allows for the creation of bookmarks and story boards which can be used to perform similar analysis for subsequent providers. The bookmarks and story boards can be simple queries or complex analysis which can be used as a collaborative tool for staff working on any given project. The criteria can also be tweaked so that they can be used for a different subset of claim data.

Pre-Payment Review Activities

Pre-payment reviews use capabilities within the Medicaid claims processing system to review some, or all, of the claims for providers of interest. Using this capability, OMIG staff in the Bureau of Payment Controls and Monitoring is able to monitor and review the claiming of providers who demonstrate aberrant, unacceptable, or inappropriate billing practices. Pre-payment review can be used as a compliance tool, a deterrent to a specific activity, and as a powerful fraud deterrent tool.

Sentinel Reviews

OMIG took a second look at providers who have previously been on pre-payment review to determine whether the providers had changed their behavior and to evaluate the impact of pre-payment review.

Twelve pharmacies were reviewed for having a high volume of Edit 00536 denials (Prescription Fill Date Greater than 60 Days from Prescription Order Date) and appeared to be changing the prescription "date written" on subsequent claims to bypass the edit and obtain payment for the outdated prescription. In the six-month period following OMIG's review, eight out of 12 providers had fewer than ten claims denied for Edit 00536 that were subsequently resubmitted and paid after changing the "date written" on the claim. Two of these providers had no claims denied by Edit 00536 that were subsequently paid after changing the date written. One of the providers had not increased compliance with Medicaid billing guidelines and continued to change the date written on claims denied for Edit 00536. In the six months following OMIG's review, the provider had an increase of 7.9 percent in claims denied by Edit 00536 that were subsequently paid after changing the date written. Based on this review, OMIG is determining its next course of action.

OMIG conducted a pre-payment review of an obstetrics provider, based upon a referral from DMI, who appeared to be unbundling procedures for all-inclusive obstetric care. This provider was identified as a result of being a high earning provider during the year. Review findings noted the provider was unbundling procedures such as urinalysis and post-partum office visits while also billing one of the "global" obstetric care codes for the same beneficiary. Global codes reimburse for all-inclusive routine obstetric care, including ante-partum care, vaginal or cesarean delivery, and postpartum care. In the six months following OMIG's review, while the billing of the global codes was fairly consistent, a significant decrease (54 percent) in the volume of claims submitted with unbundled procedure codes was noted, including evaluation and management (office visits), urinalysis and contraception services. This translated to an overall reduction of 30 percent in Medicaid payments.

Cost Avoidance Highlights

OMIG has continued to increase its efforts to prevent inappropriate Medicaid payments before they are made in order to avoid costs to the Medicaid program. Some of the results of those efforts are highlighted below:

- Total cost avoidance attributable to point of service control initiatives, Cardswipe/Post & Clear, for 2011 was $213 million.
- For 2011, cost savings for the Edit 1141 medical and dental pre-payment review process totaled $44.6 million.
- Identified a transportation provider as the top surging provider of 2011, with 99 percent of the provider's services being provided to NYC beneficiaries. This provider's enrollment in Medicaid restricted the provider from operating ambulettes in NYC. Subsequent analysis identified a second transportation provider operating

with a NYC transportation operation restriction. As a result of these targeting efforts, OMIG identified cost avoidance of more than $3 million per year and potential recoveries of more than $5 million.

Administrative Actions

Administrative Hearings and Article 78 Proceedings

A final determination by OMIG that seeks to recover overpayments, impose a sanction, impose a penalty, or some combination of all these actions gives rise to administrative hearing rights. OMIG's final determinations are issued by way of a Final Audit Report or Notice of Agency Action. Both notices, regardless of format, are subject to administrative review and, if necessary, judicial review.

In 2011, OMIG received a total of 79 requests, seeking to challenge the agency's final determination. Over the course of 2011, 39 cases in which administrative hearing was requested were subsequently resolved by stipulation of settlement, seven hearing requests were withdrawn, and three hearing decisions were issued.

Article 78 of the Civil Practice Law and Rules is the main procedural vehicle to challenge final administrative agency actions in New York. Article 78 actions must be commenced in Supreme Court within four months of a final adverse administrative agency decision. A total of 30 Article 78 proceedings were filed during 2011.

In 2010, OMIG began to file judgments in an effort to recover outstanding Medicaid overpayment dollars pursuant to Social Services Law section 145-a. In calendar year 2011, OMIG obtained 39 judgments totaling $13.2 million against delinquent providers.

Sanctions – Terminations & Exclusions

Sanctions include: censure, exclusion, or conditional or limited participation in the Medicaid program (18 NYCRR § 515.3). In 2011, OMIG conducted investigations and imposed discretionary exclusions based upon:

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

Fifty-three terminations and 766 exclusions were issued during 2011. The Restricted and Excluded Individuals or Entities list contains over 4,000 Medicaid and non-Medicaid provider exclusions, and the list of Terminated Individuals or Entities has more than 800 entries. These lists are updated daily (except on holidays and weekends) and are available to the public on OMIG's website www.omig.ny.gov.

Under the program integrity provisions of ACA § 6501, states are required to terminate the participation of any individual or entity if such individual or entity is terminated under Medicare, and/or other Medicaid State plan, and/or Children's Health Insurance Plan on or after January 1, 2011. In order to help states identify those providers whose billing privileges have been revoked, CMS established a secure web-based portal that allows states to share information regarding terminated providers. NYS was the first state to utilize this site as OMIG staff worked with CMS to successfully use the system. In 2011, 542 providers were uploaded into the database.

Conclusion

OMIG appreciates the opportunity to share the results of its Medicaid program integrity activities for 2011. 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 the agency's partnerships with other state agencies, expanding provider compliance education efforts, and increasing the level of transparency in the agency's operations.

Appendix

2011

Acronym List

ACA – Affordable Care Act

BBI – Bureau of Business Intelligence

BLT – Business Line Teams

BNE – Bureau of Narcotics Enforcement

BoC – Bureau of Compliance

CHHA – Certified Home Health Agencies

CIA – Corporate Integrity Agreement

CMS – Centers for Medicare and Medicaid Services

COBA – Medicare/Medicaid Coordination of Benefits Agreement

COPS – Comprehensive Outpatient Programs

CSP – Community Support Programs

DA – District Attorney

DME – Durable Medical Equipment

DMI – Division of Medicaid Investigations

DOH – Department of Health

DOJ – Department of Justice

EHR – Electronic Health Records

EVV– Electronic Visit Verification

FFS – Fee-for-service

HCBS – Home and Community Based Services Medicaid Waiver Program

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

HIT – Health Information Technology

LDSS – Local Department of Social Services

LTHHCP – Long Term Home Health Care Provider

MCO – Managed Care Organization

MFCU – Medicaid Fraud Control Unit

MRT – Medicaid Redesign Team

NYC – New York City

NYC HRA – New York City Human Resources Administration

NYC TLC – New York City Taxi and Limousine Commission

NYCRR – New York Codes, Rules and Regulations

NYS – New York State

OASAS – Office of Alcoholism and Substance Abuse Services

OC – Office of Counsel

OHIP – Office of Health Insurance Programs

OMH – Office of Mental Health

OMIG – Office of the Medicaid Inspector General

OPMC – Office of Professional Medical Conduct

OPWDD – Office for People with Developmental Disabilities

OSNP – Office of the Special Narcotics Prosecutor

PAC – Products of Ambulatory Care

PORTal – Provider Overpayment Reporting Terminal

RHCF – Residential Health Care Facility

TBI – Traumatic Brain Injury

2011 Operational Statistics

As required by Public Health Law §35(1), the following Appendix of Operational Statistics provides information about the audits, investigations, and administrative actions, initiated and completed by OMIG.

OMIG initiates audit collections 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. Amounts reported in the attached appendices represent the value of final audit reports, identified overpayments issued during the calendar year 2011, and the value of recoveries from mail-out and systems match activity. Recovery amounts are achieved by receipt of cash, provider withholds, and 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.

Investigative Activities

2011 Investigation Activities by Source and Region

Table 1.1						
All Investigation Types						
Source	**Downstate**		**Upstate**		**Totals**	
	Initiated	**Completed**	**Initiated**	**Completed**	**Initiated**	**Completed**
Anonymous	71	40	551	403	622	443
Bureau of Narcotics Enforcement (BNE)	0	0	1	0	1	0
CQC	0	0	1	0	1	0
CSC Fraud Unit	6	8	1	3	7	11
Drug Enforcement Agency (DEA)	1	0	9	1	10	1
Enrolled Recipient	73	45	399	264	472	309
Federal Bureau of Investigation (FBI)	6	5	0	1	6	6
Federal Department of Homeland Security (DHS)	0	0	4	1	4	1
General Public (Non-enrolled)	86	46	574	439	660	485
Health and Human Services (HHS)	23	28	2	3	25	31
Law Enforcement	0	7	0	4	0	11
Local District Social Services	7	7	28	57	35	64
Managed Care Plans	29	20	112	81	141	101
NYS Department of Health (DOH)	17	9	29	48	46	57
NYS Department of Taxation and Finance	0	0	6	4	6	4
NYS Education Department	3	10	0	4	3	14
NYS Office for People with Dev Disabilities (OPWDD)	0	1	73	74	73	75
NYS Office of Temporary and Disability Act (OTDA)	0	0	32	17	32	17
NYS Office of Health Insurance (OHIP)	5	18	62	28	67	46
NYS Office of Mental Health	0	1	0	0	0	1
NYS Office of Attorney General	67	4	21	60	88	64
NYS Office of the Inspector General	18	1	1	0	19	1
NYS Office of the State Comptroller	6	1	5	2	11	3
Non-Enrolled Provider	2	0	1	5	3	5
Non-Enrolled Recipient	1	0	16	19	17	19
OMIG Audit	23	10	26	17	49	27
OMIG Bureau of Compliance	9	4	1	0	10	4
OMIG Bureau of Payment Controls and Monitoring (BPCM)	2	6	1	1	3	7
OMIG Div. of Technology and Business Automation	2	0	6	4	8	4
OMIG Division of Medicaid Investigations (DMI)	219	234	1043	1304	1262	1538
OMIG Executive	2	2	4	7	6	9
Provider	53	21	295	222	348	243
Qui Tam	0	1	0	0	0	1
Safe Guard Services (SGS)	23	3	18	7	41	10
Unknown	2	91	3	307	5	398
Total	**756**	**623**	**3,325**	**3,387**	**4,081**	**4,010**

Table 1.2						
Investigations by Subject Type and Region Summary						
	Downstate		**Upstate**		**Totals**	
Subject Type	**Initiated**	**Completed**	**Initiated**	**Completed**	**Initiated**	**Completed**
Enrolled Recipient	91	33	2,121	2,286	2,212	2,319
Providers (Enrolled & Non Enrolled)	639	553	864	821	1,503	1,374
Non Enrolled Individual	26	37	340	280	366	317
Total	**756**	**623**	**3,325**	**3,387**	**4,081**	**4,010**

Table 1.3						
Enrolled Recipients						
Source	**Downstate**		**Upstate**		**Totals**	
	Initiated	**Completed**	**Initiated**	**Completed**	**Initiated**	**Completed**
Anonymous	3	3	435	320	438	323
Bureau of Narcotics Enforcement (BNE)	0	0	1	0	1	0
Drug Enforcement Agency (DEA)	0	0	6	0	6	0
Enrolled Recipient	0	0	92	58	92	58
Federal Bureau of Investigation (FBI)	1	0	0	0	1	0
Federal Department of Homeland Security (DHS)	0	0	4	1	4	1
General Public (Non-enrolled)	3	1	385	291	388	292
Health and Human Services (HHS)	4	6	2	2	6	8
Law Enforcement	0	3		2	0	5
Local District Social Services	2	1	18	46	20	47
Managed Care Plans	1	1	64	45	65	46
NYS Department of Health (DOH)	4	0	11	31	15	31
NYS Office of Temporary and Disability Act (OTDA)	0	0	32	17	32	17
NYS Office of Health Insurance (OHIP)	0	2	5	7	5	9
NYS Office of Attorney General	0	0	0	4	0	4
NYS Office of the Inspector General	2	0	0	0	2	0
Non-Enrolled Provider	0	0	0	1	0	1
Non-Enrolled Recipient	0	0	8	10	8	10
OMIG Audit	3	0	1	0	4	0
OMIG Div. of Technology and Business Automation	0	0	3	1	3	1
OMIG Division of Medicaid Investigations (DMI)	65	6	885	1,106	950	1,112
Provider	3	0	169	129	172	129
Unknown	0	10	0	215	0	225
Total	**91**	**33**	**2,121**	**2,286**	**2,212**	**2,319**

Table 1.4						
Providers (Enrolled & Non Enrolled)						
Source	**Downstate**		**Upstate**		**Totals**	
	Initiated	**Completed**	**Initiated**	**Completed**	**Initiated**	**Completed**
Anonymous	67	37	84	62	151	99
CSC Fraud Unit	6	8	1	3	7	11
Drug Enforcement Agency (DEA)	1	0	1	0	2	0
Enrolled Recipient	71	43	191	126	262	169
Federal Bureau of Investigation (FBI)	3	3	0	1	3	4
General Public (Non-enrolled)	83	45	106	89	189	134
Health and Human Services (HHS)	16	20	0	1	16	21
Law Enforcement	0	2	0	2		4
Local District Social Services	5	6	11	9	16	15
Managed Care Plans	28	17	27	20	55	37
NYS Department of Health (DOH)	11	9	18	15	29	24
NYS Department of Taxation and Finance	0	0	6	4	6	4
NYS Education Department	3	10	0	2	3	12
NYS Office for People with Dev Disabilities (OPWDD)	0	1	34	35	34	36
NYS Office of Health Insurance (OHIP)	4	15	57	21	61	36
NYS Office of Mental Health	0	1	0	0	0	1
NYS Office of Attorney General	67	4	21	56	88	60
NYS Office of the Inspector General	13	1	1	0	14	1
NYS Office of the State Comptroller	6	1	5	2	11	3
Non-Enrolled Provider	2	0	0	4	2	4
Non-Enrolled Recipient	1	0	3	6	4	6
OMIG Audit	17	10	16	17	33	27
OMIG Bureau of Compliance	9	4	1	0	10	4
OMIG Bureau of Payment Controls and Monitoring (BPCM)	3	6	1	1	4	7
OMIG Div. of Technology and Business Automation	2	0	3	3	5	3
OMIG Division of Medicaid Investigations (DMI)	152	219	153	191	305	410
OMIG Executive	2	2	2	5	4	7
Provider	42	19	101	69	143	88
Safe Guard Services (SGS)	23	3	18	7	41	10
Unknown	2	67	3	70	5	137
Total	**639**	**553**	**864**	**821**	**1,503**	**1,374**

Table 1.5						
Non Enrolled Individuals						
Source	**Downstate**		**Upstate**		**Totals**	
	Initiated	**Completed**	**Initiated**	**Completed**	**Initiated**	**Completed**
Anonymous	1	0	32	21	33	21
CQC	0	0	1	0	1	0
Drug Enforcement Agency (DEA)	0	0	2	1	2	1
Enrolled Recipient	2	2	116	80	118	82
Federal Bureau of Investigation (FBI)	2	2	0	0	2	2
General Public (Non-enrolled)	0	0	83	59	83	59
Health and Human Services (HHS)	3	2	0	0	3	2
Law Enforcement	0	2	0	0	0	2
Local District Social Services	0	0	4	2	4	2
Managed Care Plans	0	2	21	16	21	18
NYS Department of Health (DOH)	2	0	0	2	2	2
NYS Education Department	0	0	0	2	0	2
NYS Office for People with Dev Disabilities (OPWDD)	0	0	39	39	39	39
NYS Office of Health Insurance (OHIP)	1	1	0	0	1	1
NYS Office of the Inspector General	3	0	0	0	3	0
Non-Enrolled Provider	0	0	1	0	1	0
Non-Enrolled Recipient	0	0	5	3	5	3
OMIG Audit	3	0	4	0	7	0
OMIG Division of Medicaid Investigations (DMI)	1	9	5	7	6	16
OMIG Executive	0	0	2	2	2	2
Provider	8	2	25	24	33	26
Qui Tam	0	1	0	0	0	1
Unknown	0	14	0	22	0	36
Total	**26**	**37**	**340**	**280**	**366**	**317**

Table 1.6						
Forgery Investigations by Source and Region						
Source	**Downstate**		**Upstate**		**Totals**	
	Initiated	**Completed**	**Initiated**	**Completed**	**Initiated**	**Completed**
Anonymous	0	0	0	1	0	1
Bureau of Narcotics Enforcement (BNE)	0	0	1	0	1	0
Enrolled Recipient	0	0	1	0	1	0
General Public (Non-enrolled)	0	0	3	5	3	5
Health and Human Services (HHS)	0	1	2	2	2	3
Local District Social Services	0	0	2	26	2	26
Managed Care Plans	0	0	1	1	1	1
NYS Department of Health (DOH)	0	0	0	2	0	2
NYS Office of the Inspector General	1	0	0	0	1	0
Non-Enrolled Recipient	0	0	0	1	0	1
OMIG Audit	1	0	0	0	1	0
OMIG Division of Medicaid Investigations (DMI)	0	3	785	1,022	785	1,025
Provider	2	1	33	29	35	30
Unknown	0	1	0	63	0	64
Total	**4**	**6**	**828**	**1,152**	**832**	**1,158**

2011 Investigative Referrals

Table 1.7	
DMI Referrals to MFCU	
Provider Type	**2011**
Applicant for EAR	1
Dental Groups	1
Dentist	2
Diagnostic & Treatment Center.	5
Enrolled Provider	4
Home Health Agency	9
Hospital	1
Long Term Care Facility	3
Medical Appliance Dealer	1
Multi-Type	1
Multi-Type Group	2
Nurse	4
No Provider Type	2
Non Enrolled Provider	16
Pharmacy	14
Physician	10
Therapist	1
Transportation	10
Total	**87**

Table 1.8	
DMI Referrals to Outside Agencies	
Agency	**2011**
Bureau of Narcotic Enforcement	20
Commission on Quality of Care	1
Department of Justice	4
Health and Human Services (HHS-OIG)	3
Law Enforcement Agency	356
Local District Attorney	12
Local District Social Services	405
NYC HRA Bureau of Client Fraud Investigations	1,078
Off. for People with Developmental Disabilities	3
Off. of Prof. Discipline	15
Off. of Prof. Med. Conduct	5
Off. Of Welfare Insp Gen	1
Other DOH Unit (not OMIG)	7
Other Federal Agency	8
Other State Agency	13
Out of State	2
Total	**1,933**

Table 1.9	
DMI Recipient Referrals to Outside Agencies	
Agency	**2011**
AG – MFCU	1
Bureau of Narcotic Enforcement	18
Law Enforcement Agency	340
Local District Attorney	11
Local District Social Services	377
NYC HRA Bureau of Client Fraud Investigations	1,005
Off. Of Welfare Insp Gen	1
Other DOH Unit (not OMIG)	2
Other Federal Agency	1
Other State Agency	8
Total	**1,764**

Table 1.10	
DMI Forgery Referrals to Outside Agencies	
Agency	**2011**
Bureau of Narcotic Enforcement	18
Law Enforcement Agency	184
Local District Attorney	6
Local District Social Services	36
NYC HRA Bureau of Client Fraud Investigations	611
Total	**855**

2011 Investigative Financial Activities by Region and Provider Type

Table 1.11		
Number of Reports	**Penalties**	**Recoveries**
10	$ 909,619	$ 1,280,119

Table 1.12						
2011 Investigative Financial Activities						
Provider Type	**Penalties/Restitution**		**Total**	**Number of Reports**		**Total**
	Notice of Agency Action (NOAA)	**Stipulation**		**NOAA**	**Stipulation**	
Dentist	$ 12,039	$ 0	**$ 12,039**	1	0	**1**
Home Health Agency	362	100,110	**100,472**	1	1	**2**
Medical Appliance Dealer	330	0	**330**	2	0	**2**
Pharmacy[2]	802,778	(6,000)	**796,778**	4	1	**5**
Total	**$ 815,509**	**94,110**	**$ 909,619**	**8**	**2**	**10**

Table 1.13					
2011 Investigative Financial Recoveries					
Provider Type	**Downstate**	**Upstate**	**Upstate Western**	**Out-of-State**	**Total Recoveries**
Dentist	$ 27,268	$ 0	$ 0	$ 0	**$ 27,268**
Diagnostic & Treatment Center[3]	(461,400)	5,159			**(456,241)**
Home Health Care	362	0	100,110	0	**100,472**
Hospital	97,434	0	0	0	**97,434**
Long Term Care Facility	115,500	0	0	0	**115,500**
Medical Appliance Dealer[4]	285	(395)	0	0	**(110)**
Multi-Type	30,085	0	0	0	**30,085**
Multi-Type Group	122	0	0	0	**122**
Nurse	0	35	0	0	**35**
Pharmacy	1,071,311	15,411	0	0	**1,086,722**
Physician	860	2,829	0	0	**3,689**
Transportation	72,355	202,789	0	0	**275,144**
Total	**$ 954,181**	**$ 225,828**	**$ 100,110**	**$ 0**	**$ 1,280,119**

[2] Penalty amount lowered due to issuance of a revised final in 2011 related to a 2006 final audit
[3] Recoveries lowered due to an adverse hearing decision, funds were sent to the MFCU Civil Recovery Unit
[4] Recoveries lowered due to an overpayment, monies were refunded to the provider

2011 Sanctions – Exclusions & Terminations

Table 1.14	
Actions By Exclusion Type	
Exclusion Type	**Number of Actions Total**
Exclusion – 18 NYCRR 515	766
Termination – 18 NYCRR 504.7	53
Grand Total	819

Table 1.15			
Excluded Providers Summary			
Allegation Source	**Exclusion 18 NYCRR 515**	**Termination 18 NYCRR 504.7**	**Number of Actions Total**
Dept. of Transportation	0	1	1
HHS	205	0	205
Medicaid Fraud Control Unit	126	0	126
Office of Professional Medical Conduct	89	16	105
OMIG	218	2	220
Other States	1	0	1
SED	127	34	161
Grand Total	766	53	819

Audit Activities

2011 Summary of Audit Activities

Table 2.1				
2011 Audits Statewide				
Audit Department	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Fee-for-Service Audit Total	922	707	$ 66,022,595	$ 74,097,135
Rate Audit	216	192	100,573,119	36,963,324
Managed Care	268	308	33,818,042	38,618,052
Medicaid in Education	37	38	1,464,903	1,176,776
County Demonstration Program	105	90	11,868,039	3,978,839
Total	**1,548**	**1,335**	**$ 213,746,698**	**$ 154,834,126**

2011 Fee-for-Service Audits by Project Type and Region

Table 2.2				
2011 Upstate Region Fee-for-Service Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Dentist	0	0	$ 0	$ 390
Diagnostic & Treatment Center	2	3	3,288,867	48,804
DME and Orthopedic Shoe Vendor	0	0	0	3,862
Duplicate Clinic Match	0	6	49,417	18,874
EPOGEN Clinic Review	6	0	0	0
Exception Codes	0	4	12,626	12,626
HHC-Long Term	0	1	0	0
Misc. Self-Disclosure Under $5k	14	14	17,924	17,924
OASAS	3	2	405,360	804,931
OMH	2	2	267,538	616,588
OMH-COPS	0	23	16,539,020	10,471,527
OPWDD	0	1	803,915	0
OPWDD-Day Tx	1	0	0	0
OPWDD-IRA Res Hab	1	0	0	0
PERM	1	0	0	0
Personal Care	5	2	0	0
Pharmacies	0	6	24,080	20,986
Physician Reviews	0	0	0	20,850
PRI	8	0	0	0
Self-Disclosure	83	67	3,090,286	2,749,144
SNF PRI/MDS	0	0	0	259,622
Statewide Pharmacy Project	33	0	0	0
TBI	2	6	523,630	1,244,563
Transportation Ambulette	0	0	0	18,531
Total	**161**	**137**	**$ 25,022,663**	**$ 16,309,222**

Table 2.3				
2011 Downstate Region Fee-for-Service Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Ambulatory Surgery	0	0	$ 0	$ 123,264
Certified Home Health Agency (CHHA)	4	0	0	0
Death Match	0	0	0	4,435
Dentist	0	0	0	34,513
Diagnostic and Treatment Center	2	12	2,741,202	4,316,739
DME and Orthopedic Shoe Vendor	0	0	0	320,908
Duplicate Clinic Match	0	32	524,766	391,269
EPO/Aranesp Statewide Review	0	0	0	148,552
EPOGEN Clinic Review	21	0	0	0
Exception Codes	0	32	49,657	85,736
HHC – Long Term	1	0	0	0
High Ordering Providers	8	0	0	181,410
Hospital Outpatient Department[5]	2	0	(24,965)	25,545
Inventory Audits	0	0	0	108
Misc. Self-Disclosure Under $5K	112	112	113,939	113,939
OASAS	2	3	5,889,728	2,154,667
OASAS – Inpatient	1	0	0	0
Ob/Gyn Services[6]	0	0	(565)	19,066
OMH[7]	5	3	(1,062,566)	322,962
OMH – Outpatient	0	0	0	59,905
OMH-COPS	0	17	24,346,974	15,667,763
OPWDD	1	0	0	0
OPWDD-Day Tx	9	0	0	0
OPWDD-IRA Res Hab	1	0	0	122,996
OPWDD-MSC	1	1	23,396	23,396
PERM	5	1	277,626	277,626
Personal Care	10	0	0	0
Pharmacies[8]	4	0	(2,934,469)	131,511
Physician Reviews	1	0	0	12,235
PRI	22	0	0	0
Radiology	0	0	0	8,559
Self-Disclosure[9]	182	140	(3,858,135)	12,919,276
Statewide Pharmacy Project	106	0	0	0
Traumatic Brain Injury (TBI)	3	0	0	0
Transportation Ambulette[10]	1	0	0	(33,584)
Total	**504**	**353**	**$ 26,086,588**	**$ 37,432,796**

[5] Audit overpayments identified lowered due to a stipulation agreement issued in 2011 related to a 2009 final audit
[6] Audit overpayments identified lowered due to a stipulation agreement issued in 2011 related to a 2006 final audit
[7] Audit overpayments identified lowered due to stipulation agreements issued in 2011 related to a 2010 and a 2009 final audit
[8] Audit overpayments identified lowered due to a stipulation agreement issued in 2011 related to a 2010 final audit
[9] Audit overpayments identified lowered due to stipulation agreement issued in 2011 related to a 2010 final audit and also a revised final issued in 2011 related to a 2010 final audit
[10] Audit overpayments recovered lowered due to an overpayment as a result of a stipulation issued in 2011 relating to a 2010 final audit

Table 2.4				
2011 Western Region Fee-for-Service Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Certified Home Health Agency (CHHA)	1	0	$ 0	$ 0
Diagnostic and Treatment Center	1	2	615,100	417,895
DME and Orthopedic Shoe Vendor	0	0	0	16,441
Duplicate Clinic Match	0	9	55,180	56,599
EPOGEN Clinic Review	3	0	0	0
Exception Codes	0	7	160,651	160,651
High Ordering Providers	1	0	0	0
Hospital Outpatient Department	1	0	0	0
Misc Self-Disclosure Under $5k	34	34	26,221	28,264
OASAS[11]	1	1	(52,202)	(4,364)
OMH	0	5	394,448	331,845
OMH Rehabilitation	1	1	54,660	54,660
OMH-COPS	0	36	12,856,125	12,481,565
OPWDD-Ira Res Hab	3	0	0	0
OPWDD-MSC	1	0	0	0
PCAP	0	0	0	9,856
Personal Care	3	2	0	0
Pharmacies	1	9	627,061	622,963
PRI	7	0	0	0
Self-Disclosure	87	65	3,159,199	2,739,999
Statewide Pharmacy Project	65	0	0	0
TBI	2	2	1,089,445	310,095
Transportation Taxi/Livery	1	0	0	0
Total	**213**	**173**	**$ 18,985,888**	**$ 17,226,470**

Table 2.5				
2011 Out-of-State Fee-for-Service Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Ambulatory Surgery[12]	0	0	$ (6,868,089)	$ 255,955
Exception Codes	0	1	16,449	16,449
Hospital Inpatient	0	1	0	77,040
Misc Self-Disclosure Under $5k	39	39	14,382	14,382
Pharmacies	1	1	2,673,313	2,673,313
Physician Reviews	0	0	0	107
Self-Disclosure	3	2	91,400	91,400
Total	**43**	**44**	**$ (4,072,545)**	**$ 3,128,646**

[11] Audit overpayments identified/overpayments recovered lowered due to stipulation issued in 2011 related to a 2009 final audit
[12] Audit overpayments identified lowered due to stipulations issued in 2011 relating to a 2009 final audit and a 2010 final audit

Table 2.6				
2011 Statewide Fee-for-Service Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Ambulatory Surgery[13]	0	0	$ (6,868,089)	$ 379,220
Certified Home Health Agency (CHHA)	5	0	0	0
Death Match	0	0	0	4,435
Dentist	0	0	0	34,903
Diagnostic and Treatment Center	5	17	6,645,169	4,783,437
DME and Orthopedic Shoe Vendor	0	0	0	341,212
Duplicate Clinic Match	0	47	629,363	466,743
EPO/Aranesp Statewide Review	0	0	0	148,552
EPOGEN Clinic Review	30	0	0	0
Exception Codes	0	44	239,383	275,462
HHC-Long Term	1	1	0	0
High Ordering Providers	9	0	0	181,410
Hospital Inpatient	0	1	0	77,040
Hospital Outpatient Department[14]	3	0	(24,965)	25,545
Inventory Audits	0	0	0	108
Misc Self-Disclosure Under $5k	199	199	172,466	174,508
OASAS	6	6	6,242,886	2,955,234
OASAS-Inpatient	1	0	0	0
Ob/Gyn Services[15]	0	0	(565)	19,066
OMH[16]	7	10	(400,580)	1,271,396
OMH Outpatient	0	0	0	59,905
OMH Rehabilitation	1	1	54,660	54,660
OMH-COPS	0	76	53,742,119	38,620,855
OPWDD	1	1	803,915	0
OPWDD-Day Tx	10	0	0	0
OPWDD-IRA Res Hab	5	0	0	122,996
OPWDD-MSC	2	1	23,396	23,396
PCAP	0	0	0	9,857
PERM	6	1	277,626	277,626
Personal Care	18	4	0	0
Pharmacies	6	16	389,985	3,448,773
Physician Reviews	1	0	0	33,191
PRI	37	0	0	0
Radiology	0	0	0	8,559
Self-Disclosure	355	274	2,482,751	18,499,820
SNF-PRI/MDS	0	0	0	259,622
Statewide Pharmacy Project	205	0	0	0
TBI	7	8	1,613,075	1,554,658
Transportation Ambulette[17]	1	0	0	(15,054)
Transportation Taxi/Livery	1	0	0	0
Total	**922**	**707**	**$ 66,022,595**	**$ 74,097,135**

[13] See footnote number 12 on page A15 of the Appendix
[14] See footnote number 5 on page A14 of the Appendix
[15] See footnote number 6 on page A14 of the Appendix
[16] See footnote number 7 on page A14 of the Appendix, also due to a stipulation issued in 2011 related to a 2010 final audit
[17] See footnote number 10 on page A14 of the Appendix

2011 Rate Audits by Type and Region

Table 3.1				
2011 Upstate Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Data Warehouse	0	1	$ 755,705	$ 163,679
Medicare Crossover	1	1	46,157	0
Medicare Part B	1	0	0	0
MRT 154-8	5	2	20,605	9,136
Rollover – Sales Tax	1	0	0	0
Skilled Nursing – Base Year	1	2	383,913	1,730,333
Skilled Nursing – Capital	9	3	1,013,143	1,309,121
Skilled Nursing – Dropped Services	4	4	902,143	751,238
Skilled Nursing – Rate Appeal	1	1	77,084	79,440
Skilled Nursing - Rollovers[18]	8	12	(3,096,817)	1,916,046
Total	**31**	**26**	**$ 101,933**	**$ 5,958,993**

Table 3.2				
2011 Downstate Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Adult Day Care	1	2	$ 66,464,559	$ 0
Data Warehouse	0	1	95,363	9,755
Home Health Care (HHC)	4	0	0	0
HHC Long Term	2	0	0	0
Medicare Crossover	29	21	2,659,711	724,136
MRT 154-8	44	24	408,419	156,854
Rollover-Sales Tax	6	7	315,009	306,561
Skilled Nursing – Base Year	2	5	4,491,380	1,321,614
Skilled Nursing – Capital	35	18	13,252,344	8,547,801
Skilled Nursing – Dropped Services	9	13	2,642,078	5,537,751
Skilled Nursing – Rate Appeal	0	0	0	35,805
Skilled Nursing - Rollovers	12	22	2,231,219	4,819,116
Transportation	0	0	0	4,805
Total	**144**	**113**	**$ 92,560,082**	**$ 21,464,198**

[18] Audit overpayments identified lowered due to the issuance of 2 stipulations in 2011 relating to 2008 final audits

Table 3.3				
2011 Western Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
HHC Long Term	0	1	$ 0	$ 0
Medicare Crossover	1	1	15,686	15,686
Medicare Part B	1	0	0	0
MRT 154-8	3	0	0	0
Rollover-Sales Tax	5	5	158,669	102,490
Skilled Nursing – Base Year	4	6	1,767,460	2,099,834
Skilled Nursing – Capital	9	16	3,282,408	2,476,114
Skilled Nursing – Dropped Services	3	3	265,116	251,702
Skilled Nursing – Rate Appeal	0	1	126,714	126,789
Skilled Nursing - Rollovers	12	20	2,295,052	4,467,516
Total	**38**	**53**	**$ 7,911,105**	**$ 9,540,131**

Table 3.4				
2011 Statewide Rate Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Adult Day Care	1	2	$ 66,464,559	$ 0
Data Warehouse	0	2	851,067	173,433
HHC	4	0	0	0
HHC Long Term	2	1	0	0
Medicare Crossover	31	23	2,721,554	739,823
Medicare Part B	2	0	0	0
MRT 154-8	55	26	429,024	165,990
Rollover – Sales Tax	12	12	473,678	409,051
Skilled Nursing – Base Year	7	13	6,642,753	5,151,782
Skilled Nursing – Capital	53	37	17,547,895	12,333,036
Skilled Nursing – Dropped Services	16	20	3,809,337	6,540,691
Skilled Nursing – Rate Appeal	1	2	203,798	242,035
Skilled Nursing - Rollovers	32	54	1,429,454	11,202,678
Transportation	0	0	0	4,805
Total	**216**	**192**	**$ 100,573,119**	**$ 36,963,324**

2011 Managed Care and Provider Review Audits by Type and Region

Table 4.1				
2011 Upstate Region Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Death Match	10	10	$ 764,129	$ 764,129
Family Plan Chargeback/MCO	0	6	943,590	896,912
Locator Code	3	2	70,326	70,326
Mat/Kick	7	5	36,588	36,588
Multiple CIN	1	0	0	0
No Reported Encounter Data	0	1	33,517	128,556
Prison Match	7	7	667,627	667,627
Retroactive Disenrollments	32	37	2,740,076	2,740,076
Total	**60**	**68**	**$ 5,255,853**	**$ 5,304,214**

Table 4.2				
2011 Downstate Region Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Bed Reserve	0	11	$ 1,158,757	$ 3,517,934
Clinic – FQHC	0	2	319,720	319,720
DME	4	0	0	0
FFS-GME Crossover	0	2	13,752	13,752
Death Match	28	25	2,771,235	2,866,906
Dental	2	1	244,000	244,000
Duplicate Payments	1	0	0	0
Family Plan Chargeback/FFS	6	5	184,155	198,825
Family Plan Chargeback/MCO	0	12	7,807,966	9,664,316
Locator Code	9	6	1,309,902	698,007
Mat/Kick	19	12	332,673	332,672
Multiple CIN	1	1	1,576	0
No Reported Encounter Data	1	2	569,254	1,054,206
Prison Match	14	14	1,291,305	1,291,305
Recruitment & Retention	2	0	0	0
Retroactive Disenrollments	68	80	7,718,852	7,845,119
Newborn FFS-MC Crossover	2	4	1,163,533	1,402,026
Total	**157**	**177**	**$ 24,886,680**	**$ 29,448,788**

Table 4.3				
2011 Upstate Western Region Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Death Match	8	8	$ 265,998	$ 247,845
Family Plan Chargeback/FFS	2	2	7,465	7,465
Family Plan Chargeback/MCO	0	6	253,518	282,802
Locator Code	2	2	244,228	244,228
Mat/KICK	4	4	5,607	5,607
No Reported Encounter Data	0	1	16,746	129,907
Prison Match	8	8	294,788	292,358
Retroactive Disenrollments	26	31	2,577,929	2,645,608
Total	**50**	**62**	**$ 3,666,279**	**$ 3,855,820**

Table 4.4				
2011 Out-of-State Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
DME	1	0	$ 0	$ 0
Newborn FFS-MC Crossover	0	1	9,229	9,229
Total	**1**	**1**	**$ 9,229**	**$ 9,229**

Table 4.5				
2011 Statewide Managed Care and Provider Review Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Bed Reserve	0	11	$ 1,158,757	$ 3,517,934
Clinic – FQHC	0	2	319,720	319,720
DME	5	0	0	0
FFS-GME Crossover	0	2	13,752	13,752
Death Match	46	43	3,801,362	3,878,880
Dental	2	1	244,000	244,000
Duplicate Payments	1	0	0	0
Family Plan Chargeback/FFS	8	7	191,620	206,290
Family Plan Chargeback/MCO	0	24	9,005,074	10,844,030
Locator Code	14	10	1,624,456	1,012,561
Mat/KICK	30	21	374,867	374,867
Multiple CIN	2	1	1,576	0
No Reported Encounter Data	1	4	619,518	1,312,669
Prison Match	29	29	2,253,720	2,251,290
Recruitment & Retention	2	0	0	0
Retroactive Disenrollments	126	148	13,036,857	13,230,803
Newborn FFS-MC Crossover	2	5	1,172,763	1,411,256
Total	**268**	**308**	**$ 33,818,042**	**$ 38,618,052**

2011 School Supportive and Preschool Supported Health Services Programs Audits by Type and Region

Table 5.1

2011 Upstate Region Medicaid in Education Audits

Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
PSHSP	4	0	$ 0	$ 0
SSHSP	6	9	714,443	469,748
Total	**10**	**9**	**$ 714,443**	**$ 469,748**

Table 5.2

2011 Downstate Region Medicaid in Education Audits

Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
PSHSP*	2	1	$ 0	$ 0
SSHSP**	3	3	99,385	99,385
Total	**5**	**4**	**$ 99,385**	**$ 99,385**

Table 5.3

2011 Western Region Medicaid in Education Audits

Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
PSHSP	7	5	$ 430,359	$ 430,359
SSHSP	15	20	220,716	177,285
Total	**22**	**25**	**$ 651,075**	**$ 607,644**

Table 5.4

2011 Statewide Medicaid in Education Totals

Project Type	Initiated	Finalized	Overpayments Identified for Recovery	Overpayments Recovered
PSHSP	13	6	$ 430,359	$ 430,359
SSHSP	24	32	1,034,544	746,417
Total	**37**	**38**	**$ 1,464,903**	**$ 1,176,776**

*Pre-School Supportive Health Services Program
**School Supportive Health Services Program

2011 Medicaid Fraud, Waste, and Abuse County Demonstration Program Audits by Type and Region

Table 6.1				
2011 Upstate Region County Demonstration Program Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
DME and Orthopedic Shoe Vendors	0	0	$ 0	$ 6,803
Personal Care	3	0	0	0
Pharmacies	0	17	1,598,808	394,467
Physician Reviews	0	1	0	0
Transportation	9	0	0	0
Total	**12**	**18**	**$ 1,598,808**	**$ 401,270**

Table 6.2				
2011 Downstate Region County Demonstration Program Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
DME and Orthopedic Shoe Vendors	3	2	$ 2,698,866	$ 125,511
Pharmacies	68	57	6,143,549	4,353,665
Transportation	16	5	2,426,756	178,472
Total	**87**	**64**	**$ 11,269,171**	**$ 4,657,648**

Table 6.3				
2011 Western Region County Demonstration Program Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Pharmacies[19]	4	8	$ (999,939)	$ (1,080,079)
Transportation	2	0	0	0
Total	**6**	**8**	**$ (999,939)**	**$ (1,080,079)**

Table 6.4				
2011 Statewide County Demonstration Program Audit Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
DME and Orthopedic Shoe Vendors	3	2	$ 2,698,865	$ 132,314
Personal Care	3	0	0	0
Pharmacies	72	82	6,742,418	3,668,053
Physician Reviews	0	1	0	0
Transportation	27	5	2,426,756	178,472
Total	**105**	**90**	**$ 11,868,039**	**$ 3,978,839**

[19] Audit overpayments identified/overpayments recovered lowered due to a revised stipulation agreement issued in 2011 related to a 2008 stipulation

Medicaid Payment Monitoring and Recovery Activities

2011 Systems Match Recoveries by Type and Region

Table 7.1				
2011 Upstate Region Systems Match Recovery Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
ALP	2	0	$ 0	$ 0
Deceased Recipients	0	0	0	486
Dental	11	5	135,101	135,101
DME/SNF	0	1	41,955	41,955
DME Crossover – Medicaid with Medicare Detail	0	1	54,578	37,719
General Clinic	4	5	14,842	142,989
Home Health	0	2	4,595	4,595
Inpatient Crossover/Clinic/ER	7	6	96,265	0
Inpatient/Ancillary/Lab	0	5	10,731	14,920
NAMI	0	1	0	4,711
OB/Gyn[20]	0	0	(11,624)	5,606
PAC & PAS	0	2	152,095	184,572
Partial Hospitalization	0	4	269,915	297,984
PCAP	0	1	30,840	193,228
Physician – Place of Service	26	2	2,871	2,957
Total	**50**	**35**	**$ 802,164**	**$ 1,066,823**

[20] Audit overpayments identified lowered due to issuance of a stipulation in 2011 relating to a 2010 final audit

Table 7.2				
2011 Downstate Region Systems Match and Recovery Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
ALP	7	1	$ 4,439	$ 0
Chemotherapy	0	1	8,860	5,000
Deceased Recipients	0	4	42,271	65,279
Dental	114	64	1,477,026	1,194,870
DME/SNF	1	3	78,062	131,943
DME Crossover – Medicaid with Medicare Detail	0	3	521,093	105,359
Duplicate Clinic Payments	0	3	68,169	706,780
General Clinic	9	26	135,043	422,821
Home Health	0	11	85,619	87,615
Inpatient Crossover/Clinic/ER	2	3	63,476	52,415
Inpatient/Ancillary/Laboratory	0	6	6,165	6,165
NAMI[21]	0	6	164,611	(16,819)
OB/Gyn	0	1	10,959	31,834
PAC & PAS	0	7	847,680	998,447
Partial Hospitalization	0	10	413,751	559,332
Prenatal Care Assist Program (PCAP)	0	1	0	24,621
Physician – Place of Service	104	20	51,240	26,397
Podiatrists	0	0	156	468
Self-Disclosure	2	3	3,364	1,467
Total	**239**	**173**	**$ 3,981,984**	**$ 4,403,994**

Table 7.3				
2011 Western Region Systems Match Recovery Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
ALP	1	0	$ 0	$ 0
Chemotherapy	0	0	0	15,724
Deceased Recipients	0	0	5,147	5,147
Dental	30	11	62,292	68,590
General Clinic	2	24	91,844	119,646
Home Health	0	2	3,761	4,290
Inpatient Crossover/Clinic/ER	6	4	54,628	0
Inpatient/Ancillary/Lab	0	8	36,319	34,612
NAMI	0	0	0	39,296
OB/Gyn	0	0	0	8,233
PAC & PAS	0	5	481,961	484,408
Partial Hospitalization	0	2	5,918	30,385
Physician – Place of Service	54	5	18,911	12,334
Radiology[22]	0	0	0	(81)
Self-Disclosure	0	1	10,886	10,886
Total	**93**	**62**	**$ 771,667**	**$ 833,470**

[21] Audit overpayments recovered lowered due to refunds released to 2 providers as a result of stipulation agreements issued in 2011 relating to final audits in prior reporting periods

[22] Audit overpayments recovered lowered due to identification of overpayments received by OMIG from the provider necessitating a refund in 2011

Table 7.4				
2011 Out-of-State Systems Match Recovery Audits				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
Dental	77	46	$ 1,129,956	$ 688,095
DME/SNF	0	0	0	14,846
DME Crossover – Medicaid with Medicare Detail	0	0	0	11,774
General Clinic[23]	0	4	0	(19)
OB/Gyn	0	0	0	25,471
Physician – Place of Service	18	4	62,282	2,969
Radiology	0	0	0	10,834
Total	**95**	**54**	**$ 1,192,238**	**$ 753,970**

Table 7.5				
2011 System Match and Recovery Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Overpayments Identified for Recovery**	**Overpayments Recovered**
ALP	10	1	$ 4,439	$ 0
Chemotherapy	0	1	8,860	20,724
Deceased Recipients	0	4	47,418	70,912
Dental	232	126	2,804,375	2,086,655
DME/SNF	1	4	120,017	188,744
DME Crossover – Medicaid with Medicare Detail	0	4	575,671	154,852
Duplicate Clinic Payments	0	3	68,169	706,780
General Clinic	15	59	241,729	685,437
Home Health	0	15	93,975	96,500
Inpatient Crossover/Clinic/ER	15	13	214,368	52,415
Inpatient/Ancillary/Lab	0	19	53,216	55,697
NAMI	0	7	164,611	27,188
OB/Gyn[24]	0	1	(666)	71,144
PAC & PAS	0	14	1,481,736	1,667,427
Partial Hospitalization	0	16	689,584	887,701
PCAP	0	2	30,840	217,849
Physician – Place of Service	202	31	135,303	44,657
Podiatrists	0	0	156	468
Radiology	0	0	0	10,753
Self-Disclosures	2	4	14,250	12,352
Total	**477**	**324**	**$ 6,748,051**	**$ 7,058,255**

[23] Audit overpayments recovered lowered due to identification of overpayments received by OMIG from the provider necessitating a refund in 2011

[24] Audit overpayments identified lowered due to the issuance of a stipulation and 2 revised finals relating to 2010 final audits

Third-Party Liability Recoveries

Table 8.1	
Activity Area	**2011**
HMS	$ 222,675,532
UMASS	22,850,097
Self-Disclosed TP Health Insurance	1,690,852
Total	**$ 247,216,481**

Cost Savings Activities

Table 8.2	
Activity Area	**2011**
Card Swipe Program/ Post & Clear Program	$ 213,336,442
Clinic License Verification	13,665,503
Duplicate Clinic/Nursing Home Claim Editing	139
Edit 102 – Service Date prior to Birth Date	111,362
Edit 1141 – Dental Activities	1,190,094
Edit 1141 – Medical Activities	43,454,308
Edit 1236/1238 - Order/Servicing/Referring Provider #	5,862,738
Edit 1344 – Transportation Claims	358,037
Edit 1357 – Provider ID/Service ID are the same	2,502,421
Edit 748 – DME Denied Claims	21,868
Edit 760 – Suspected Duplicate, Covered by Inpatient	2,534,890
Edit 903 – Ordering/Referring Provider Number Missing	14,768,038
Edit 927 – Transportations Claims	212,741
Edit 939 - Ordering Provider Excluded Prior to Order Date	7,035,036
Edit 941/944 – Practitioner Claims	96,976
Enrollment and Reinstatement	70,217,001
Exception and Conflict Report	310,444,130
Exclusions/Terminations – Internal	12,678,999
Exclusions/Terminations – External	11,150,082
High Ordering Physicians	97,998,449
Hospice Audit – Jacob Perlow	2,684,445
Managed Care Locator Code	61,897,416
Medicaid Payments for Deceased Recipients	62,140
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	58,961,585
Pharmacy Claims – Credits for Prescriptions	172,463,350
Pharmacies License Verification	12,629,830
Pharmacy Prior Authorization (Serostim)	39,503,170
Pre-Payment Insurance Verification Commercial	1,130,162,170
Pre-Payment Insurance Verification Medicare	69,499,794
Recipient Restriction	169,668,191
Serialized Prescription Program Edits	20,960,751
Transportation Crossover Edit	137,566
Total	**$ 2,546,269,662**