New York State
Office of the Medicaid Inspector General

2006 Annual Report

Eliot Spitzer
Governor

James G. Sheehan
Medicaid Inspector General

STATE OF NEW YORK
DEPARTMENT OF HEALTH

OFFICE OF THE MEDICAID INSPECTOR GENERAL

150 Broadway
Albany, NY 12204

Governor Spitzer
Senator Bruno
Speaker Silver
State Comptroller DiNapoli
Attorney General Cuomo

The 2006 Annual report of the Office of the Medicaid Inspector General is hereby submitted.

Pursuant to Public Health Law, §35, the Medicaid Inspector General is required annually prior to October 1, to submit a report to the Governor, the Temporary President of the Senate, the Speaker of the Assembly, the Comptroller and the Attorney General on activities undertaken by the Office over the course of the preceding calendar year. We have extended this report through June 2007 because the Office of the Medicaid Inspector General was only created in June 2006.

This report includes information regarding the number, subject and other relevant characteristics of investigations, audits, administrative actions, referrals and civil actions initiated and completed by the Office of the Medicaid Inspector General. Additionally, the report requires that specific details be provided regarding the activities initiated and completed. These details include, but are not limited to the outcome, region, source of complaint and total dollar values identified and collected.

The New York State Medicaid program is the largest in the nation. The Medicaid program reimbursed over 61 thousand health care providers over $44.2 billion for services given on behalf of over 4 million Medicaid recipients during the calendar year 2006.

The Office of the Medicaid Inspector General is well on its way to meeting its mission "to improve and preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste and abuse control activities for all State agencies responsible for services funded by Medicaid." We look forward to working with you in the future and welcome any questions.

Sincerely,

James G. Sheehan
Medicaid Inspector General

Table of Contents

OMIG Background

Executive Order 140 was issued in August 2005, creating the position of New York State Medicaid Inspector General. The Order directed the Inspector General to coordinate Medicaid fraud, waste and abuse control activities of all state executive branch agencies, and to recommend legislative, policy and structural changes needed to strengthen the integrity of the Medicaid program.

On February 2, 2006 the Office of the Medicaid Inspector General (OMIG) was established through the issuance of a superseding Executive Order, Number 140.1. Audit, investigative, fraud detection systems and third party liability staff were transferred to the OMIG.

Efforts were undertaken to separate the administrative functions and program integrity while still preserving the single state agency structure required by Federal law. Although the OMIG is part of the New York State Department of Health, the Medicaid Inspector General reports directly to the Governor.

On July 26, 2006, Chapter 442 of the Laws of 2006 was signed, establishing the OMIG as a formal state agency. Section 34 of the Chapter required existing state personnel from various other state executive branch agencies, including the Office of Mental Retardation and Developmental Disabilities, the Office of Mental Health, and the Office of Alcohol and Substance Abuse Services, who engaged in the detection and prevention of Medicaid fraud, waste and abuse, to be transferred to the OMIG. The transfer of staff is still in process. The legislation amended several existing statutes, including the executive, social services, insurance and penal laws in order for the Office of the Medicaid Inspector General to accomplish the reform needed to effectively fight fraud, waste and abuse in the Medicaid system.

The functions of the OMIG include:

- conducting and supervising activities to prevent, detect and investigate Medicaid fraud, waste and abuse and, coordinating such activities with
    - the Department of Health
    - the Offices of Mental Health, Mental Retardation and Developmental Disabilities, Alcoholism and Substance Abuse Services, Temporary Disability Assistance, and Children and Family Services
    - the Commission on Quality of Care and Advocacy for Persons with Disabilities
    - the Department of Education
    - the fiscal agent—Computer Sciences Corporation (CSC)—employed to operate the Medicaid management information system
    - local governments and entities
- working in a coordinated and cooperative manner with, to the greatest extent possible,

  - the State Attorney General for Medicaid Fraud Control
  - the State Comptroller

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

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

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

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

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

The Medicaid Inspector General is headquartered in Albany with regional offices in New York City, White Plains, Hauppauge, Syracuse, Rochester, and Buffalo.

Finance – State Budget

The SFY 2006-07 Budget statutorily established the OMIG as a separate, independent entity within the Department of Health to improve and preserve the integrity of the Medicaid program. The Budget provided $96 million to support 440 existing positions and to establish 81 new positions. All existing audit and investigative resources, including related staff were transferred from the Department of Health to the OMIG.

The 2007-08 Enacted State Budget provides $98 million to support the continued operations of the OMIG. This includes $5 million to be transferred to the State University of New York to develop clinical expertise and establish guidelines and improved protocols to identify patterns of waste, fraud or abuse. The Budget also adds $4.8 million to support 157 new staff and fund the necessary investments in technology needed to improve the State's ability to combat Medicaid fraud, waste and abuse. These technology investments will:

- Strengthen the prepayment identification and verification process to maximize third party recoveries;
- Enhance the State's ability to investigate fraud and ensure compliance with provider Medicaid standards;
- Implement new technologies to utilize the capabilities of the eMedNY system for assisting in the detection of fraud, waste and abuse; and

- Improve the coordination of anti-fraud activities with other state agencies in order to improve the procedures and protocols for the detection and prevention of Medicaid fraud.

In addition, the Budget advances a series of statutory reforms to improve the State's ability to combat Medicaid fraud including the establishment of a False Claims Act to allow private persons to bring civil actions for damages and to establish whistleblower protections for employees reporting health care fraud. Other statutory measures include strengthening criminal penalties for certain fraudulent health care practices and providing the OMIG with access to vital statistics records, Tax Department wage reporting data and worker's compensation records.

New York Fraud, Waste and Abuse Recovery and Detection Project

A private consulting firm, MAXIMUS, was awarded a contract after a 2005 RFP to implement a two phase fraud, waste and abuse recovery and detection project (NY-FWARD). The OMIG is collaborating with MAXIMUS on the project. MAXIMUS will assist in identifying new activities not currently undertaken by the State to combat fraud, waste and abuse in health care programs administered by the State Medicaid program. They will also provide the means to avoid inappropriate future payments, as well as to detect and recover any overpayments that may have been made.

Phase I of the contract consists of a review and evaluation of the current fraud, waste and abuse recovery and detection efforts by DOH and the OMIG, as well as the identification of areas for improvement and new methodologies/technologies to be used for detecting, preventing and recovering improper payments. MAXIMUS is contracted by the OMIG to

- **Identify** opportunities to enhance existing fraud, waste and abuse (FWA) activities
- **Implement** processes and procedures to mitigate FWA
- **Assist** in the identification of both provider and recipient Medicaid FWA
- **Support** recovery of associated overpayments

MAXIMUS's approach includes:

- **Evaluating** current FWA activities, pre- and post-payment reviews, and technologies utilized through data mining and analysis
- **Identifying** new initiatives to detect and prevent improper payments
- **Estimating** possible savings, costs, and time
- **Implementing** new improvements and initiatives approved by the State and assisting New York in changing current processes in order to improve recoveries and cost avoidance.

Phase II of the contract will be the implementation of the new overpayment detection and recovery strategies resulting from the Phase I review and evaluation of the current fraud, waste and abuse prevention program. Phase I should be completed by December 2007.

Investigations & Enforcement

Functional Description

The Bureau of Investigations & Enforcement (BIE) performs investigations of Medicaid providers and recipients. Fraud and abuse discoveries result in the initiation of an administrative action or a referral for civil and criminal prosecution. Administrative actions include the exclusion or termination of providers from the Medicaid Program, monetary penalties, suspension of Medicaid privileges for a specified period of time, the closing of the recipient's case and the restriction of a Medicaid recipient to a single provider of a particular service. Provider issues that could result in criminal prosecution are referred to the New York State Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) for possible criminal prosecution. Providers are also referred to other government agencies including the Office of Professional Medical Conduct (OPMC), the Bureau of Narcotic Enforcement, New York State Department of Education, the Office of the Welfare Inspector General and the Health and Human Services Office of the Inspector General (HHS OIG). Referrals are also made to the OMIG Bureau of Medicaid Audit when billing irregularities suggest a need for more systemic review.

The OMIG Investigations Unit is organized into two geographic regions. The Upstate Region includes all areas of New York State, except New York City and Long Island, which make up the Downstate Region.

Investigators receive allegations from several sources including:

- the State Medicaid fraud hotline (1-877-87-FRAUD)
- other State and Federal agencies
- the NYS DOH and OMIG website contact links
- in-house referrals
- Explanation of Medical Benefits (EOMB) responses
- written correspondence
- information that is brought to the attention of an investigator during the course of unrelated investigations
- media
- Local Social Services Districts
- Medicaid Recipients

A breakout of allegation sources by region of investigation can be found in Appendix – Operational Statistics.

Hotline contact information is disseminated to the public through a number of avenues including the distribution of posters and the DOH and OMIG web sites. Calls to the hotline are entered into the Fraud Activity Comprehensive Tracking System (FACTS) by hotline staff and are then reviewed by OMIG staff for assignment and investigation.

The New York State Department of Health website http://www.nyhealth.gov/ and New York State Medicaid Inspector General's website http://www.omig.state.ny.us contain information on how to file an electronic complaint with the New York State Medicaid Inspector General. These sites also provide information on submitting complaints via mail as well as telephone contact numbers to report fraud.

For more information on the various fraud hot lines, see Fraud Hotlines Available to the Public in the Problems/Areas of Concerns section of the report.

Undercover Shopper Program

The undercover shopper program has been very successful at both identifying fraud and assisting in other investigations by confirming the existence of fraud. “Shoppers” are undercover investigators who play the part of Medicaid recipients. Medicaid benefits cards are utilized to seek and/or obtain medical services from a variety of provider types.

After conducting a shop, the shopper writes a report of his or her experience with the provider. Anomalies are noted and additional shops may be ordered to verify the findings. As cases are developed, referrals are made to the appropriate entity and/or actions are taken against the provider. The program’s findings have resulted in exclusions, terminations, penalties and referrals to the Attorney General’s Medicaid Fraud Control Unit, Bureau of Narcotic Enforcement, Office of Professional Medical Conduct and Bureau of Medicaid Audit.

The shopper program has identified physicians who billed Medicaid for services not rendered as well as those who provided substandard care to Medicaid patients. Part-time clinics are also identified for billing outside of clinic hours. Optical providers have billed Medicaid for glasses when none have been ordered or billed for extra services that were not provided. Pharmacies billed Medicaid for refills without providing the service. In addition, the shopper program has teamed with BIE’s Enrollment Audit Review Unit to identify at-risk entities before they become Medicaid providers.

The shopper program has grown exponentially since 1999. In SFY 2000-2001, 228 shops were conducted. For SFY 2006-2007, 1,018 shops were conducted.

Enrollment, Audit & Review

The Enrollment Audit Review (EAR) Unit within the Bureau of Investigations and Enforcement works in conjunction with the Provider Enrollment unit in DOH’s Office of Health Insurance Programs. OHIP staff forward to EAR the enrollment applications that are unable to be completed. The factors taken into consideration when application types are forwarded to EAR include: previous problems within the geographic area, past audit activity, business types known to be problematic and the prior conduct of the applicant.

Approximately 10% of the applications received by OHIP are forwarded to EAR for a thorough and in-depth provider review. This review includes the examination of audit files,

sanction files, State Education and the OPMC reports, as well as density criteria to determine existing levels of service availability.

Approximately 15% of the applications reviewed and processed by EAR result in a denial, netting a cost savings of approximately $52.3 million for 130 denials in 2006 and $27.1 million for 69 denials during the first half of 2007.

The unit conducts on-site inspections for Durable Medical Equipment (DME) applicants and pharmacies. On-site inspections have long been used in this office; HHS has only recently adopted this for providers of concern.

Ownership changes for all business applications are forwarded to EAR and any applicant who had been previously sanctioned, terminated, excluded or denied, or had a disciplinary action taken may have their application denied. The unit can terminate a provider for failing to comply with regulations regarding reporting of an ownership change or compliance with enrollment criteria.

Recipient Restriction Program

The New York State Recipient Restriction Program (RRP), within the Recipient Activities and Utilization Review unit of OMIG, is an administrative mechanism whereby selected recipients, with indicators of inappropriate utilization of Medicaid services, are restricted to specific primary providers.

Overall, the RRP reviewed over 11,250 recipient case records. In 2006, 7,500 cases were reviewed and 3,750 in the first half of 2007. Of the cases reviewed, 6,273 resulted in comprehensive reviews. Following local district review and processing, 2,807 restrictions were implemented in 2006 and 1,952 in the first half of 2007. Of these restrictions, 1,535 in 2006 and 1,023 in the first half of 2007 were for instances involving Alcoholism and Substance Abuse services.

RRP activities resulted in annual cost savings of approximately $75.4 million in 2006 and $40.3 million for the first half of 2007.

Drug Utilization Review Programs

The Drug Utilization Review (DUR) programs attempt to ensure that prescriptions are appropriate, medically necessary and not likely to result in adverse medical consequences. Expert software is used to select providers that are not treating or dispensing appropriately, as well as identifying recipients that are receiving drugs that can lead to adverse actions resulting in costly hospitalizations, or who are misusing prescription drugs.

In 2006 OMIG staff reviewed over 6,000 recipient cases and an additional 3,000 cases in the first half of 2007.

Using Retrospective DUR, intervention letters were sent to:

- 2,136 pharmacists serving the identified recipients in 2006, and 818 in the first half of 2007
- 6,352 treating prescribers in 2006 and 3,131 in the first half of 2007

The total interventions were 8,488 in 2006 and 3,949 in the first half of 2007

Criteria for selection included Drug to Disease Interactions (Iatrogenic & Exacerbation); Drug Interaction; Overutilization of Therapy; and Clinical Appropriateness.

- Cost savings attributed to Retrospective DUR include $4,616,055 in 2006 and an additional $3,245,739 in the first half of 2007.
- Cost savings for Prospective DUR accrued a gross savings of $140,323,782 due to the 1,839,347 net on-line rejects which were not overridden in 2006 and additional savings of $65,631,025 due to 898,932 net on-line rejects which were not overridden in the first half of 2007.

2006 - June 2007			
DUR Cases Reviewed	**DUR Cases Referred to RRP**	**Referrals Promoted to Full Case Review**	**Resulting RRP Actions**
6,000 CY 2006	900	639	262
3,000 first half 2007	322	252	74

At the request of the OHIP, the DUR Programs were transitioned to OHIP at the end of July 2007.

Summary of Investigations and Referrals

Investigations often result in referrals to other entities for closure. However, more frequently the investigation is opened and closed by the OMIG and results in dollar findings.

Investigations	Initiated	Finalized	Findings	Recoveries
2006	341	99	$7,153,257	$1,858,528
Jan.-June 2007	15	135	$3,513,865	$1,194,708

The OMIG refers preliminary findings to many different agencies. The first table below shows referrals made to the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) for 2006 and the first half of 2007. The second table shows investigative referrals made to outside agencies other than MFCU.

Investigation Referrals to MFCU		
ProviderType	**2006**	**Jan. – June 2007**
Dental Groups	1	0
Dentist	9	6
Diagnostic & Treatment Ctr.	6	8
Home Care Agency	15	6
Hospital	0	3
Long Term Care Facility	8	2
Medical Appliance Dealer	6	2
Multi-Type Group	1	0
Nurse	13	8
Pharmacy	19	10
Physician	11	15
Physician Group	0	1
Other	6	1
Therapist	2	0
Transportation	6	5
Total	**103**	**67**

Investigation Referrals to Other Agencies		
Agency	**2006**	**Jan. – June 2007**
Center for Medicare & MA	2	1
Computer Sciences Corp.	1	0
Law Enforcement Agency	1	1
Local District	236	124
OASAS	0	1
OMRDD	0	6
Off. of Prof. Discipline	10	6
Off. of Prof. Med. Conduct	4	5
Off. of Welfare Insp. General	2	2
Other	10	1
Other DOH Unit (not OMIG)	6	6
Other State Agency	11	4
Total	**283**	**157**

Division of Audit

Functional Description

The Division of Audit staff conducts audits and reviews of Medicaid providers to ensure compliance with program requirements and to determine the amount of any overpayments made. Field staff has experience in a broad range of health care programs, and have knowledge of the various types of medical providers. This affords the Division the opportunity to organize and coordinate statewide projects covering the broad spectrum of Medicaid covered services and the various program initiatives of the Department of Health, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, and the Office of Alcoholism and Substance Abuse Services.

Provider Audit

The Bureau of Medicaid Audit, Ambulatory Care conducts billing audits of Medicaid providers that are paid on a fee for service (FFS) basis, as well as rate based facilities providing outpatient services. Staff reviews and audits ordering practices of hospitals, diagnostic and treatment centers, physicians and other health care providers. The Bureau is responsible for coordinating all Medicaid related "self-disclosure" cases. Audits are also conducted to determine the medical necessity and quality of care provided.

Pharmacy Projects

In 2006, the primary focus of pharmacy audits was to verify compliance with requirements in support of Medicaid pharmacy billings. Audits were conducted using a random selection of paid services. Seventeen pharmacy audits were finalized in 2006 with total findings of $3,820,232.

New areas of concern in 2007 include information requirements on nursing home prescriptions for carve-out drugs, fax-back prescriptions, and pharmacy deliveries.

Diagnostic and Treatment Center

During calendar year 2006, 20 Diagnostic and Treatment Center (D&TC) audits were completed and a total of $2,612,011 in recoveries was identified.

During the first half of 2007, 19 D&TC audits were completed identifying $1,176,067 in recoveries.

Outpatient Chemical Dependence Providers

OMIG conducted audits of Office of Alcoholism and Substance Abuse Services (OASAS) outpatient chemical dependence providers. Case record documentation was reviewed to

determine compliance with OASAS regulations and Medicaid billing requirements. During calendar year 2006, 5 final audits were issued involving a total of $352,763 in recovery.

From January 2006 to August 2007, OASAS performed 11 investigations; issued 4 Notices of Intent to Revoke and 3 Notices to Revoke; made 5 referrals to OMIG for audit action; and made 2 referrals to the MFCU.

The combined value of OASAS fines for the time period totaled $19,841,900. OASAS estimated the value of Medicaid cost savings for the same time period at $11,700,000.

Outpatient Mental Health Services

Office of Mental Health (OMH) outpatient mental health services continued to be the subject of billing audits. During calendar year 2006, 17 final audits were completed identifying a total of $1,252,853 in recoveries.

For the period January 1, 2007 through June 30, 2007, 31 final reports were issued that identified $1,118,096 for recovery.

A data warehouse analysis of partial hospitalization payments from January 1, 2002 through December 31, 2005 identified $1.7 million in overpayments that were improperly received by providers that had exceeded treatment period requirements. Twenty-four final reports and stipulations have been issued in the first half of 2007, with a total disallowance of $868,557.

OMH policy is to refer instances of suspected Medicaid fraud, waste and abuse to the OMIG. During the above periods, OMH referred one provider for audit and also a self-disclosure involving alleged forgeries of client and staff signatures and the creation or alteration of records.

Office of Mental Retardation and Developmental Disabilities (OMRDD)

OMRDD's recoveries in 2006 from desk and field recoveries totaled $3.9 million. In addition, OMRDD referred 3 providers to the OMIG for settlement negotiations involving $803,157.

OMRDD's Bureau of Fiscal Audit conducts Limited Fiscal Reviews which include routine Medicaid billing and claiming reviews and also special reviews of providers targeted by their data analysis unit. OMRDD also utilizes a private CPA contractor to conduct fiscal reviews.

Hospital Outpatient Department (OPD)

Continued billing audits of Hospital Outpatient Departments were undertaken. These audits involve ER/Clinics, Referred Ambulatory Services and Laboratory Services.

For calendar year 2006, 24 audits were completed and $1,778,002 in overpayments was identified.

For the first six months of 2007, an additional 20 audits were completed and $4,220,457 in overpayments was identified.

Durable Medical Equipment

In 2006, audits were finalized for 13 DME providers resulting in a recovery of $492,150.

In addition to the finalized audits, three cases were referred to the New York State Office of the Attorney General's Medicaid Fraud Control Unit (MFCU). In one case, in excess of 90% of the sampled claims were disallowed. The audit identified $11,167,655 in potential overpayments. The MFCU has filed a civil recovery action seeking the recovery of these funds. Their criminal investigation is ongoing.

The other two cases involved the improper claiming for barrier wipes when standard wipes were being routinely dispensed. The potential recovery in these cases is $2,719,818.

To date in 2007, six audits have been completed with $383,868 identified for recovery.

Physician Reviews

All of the physician reviews were related to earlier similar self disclosures by other providers. Data warehouse analysis was done to evaluate whether the billing issues reported through self disclosure were present with other providers.

Twenty-five audits involving improper physician billings were completed in 2006 with findings of $426,802. Two reviews were finalized in 2007 with findings of $4,593.

Voluntary Disclosures

The Office of the Medicaid Inspector General administers the voluntary "self disclosure" process for all types of Medicaid providers.

The OMIG reconciles and validates the overpayments identified by looking at a time frame before and after the disclosure period to ensure accuracy.

Period	Cases Received	Cases Finalized	Identified Overpayment
2006	92	69	$4,597,438
Jan.-June 2007	37	57	$990,771

Prenatal Care Assistance Program

The Prenatal Care Assistance Program (PCAP) delivers complete prenatal care services to eligible low-income women. The PCAP providers are Article 28 hospital outpatient

departments and freestanding diagnostic and treatment centers who are paid an enhanced Medicaid clinic rate to deliver a full range of comprehensive services.

This matching project identified instances of Medicaid being inappropriately billed for PCAP clinic services and/or ancillary services covered in the PCAP clinic rate. In 2006, 94 final reports and stipulation agreements were issued with a total disallowance of $4,208,415.

In the first half of 2007, seven PCAP audits were finalized with a total disallowance of $216,923.

Obstetric and Gynecology Services

In the course of the PCAP review, improper Medicaid billings by physicians for obstetric and delivery services were identified. The PCAP clinic rate includes routine ante-partum physician services. Physicians billing Medicaid for ante-partum office visits, or the global delivery rate which includes ante partum care, were considered overpayments. In addition, there were numerous instances of duplicate delivery charges for the same delivery.

In 2006, 82 final reports and stipulations were issued to physicians with a total disallowance of $1,217,248**.**

In the first half of 2007, 75 final reports and stipulation agreements were issued with a total disallowance of $837,276.

Rate Based Audit

The OMIG Rate-based Audit Management and Development (AMD) Bureau is responsible for financial audits and desk reviews of cost reports used to set rates for Medicaid providers. AMD also performs billing audits of Medicaid providers who are paid on a rate basis; for example, nursing homes and managed care plans. Match projects to determine whether or not rates have been appropriately billed to Medicaid for incarcerated or deceased recipients, for example, are also conducted. OMIG staff routinely use audits and desk reviews to make these determinations. Administrative processing and collection based upon audit findings is performed in conjunction with the Department of Health, the New York State Attorney General's Office, and Medicaid providers.

Managed Care

The OMIG performs various match based and targeted reviews in the area of Managed Care to identify and recover overpayments and to determine corrective action, as appropriate, to address detected issues and errors.

In 2006, the OMIG recovered $28.3 million in overpayments from the Managed Care reviews. Continuing OMIG efforts in 2007 have resulted in recoveries of $11.5 million.

Assisted Living Facilities Billing for Residents During a Hospital Stay

An audit of New York State's Medicaid Program by the Department of Health and Human Services Office of the Inspector General identified billing errors by Assisted Living Facilities (ALF) where the ALF was improperly claiming Medicaid reimbursement when their residents were in hospitals.

As a corrective action, DOH submitted an evolution request for implementation of an edit to deny these types of payments.

In February 2007, the OMIG sent recovery letters to 51 ALF's requesting repayment of the per diem paid to the facility while the Medicaid recipient was hospitalized. For dates of service from March 1, 2001 through August 31, 2006, $164,900 was recovered.

Bed Reserve Payments to Nursing Facilities for Temporary Client Absence

The New York State Medicaid program makes approximately $100 million in payments annually to reserve nursing facility beds. A nursing facility is eligible to bill a bed reserve for a recipient when:

- the recipient has been a patient in the institution for at least 30 days since the date of initial admission;
- the institution has a vacancy rate of no more than 5 percent on the first day the recipient is hospitalized or on leave of absence;
- the recipient is expected to return to the institution in 15 or fewer days.

The OMIG performs reviews to ensure that these requirements are met. This project is self directed, and the providers selected for audit are targeted based on provider submitted cost reports and Medicaid payment history.

In 2006, the OMIG recovered $896,100 from bed reserve audits for 2001 and 2002 dates of service.

In 2006, the OMIG initiated audits of 30 facilities with $48.8 million in bed reserve billings for dates of service from January 1, 2002 through December 31, 2004. Nineteen final reports were issued with $947,566 in findings for 2006, and four reports were issued through June 2007 with total findings of $474,800.

Nursing Facilities

Nursing facilities' Medicaid rates have two components, operating and capital. The base year for the operating portion is fixed, whereas, each year's capital costs are used for the capital portion of the rate. Medicaid rates for nursing facilities are based on costs reported in 1983, or later if the facility had a change of ownership or opened since 1983. The same reported costs, with appropriate trend factors, are used for multiple years of reimbursement for the

operating portion until a new base year is set. Nursing facilities may try to maximize their Medicaid reimbursement by including inappropriate or unallowable costs in the base year.

OMIG audits identify inappropriate or unallowable costs, duplicate Medicare Part B payments, services dropped by the nursing facility but included in the reimbursement formula, rate appeal adjustments, and prior audit adjustments to property and operating costs that need to be carried over into subsequent rates.

Audit Type	2006		Jan – June 2007	
	Audits Issued	Findings (millions)	Audits Issued	Findings (millions)
Medicare Part B	5	$1.6	5	$1.8
Base Year	4	1.2	8	1.7
Rollover	201	42.6	51	8.0
Rate Appeal	25	8.6	16	4.4
Property	21	5.5	12	9.0
Dropped Services	33	6.7	15	5.7
Other	1	.1	0	0
Total	**290**	**$66.3**	**107**	**$30.6**

The NYS Department of Health will re-base all nursing facilities effective with the January 1, 2009 rate period. As a result, OMIG staff will have to analyze over 650 nursing facilities' 2002 base period costs. This analysis will begin in November 2008 and will result in the targeting of facilities for audit.

For 2006, the OMIG issued 290 audits and identified $66.3 million in overpayments. Similar OMIG efforts so far in 2007 have resulted in the issuance of 107 audits and the identification of $30.6 million in overpayments.

Systems Match & Recovery

The OMIG looks at all data within the payment system that appears to contradict acceptable conditions for payment. Often other OMIG audit activity is the identifying source for these reviews. Providers are mailed the results of reviews and are required to substantiate the payments received or, where payments can not be substantiated, return any overpayments.

In 2006, over 1,000 providers were contacted and $18.2 million in overpayments were identified with $14.2 million recovered. In the first half of 2007, over 800 providers were contacted with $6.2 million in overpayments identified and $3 million recovered.

2006 Audits				
Audit Dept.	Audits Initiated	Audits Finalized	Audit Findings	Audit Recoveries
Provider Audit Total	366	399	$ 21,489,548	$18,713,737
Rates/Audit Mgmt. & Dev. Unit	564	667	97,975,594	72,501,831
School Medicaid Program	106	91	1,081,902	1,242,565
Systems Match & Recovery Unit	1,012	1,016	18,246,809	14,190,116
Total	**2,048**	**2,173**	**$138,793,853**	**$106,648,249**

2007Audits (Jan. '07 – June '07)				
Audit Dept.	**Audits Initiated**	**Audits Finalized**	**Audit Findings**	**Audit Recoveries**
Provider Audit Total	268	300	$22,125,963	$8,083,820
Rates/Audit Mgmt. & Dev. Unit	555	425	38,358,551	35,206,733
School Medicaid Program	52	63	1,144,482	1,707,238
Systems Match & Recovery Unit	801	803	6,267,330	3,001,815
Total	**1,676**	**1,591**	**$ 67,896,326**	**$ 47,999,606**

Administrative Actions

Terminations and Exclusions

Medicaid providers can be terminated from the Medicaid program "without cause", pursuant to 18 NYCRR 504.7(a), or upon a finding that the provider has engaged in unacceptable practices pursuant to 504.7(b). In the case of a "without cause" termination, the provider's participation can be terminated by the provider or the OMIG upon 30 days written notice.

In addition, the OMIG has the discretionary power to exclude persons for "unacceptable practices" when certain conditions have been met. OMIG can also impose an "Immediate Sanction" (18 NYCRR 515.7), and/or a "Mandatory Exclusion". Mandatory Exclusions and Immediate Sanctions are imposed based upon a person:

- being charged with the commission of a felony which relates to or results from the furnishing or billing for medical care services and supplies;
- being convicted of a crime that results from the furnishing or billing for medical care, services or supplies;
- whose continued participation in the program would imminently endanger the health and welfare of the public or an individual;
- who violates a State or Federal statute and results in a final decision that the person engaged in professional misconduct or unprofessional conduct; and/or
- being excluded or terminated from participation in the Medicare program.

OMIG investigated providers and imposed discretionary exclusions during this time period based upon:

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

There were 169 terminations and 511 exclusions for 2006. For the first half of 2007, there are 105 terminations and 291 exclusions. OMIG's current exclusion list is maintained on its website and contains 767 non-Medicaid provider exclusions, and 643 Medicaid provider exclusions.

Monetary Penalties

The OMIG may impose a monetary penalty on providers and other Medicaid participants when it is determined that a person has:

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

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

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

The OMIG is authorized to seek a monetary penalty of up to $10,000 per claim found to be in violation of the above, and $30,000 if a repeat violation occurs within five years. If an audit determines that 25% or more of the reviewed claims are subject to overpayment recovery, then the OMIG may seek both recovery for each claim and the monetary penalty. In addition, the OMIG is authorized to seek monetary penalties from more than one person or persons (excluding Medicaid recipients), for the same improper claim found to have caused the overpayment.

For 2006, 50 providers were penalized for a total of $117,405. In the first half of 2007, 90 providers were penalized for a total of $301,200.

Social Services Law §145-b

Social Services Law §145-b(5) addresses the right of the State or local social services districts to recover damages from providers who knowingly make false statements or representations or who deliberately conceal material information to obtain payment from Medicaid for services or supplies. The law requires a social service district that discovers that

a provider "may have committed criminal fraud" to refer the case to OMIG. OMIG reviews the case and, if appropriate, refers the case to MFCU. If the case is not referred, OMIG must either "…further investigate the case, with notice to the social services district, or return the case to the participating social services district, which may resume its investigation of the provider."[1]

During the time period of this report, the OMIG did not undertake any 145-b actions. A number of 145-b actions are pending by local social services districts.

Attorney General Civil Collection Efforts

When the OMIG is not successful in recouping outstanding amounts due from providers, these matters are referred to the Civil Recoveries Bureau of the Office of the Attorney General (Civil Recoveries Bureau). Currently, there are 40 active civil recovery files being handled by the Civil Recoveries Bureau with a total amount due of $9,457,979 against which $1,827,099 has been collected.

According to 42 CFR §433.318, the State may seek a refund if the agency submits documentation to CMS that it has made reasonable efforts to obtain recovery. This refund is accomplished through filing of an Affidavit of Uncollectability with CMS.

Civil Affirmative Proceedings

The OMIG has authority to initiate or participate in civil proceedings, including actions at law or in equity to recover any overpayment where the action or proceeding would be more efficient or effective or in the best interests of the program. No such actions were undertaken during the reporting period.

Article 78 Proceedings

All final determinations of the OMIG are subject to judicial review after exhausting all administrative remedies. Judicial review of OMIG final determinations are commenced in Supreme Court pursuant to Article 78 of the Civil Practice Law and Rules (CPLR).

During the period of this report, there were 15 Article 78 proceedings filed. At the conclusion of the reporting period, 7 proceedings were closed.

[1] New York State Social Services Law §145-b(5)

Accomplishments

Medicaid Fraud, Waste and Abuse - County Demonstration Project

The OMIG is responsible for managing a demonstration project, authorized by the State Budget Bill of 2005, aimed at providing counties with additional incentives to pursue Medicaid fraud, waste and abuse. This created an opportunity for counties to partner with the State in its pursuit to recover improperly expended Medicaid funds. Counties interested in participating in the "County Fraud Waste and Abuse Demonstration Project" ("Demonstration Project") entered into Memoranda of Understanding (MOU) with the OMIG and the Department of Health. The MOU sets forth the respective roles and responsibilities of the counties and the OMIG relative to audits of Medicaid providers. An Administrative Directive was issued by the OMIG to the local Commissioners of Social Services in June of 2006 advising the counties of their responsibilities under the Demonstration Project relative to the audit and investigation of Medicaid providers.

During 2006, 12 counties and the City of New York joined forces with the OMIG to detect, audit and/or investigate potentially fraudulent and/or abusive practices by Medicaid providers.

Once a provider is flagged or targeted, counties request clearance from the OMIG to proceed with an audit or investigation. When approval is granted, the county submits an audit or investigative plan which is also approved by the OMIG.

Counties may use their own staff or contract with a private company to perform the necessary work. The OMIG provides a statistically valid sample of claims or cases to the counties. Their findings will be extrapolated over the audit universe to identify overpayments owed by the provider.

Investigations conducted by the counties are summarized, discussed with and reviewed by OMIG staff and, when warranted, referred to the NYS Attorney General's Office for possible criminal prosecution. While the OMIG is responsible for issuing the audit reports and completing the recovery process, the counties must be prepared to testify at administrative hearings and/or court proceedings resulting from the audits.

During 2006, two counties initiated 17 audits and 2 investigations. In the first six months of 2007, a third county became active with audits/investigations resulting in an additional 19 audits and 3 investigations being initiated. More audits/investigations are expected as the other counties finalize contracts and data exchange agreements.

Identification of Third Party Insurance

Medicaid is the payor of last resort, but providers often do not bill the responsible third party insurer. A significant amount of the State's Medicaid recoveries are the result of the OMIG's

efforts to obtain payments from third party insurers responsible for services inappropriately reimbursed by Medicaid funds.

There are two main methods for determining if a recipient has third party insurance coverage:

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

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

Application of Third Party Insurance

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

1. Claims Processing Edits. The Medicaid Management Information System (MMIS), eMedNY in New York State, applies edits that identify the existence of a recipient's other insurance during claims processing. Medicaid claims for these recipients are denied when available third party insurance has not been used. These front-end edits prevent inappropriate payment from being made in cases where a third party carrier would cover part, or all, of the service provided.

2. Post-payment Review and Recovery. A post-payment review of paid Medicaid claims, also known as pay and chase, is done by State contractors who test claims for the existence of responsible third party payors. The availability of third party insurance for the specific services provided is verified and, where determined appropriate, Medicaid recovery activities are undertaken.

This activity is designed to verify that the Medicare or other insurance payment amount entered on the Medicaid claim is the amount actually paid. If discrepancies in the third party amount resulted in an excess Medicaid payment, recovery efforts are pursued. In this situation the contractor will retroactively pursue reimbursement from the responsible provider. The contractor may also be required to pursue recoveries identified by external agencies.

OMIG initiated 6,101 third party reviews, with recoveries totaling $230,693,679 for the time period of January 1 – December 31, 2006. For the time period of January 1, 2007 – June 30, 2007, 3,677 third party reviews were initiated, yielding recoveries of $57,336,463.

Data Mining

In the area of technology, OMIG is improving the focus on data mining and is using more sophisticated methods to discover data relationships. An investment is being made in both State and contract staff with expertise in data mining technology and associated analysis. In conjunction with these efforts, we are reviewing a number of vendor software products which specialize in discovering relationships within seemingly disparate data. OMIG is also working with state, local and federal partners (through the Medi-Medi project) to acquire non-Medicaid data, such as vital statistics data, and Medicare data from additional sources to maximize the utility of these tools and improve our ability to expose anomalous behavior.

These efforts are not without challenges. The success of data mining efforts can be directly correlated to the richness of the data available. Due to national data transmission standards propagated by the Health Insurance Portability and Accountability Act, a number of data elements used to detect fraudulent and wasteful billing behaviors are no longer included. In addition, certain aspects of the Medicaid program, such as rate-based billing for some service modalities, make a data mining approach to detection less effective or simply not feasible.

Cost Savings Initiatives

The Office of the Medicaid Inspector General undertakes a variety of program integrity initiatives which result in significant cost savings to the Medicaid program. Such initiatives include:

- enhanced data matching to identify other liable third parties;
- claims processing edits that are used to prevent inappropriate payments;
- prepayment claims review;
- prior authorization initiatives;
- utilization initiatives designed to control over-utilization of prescription drugs;
- provider enrollment reviews that include a background check of the applicant and frequently on-site inspection, and;
- restricted recipient initiatives designed to control abusive and excessive utilization of services through the assignment of a recipient to a primary care provider.

Pre-Payment Insurance Verification

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

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

For 2006, the estimated cost savings totaled $679.0 million**.** For the first half of 2007, the estimated cost savings total $320.4 million**.**

System Edits

Edits are one of the most effective tools, and the first line of the defense, the OMIG uses to prevent fraud, waste and abuse. These are automated controls built into eMedNY to help ensure the proper payment of all Medicaid claims.

The development of edits is a collaborative effort, involving staff from the OMIG, the Office of Health Insurance programs (OHIP), and the DOH fiscal agent, Computer Sciences Corporation (CSC). Initiation of an edit request follows identification of a problem that can be resolved through development of front-end systems controls. However, many of the 1,500 edits of various types in the eMedNY system are initiated by the OMIG as a result of audit and investigation activities.

Some edits are used to assess the validity of a claim based on the information provided on the claim, for example a client is not Medicaid eligible on the date of service. Other edits use historical claims to assess the appropriateness of the current claim (e.g. current claim is a duplicate of a previously paid claim), or apply combination and service limitation editing to identify duplications and excess services.

When OMIG sponsors fraud, waste and abuse edit projects, there are timetables for implementation in order to meet budgetary goals. These goals often conflict with Medicaid policy goals for commencing programs to provide care. OMIG has proposed that the fiscal agent hire dedicated evolution staff to work on OMIG's projects. Fraud, waste and abuse projects would get completed more quickly and annual savings would be recognized sooner and at higher levels.

Prior to implementation, providers are notified of the impending edit, or edit change, usually via Medicaid Update articles, outreach to provider associations, and targeted mailings to providers. CSC's Provider Services staff receives training to assure they are able to interpret and educate providers on edit messages contained on remittance advices.

Edits that have a fiscal impact are tracked by OMIG to calculate and report on savings associated with their implementation.

Pre-Payment Review Process (Edit 1141)

Edit 1141 is a prepayment review function that historically has generated substantial cost savings to the Medicaid Program. The edit, which was developed in the early 1990's, generated on average $35M in savings annually. When Medicaid was moved from the Department of Social Services to the Health Department, the function was moved outside of the audit/investigative arena. It is a strong fraud, waste and abuse detection tool that also has

substantial value as a gatekeeper. In recognition of that value, the OMIG has redeployed Edit 1141 for its activities.

For 2006, cost savings totaled $4.8 million. For the first six months of 2007, cost savings total $26.7 million.

Clinic License Verification

This edit was developed to monitor the clinic license verification edits that were activated on August 10, 2002, to deny claims submitted by clinic outpatient departments and free-standing clinics with blank or misreported servicing practitioner information.

The edit values are derived by establishing a six-month pre-edit baseline and recording post-edit actual saving against the baseline. Cost savings for 2006 totaled $151.6 million**.** For the first half of 2007, cost savings total $23.0 million.

Card Swipe Program

The OMIG designates providers, based on various criteria, to become a mandatory "swiper". Providers designated as such are required to swipe the recipient's Medicaid card in a substantial number of instances. This can only be accomplished by using the VeriFone terminal. If a provider is designated as a mandatory swiper, the terminal will be supplied to the provider at no cost.

OMIG staff monitors the level of transactions that are swiped. If the OMIG determines that no valid reason exists for the low percentage of cardswipe transactions, payment of claims equivalent in dollar value to the percentage of non-swiped claims may be withheld, pending an audit or review of the claims submitted and the provider's service and claiming practices. The OMIG may treat a provider's unjustified failure to swipe as an unacceptable practice under Part 515 of Title 18 NYCRR.

The 2006 total cost savings are **$**41.1 million**.** For the first six months of 2007, cost savings total $25.7 million.

Post and Clear Program

Providers of Medicaid services are required to verify the eligibility of the Medicaid recipient. There are three methods available for utilization:

1. The Automated Response Unit (ARU or telephone).
2. The VeriFone terminal through which the recipients card may be swiped.
3. The ePACES software utilizing a computer.

These systems enable providers to:

- quickly verify eligibility,

- facilitate electronic submission of claims,
- allow pharmacies to check for potentially harmful drug interactions and costly over-utilizations, and
- significantly increase the efficiency of pre-authorizations by providers and pharmacists.

The OMIG required 358 providers who were able to order medical care, services or supplies to enter, via one of the three methods listed above, the number of pharmacy prescriptions and laboratory tests ordered. This is referred to as "posting".

Posting of the order establishes a record that the care, services or supplies have been ordered by a qualified provider. It also enables the OMIG to verify that the order has been legitimately requested prior to paying a provider who submits a claim for furnishing the service. Orders entered by a designated provider must be "cleared" off the MEVS system by the laboratory or pharmacy rendering the service.

Utilizing the post and clear system helps to ensure that only services and supplies requested by the posting provider are furnished to the recipient. It aids in the elimination of fraudulent practices such as forged prescriptions, duplication of services and serves as an additional means of control to assure the validity of prescriptions or fiscal orders. Post and Clear staff review prescriber and orderer practices to identify those whose patients are "doctor shopping", those who have had their prescription pads stolen by patients, or whose practice of prescribing or ordering Medicaid services appears to be outside the norms of their peers.

During calendar 2006, gross savings attributable to Post & Clear activities totaled $52.3 million. For the first 6 months of 2007, gross savings totaled **$**28.5 million.

Program Initiatives

OMIG Coordination with Medicaid Program Agencies

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

The first year of OMIG's operations were focused primarily on establishing the agency and developing management systems to identify activities and vulnerabilities. In 2007, OMIG has undertaken formal efforts to reach out to each of the agencies responsible for administering aspects of healthcare fraud investigations and enforcement. OMIG expects that the recent appointment of a new Deputy Inspector General for Investigations, and our planned

expansion of staff will permit OMIG to structure and develop the cooperative efforts with these agencies.

Interagency Workgroup

The Interagency Workgroup was established to help meet the primary focus of coordinating the Medicaid fraud, waste and abuse control activities of the various agencies who have a role in administering the Medicaid program. Monthly meetings with representatives from state agencies that play a part in the Medicaid Program are held to address issues, coordinate plans and foster the communication necessary to administer the Medicaid program. The participants deal with such issues as:

- resolving regulatory differences between the agencies,
- provider education/communication,
- differences in audit documentation requirements,
- interaction with law enforcement and the Attorney General's MFCU, and
- data issues pertaining to Medicaid payment systems.

The Workgroup is comprised of staff from the:

- Office of Alcoholism and Substance Abuse Services,
- Office of Mental Retardation and Developmental Disabilities,
- Office of Mental Health,
- Office of Children and Family Services,
- Office of Temporary and Disability Assistance,
- DOH Office of Health Insurance Programs,
- DOH Division of Legal Affairs, and
- Commission on Quality of Care and Advocacy for Persons with Disabilities.

Relationship with the Attorney General's Medicaid Fraud Control Unit

In order for the OMIG to be truly effective, it is vital that a high level of cooperation and coordination exists between the Medicaid Fraud Control Unit (MFCU) and the OMIG. In accordance with State law and federal regulations, MFCU is the first referral destination for all cases of suspected provider fraud. PHL **§** 32(7) See 42 CFR 455.21

OMIG continues to pursue activities that will improve and strengthen the relationship with MFCU. The BIE meets with the MFCU on a monthly basis. There is a single central coordinator assigned to ensure referrals to and from the MFCU are appropriately addressed. The Deputy Medicaid Inspector General (Deputy MIG) for BIE has been placed in New York City. One of the benefits of this placement is the proximity of the Deputy MIG with senior management in the MFCU.

State requirements under Social Services Law §363d

The State Legislature passed Social Services Law §363-d, effective January 1, 2007, requiring certain classes of medical assistance program providers to develop and implement compliance programs. This statute is based on the belief that medical assistance providers may be able to detect and correct payment and billing mistakes and fraud if they implement effective compliance programs.

Consistent with the obligations of this statute, the Office of the Medicaid Inspector General is currently in the process of drafting regulations and creating compliance guidelines that will assist providers in the development and implementation of their own compliance programs. OMIG is seeking input from key stakeholders to provide guidance that will ultimately be sufficiently comprehensive and useful. It is OMIG's expectation that the implementation of effective compliance programs by medical assistance program providers will result in fewer inaccurate billings, reduce fraud, and improve the quality of patient care while, at the same time, reducing provider costs in the long run as provider operational systems are effective and efficient.

Deficit Reduction Act of 2005

Section 6032 of the Deficit Reduction Act of 2005 added a new section, §1902(a)(68), to the Social Security Act. Under this new provision, entitled "Employee Education About False Claims Recovery", certain covered entities providing care, services, and supplies under the Medicaid program are required to establish written policies for employees, contractors and other agents relating to false claims, whistleblower protections and entity programs designed to address program fraud, waste, and abuse. State oversight of provider compliance is the responsibility of the OMIG.

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

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

All of the above information and requirements have been disseminated to the health care provider community through both the OMIG website and a Department of Health publication entitled the Medicaid Update.

Federal-State Health Reform Partnership

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

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

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

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

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

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

In order to receive the $1.5 billion in Federal Financial Participation (FFP), the following milestones must be met:

- By October 31, 2006, the State must develop and submit to CMS its plan for achieving this milestone by the end of the demonstration period, including details of Office of the Medicaid Inspector General (OMIG) staffing and new budget proposals to further enhance OMIG resources.
- By September 30, 2008, for the period of 10/01/07 – 9/30/08, the State must demonstrate its annual levels of fraud and abuse recoveries are equal to .5% of total computable Medicaid expenditures - $215 million.

- By September 30, 2009, for the period of 10/01/08 – 9/30/09, the State must demonstrate its annual levels of fraud and abuse recoveries are equal to .75% of total computable Medicaid expenditures - $322 million.
- By September 30, 2010, for the period of 10/01/09 – 9/30/10, the State must demonstrate its annual levels of fraud and abuse recoveries are equal to 1% of total computable Medicaid expenditures - $429 million.
- By September 30, 2011, for the period of 10/01/10 – 9/30/11, the State must demonstrate its annual levels of fraud and abuse recoveries are equal to 1.5% of total computable Medicaid expenditures - $644 million.

Achievement of the above milestones will be assessed within 90 days of the end of each year in the demonstration. If the State does not meet the targets in any of the years, it will be required to pay the federal government the lesser of:

- The dollar difference between actual recoveries and target recoveries as outlined above; or
- Total claimed FFP for designated State health programs in that demonstration year; not to exceed $500 million over the five year demonstration period.

Additionally, failure to reach other milestones will result in termination of the waiver.

Collections

A centralized unit has been created to increase the efficiency and effectiveness of collecting Medicaid recoupments. Since the formation of the unit, great progress has been made in improving the speed and efficiency of collection processes as well as improvements in the clarity of the information being collected and reported.

In addition to consolidation of collection functions from different bureaus within OMIG, the Collections Management Unit has been working on the following initiatives:

- The Collections Management Unit will be the single point of contact pertaining to withhold requests from the NYS Office of the Attorney General Medicaid Fraud Control Unit (MFCU) in connection with their ongoing investigation of a provider.
- Single point of contact for referral of uncollectible civil recoveries: amounts to the NYS Office of the Attorney General Civil Recoveries Bureau. Responsible for referral, follow-up and tracking.
- Single point of contact with the NYS Department of Health Legal staff pertaining to bankruptcy petitions filed by Medicaid providers that have outstanding amounts due to the Medicaid program.
- The Collections Management Unit has been appointed the task to track and report all sources of F-SHRP fraud and abuse recoveries, including any amounts generated by MFCU and the Mental Hygiene agencies.

Medi-Medi

The Medicare-Medicaid Data Match Program (Medi-Medi) is a partnership between Medicaid and Medicare that enhances collaboration and reduces fraud, waste, and abuse.

It includes state, regional, and national efforts and requires collaboration among state Medicaid agencies, the Centers for Medicare & Medicaid Services (CMS), and state and federal law enforcement officials.

The program provides an opportunity to identify fraud, waste, and abuse across Medicare and Medicaid that would otherwise go undetected when reviewing each program in isolation. Medi-Medi matches Medicaid and Medicare data in order to identify improper billing and utilization patterns. Given the breadth of Medi-Medi's mandate, programs have been able to identify a wide variety of fraud, waste and abuse. Examples include:

- fraudulent providers intentionally over-billing the programs;
- provider education issues that result in significant but unintentional abuse; and,
- systematic problems that leave the programs vulnerable to overpayments.

In some cases, the identified fraud or abuse will result in case referrals to law enforcement agencies for further investigation.

Medicaid in Education

The OMIG, in collaboration with the New York State Department of Education, has been responsible for the oversight of the Medicaid in Education under the Preschool and School Supportive Health Services Programs (P/SSHSP).

Corrective Action Reviews (CARs) have been done at the school districts and counties in order to review Medicaid claim documentation. The purpose of the CAR is to review all areas of claiming by either the district or county for proper documentation. When errors are found the district or county is asked to void the inappropriate claims. A school districts or county with a systemic error issue is required to review all claims in that service area back to the date of the last federal audit. Performing CAR rather than audits allows the agency to review claims from more districts and counties than would be able to be completed by eliminating the lengthy administrative processes required for audits. Districts and counties have not objected to self reviews of systemic error claim areas and have voided inappropriate claims as well as reported voids to OMIG. All voids, both the sample claims and the systemic error claims are tracked and reported. OMIG will focus its future efforts on pre and post payment reviews and is committed to the continual monitoring of Medicaid claims paid under P/SSHSP.

OMIG initiated 106 reviews and completed 91 reviews in calendar year 2006. For the first six months of 2007 the OMIG initiated 52 reviews and completed 63 reviews.

Payment Error Rate Measurement (PERM) Program

In order to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300) the Medicaid PERM program was initiated to estimate state-level payment error rates and, from this, national-level payment error rates for Medicaid and State Children's Health Insurance Program (SCHIP).

One third of the states were sampled in Federal Fiscal Year (FFY) 2006, one third is currently being sampled in FFY 2007 and one third will be sampled in FFY 2008. New York State is part of the FFY 2008 states.

The OMIG is responsible for two of the four areas to be reviewed under PERM. OMIG will be responsible for the Fee for Service (FFS) payments and Managed Care capitation payments. The other two areas, Medicaid eligibility and SCHIP eligibility, fall under the Office of Health Insurance Programs (OHIP).

OMIG will provide the universe of claims for FFS and Managed Care capitation payments. The first claim universes are due to the CMS contractor on January 15, 2008 for claims paid during the first Federal Fiscal Quarter of October 1, 2007 through December 31, 2007. This information will be provided to the contractor for CMS to draw samples of 300 FFS claims and 125 Managed Care claims. Each remaining Quarter of the FFY will be similarly sampled.

Once the contractor has drawn the samples, they will be provided back to OMIG for additional information.

OMIG will be contacting each of the providers in the sample and requesting a second copy of the documentation for in-house review. A large problem in the FFY 2006 PERM states is that the documentation received by the contractor from the provider is insufficient. OMIG intends to review the documentation within the agency and follow-up with providers when documentation is lacking. OMIG will also be reviewing the documentation in an effort to direct future audits and investigations into areas with potential audit findings or suspected fraud activity.

Office of Health Insurance Programs

The Office of Health Insurance Programs (OHIP) uses the Public Assistance Reporting Information System (PARIS) to review cases where Medicaid recipients are suspected of being enrolled in more than one state. This review was transferred from the Office of Temporary and Disability Assistance (OTDA) in April 2007. The table below summarizes OHIP's review of 2,370 cases.

Activity	Cases
Closed/Removed by New York State prior to the PARIS Match	460
Closed/Removed by Match	597
Multi-Person Case Closed	462
Determined Eligible for Benefits in NYS	817
Under Investigation	28
Wrong Individual Identified	6
Total	**2,370**

Office of Temporary and Disability Assistance

The Office of Temporary and Disability Assistance had a number of program integrity initiatives that impact Medicaid recipients. The results of those initiatives during the state fiscal year ended March 31, 2007 are summarized below:

Initiative	Cases Closed	
	Medicaid Only	Public Assistance & Medicaid
Automated Finger Imaging System – Identified instances of duplicate participation by recipients through a finger print match.	570	1,732
Public Assistance Recipient Information System – Identified recipients in receipt of benefits in more than one state.	2,359	1,712
Prison Match – Identifies recipients that are incarcerated.	1,570	344
Total	**4,499**	**3,788**

Problems and Concerns

At the time the OMIG was created, one of the primary issues in controlling Medicaid fraud and abuse was the lack of effective program integrity oversight of providers whose conduct did not meet the criminal threshold of intentional fraud provable beyond a reasonable doubt, but who were receiving Medicaid funds to which they were not entitled. Prior to 2006, the Department of Health represented to the Center for Medicare and Medicaid Services that program abuse was very limited, and was being effectively controlled by the use of computer edits prior to payment. In a June 2006 report, CMS rejected this analysis, stating: "The review team does not believe that New York's oversight of Medicaid program integrity is

commensurate with the risk incurred by its Medicaid program, the largest in the country", and "Enforcement, not education, should be the primary goal of program integrity staff."

New York has responded to this criticism from CMS and other observers with a fundamental change in the structure and operation of OMIG. These changes are ongoing.

However, there remain significant impediments to OMIG's success:

1. The complex structure of the New York Medicaid payment systems, and the use of codes and payment systems unique to New York. This structure results in significantly different payments to different providers for the same service. A recent study by Public Consulting Group found that the amount paid for a common mental health service "clinic regular" varied by provider from $49.64 to $567.25 for the same type of visit. This structure and complexity cause common anti-fraud and audit techniques, including data mining, to not easily be adapted to the businesses of many New York providers. OMIG employees cannot avail themselves of auditing conventions as well as training opportunities regarding national coding.

2. Weaknesses in the Medicaid enrollment systems for recipients. Responsibility for Medicaid eligibility and enrollment in New York State is multi-layered. Eligibility determinations are done by Local Departments of Social Services (LDSS) in 57 counties and the City of New York. LDSS are also responsible for determining eligibility for temporary assistance (TA – typically cash) and Food Stamps (FS), as well as family and children's services. The eligibility rules for these programs vary, but generally a person eligible for TA will also be eligible for Medicaid, as will many who are eligible for FS; thus a county TA or FS worker may also determine Medicaid eligibility and establish Medicaid coverage. Most counties also handle managed care enrollments for Medicaid recipients who either choose to, or must, enroll in managed care. In all instances, the enrollment information is transmitted to, and maintained by, the eligibility system(s) – WMS.

   LDSS staff is employed by their respective county or by New York City, not the State. Each LDSS is headed by a local commissioner who reports to his or her local executive management – County Executive and Legislature; Board of Supervisors; Mayor of New York City. State program oversight of local districts is divided among three primary State agencies:

   - DOH/OHIP supervises Medicaid
   - Office of Temporary and Disability Assistance (OTDA) supervises TA and FS
   - Office of Children and Family Services (OCFS) supervises family and children services

   Some aspects of State administration are shared, or handled by one State agency under an MOU with another. For example, Fair Hearings for the Medicaid program are conducted by hearing officers employed by OTDA, through an MOU with DOH. In addition, WMS is maintained by OTDA.

At the LDSS level, there are two separate WMS systems, one for New York City and one for the rest of the State. Although all data is ultimately aggregated at OTDA and communicated to the Medicaid payment system, eMedNY, workers using the New York City system cannot view the Upstate system, and vice versa.

The State has several methods to assist LDSS in identifying individuals who may be ineligible for benefits. Information regarding an individual who may be ineligible for benefits is forwarded by OMIG, OTDA and/or OHIP to the LDSS. Each LDSS then has the responsibility for tracking down the recipients as appropriate, confirming the information and taking appropriate action. For some counties, performing this task in addition to other obligations can be overwhelming. Effective identification of multiple enrollments, deceased, ineligible, imprisoned or relocated enrollees is not the responsibility of any single agency or system.

3. The New York Medicaid data system, eMedNY. eMedNY is in many respects an outstanding data management system which processes almost $1 billion weekly in payments for over 67,000 providers. However, it is built on an older programming platform which makes the development and application of new edits difficult. OMIG must request an evolution to impose new claims edits based upon OMIG's acquired knowledge from audits and program matches. These evolution requests must compete with requests from other agencies for limited programming personnel and time. As a result, certain OMIG requests cannot be implemented and others require over one year between the formulation of the request and implementation.

4. The diffusion of responsibility among multiple agencies each having some jurisdiction over claims review and audit. The OMIG statute contemplated centralization of most fraud and audit functions in a single state agency. This centralization has not yet occurred. In addition, there are a number of federal, state, local and private entities who have become more active in Medicaid provider auditing and investigative work since the creation of OMIG. Coordination of all these entities is beyond the statutory power of OMIG. The Office must rely on voluntary cooperation among entities with different missions, goals, management and accountability. The potential for audits being conducted by multiple overlapping agencies also raises fairness and consistency concerns for providers. These problems can be resolved, but they must first be acknowledged and addressed.

5. Inconsistent capture of findings and recoveries. The Medicaid program has had a custom of agreeing to maximum recoveries from providers at 10% of the amounts otherwise payable to the provider. In certain cases, there are providers who will not pay their existing obligations, including interest, for over twenty years with little likelihood that any further audit, no matter how egregious the result, will yield further recoveries. OMIG plans to change this practice going forward, recouping amounts due more promptly unless compelling evidence of an inability to pay exists.

6. Recruitment, staffing, and promotion problems. The OMIG law provided initial staffing for OMIG from individuals who were "substantially" engaged in audit and fraud control in other agencies. This did not include administrative and support staff – personnel, budget, operations-needed to make the agency run. These functions have been created and are being staffed from the new personnel allocations provided in the budget. Until May 2007, OMIG had limited personnel staff. Recruitment and staffing for line positions in audit and investigations have also been experiencing ongoing problems for the OMIG, due to low salaries, significant competition for new graduates in accounting and less rigid hiring and promotion rules at the competing agencies involved in enforcement and audit-the Department of Law and the Office of the State Comptroller. Promotions have presented similar problems. In several field offices, not a single employee has been promoted in ten years, there is no career ladder for current employees, and civil service lists produce individuals with no experience or knowledge in the discipline of fraud control and enforcement.

   As significant a problem is the continuing loss of senior staff to retirement. With no new hires in almost ten years, the work force in place is largely retirement eligible. Their knowledge and skills depart with them. OMIG is working diligently to address these issues.

7. Professionalization of existing work force. Few OMIG auditors have professional certifications as CPAs; no OMIG investigators are currently police officers or peace officers because of the OMIG enabling statute. The lack of professional credentials for both individuals and the organization hinders our enforcement efforts, and limits our ability to participate in joint investigations.

8. Fraud Hotlines Available to the Public. There are a number of fraud hotlines available to the public on a toll-free basis. The New York State Office of the Medicaid Inspector General receives complaints from the New York State Department of Health Medicaid fraud hotline on a routine basis. Staff from this hotline has the ability to enter complaints directly into the Medicaid Inspector General's Fraud Activity Comprehensive Tracking System.

   There are also a number of other state and federal agencies who maintain additional fraud hotlines:

   - the New York State Attorney General's Medicaid Fraud Control Unit,
   - the New York State Attorney General's Health Care Fraud Unit,
   - the United States Department of Health And Human Services Agency, and
   - the New York City Human Resources Administration

   Multiple hotlines which are not coordinated can result in duplication of efforts.

9. Peace/Police Officer Status for Investigators. OMIG investigators are subjected to the same high risk situations as Police Officers and Peace Officers of other agencies. OMIG investigators are conducting complex and specific types of Health Care Fraud

investigations and are uniquely qualified and positioned to make arrests, pursuant to New York State Penal Law § 177, in such instances involving Health Care Fraud.

OMIG Medicaid fraud investigators are utilized similarly to other Specialized Law Enforcement units such as NYS Insurance Fraud Investigators, NYS Attorney General's Investigators, US Office of the Inspector General, and other state and federal agencies, all having Police/Peace Officer status.

OMIG investigators are frequently put into high risk situations in their day to day assignments. Examples of these situations include:

- interviewing recipients and complainants in high crime locations,
- undercover operations posing as a recipient in high crime locations,
- entering facilities of providers and accepting substandard treatment from providers, many times in non-sterile hazardous locations.

Having an investigative staff that conducts business as a civilian arm to combat Medicaid fraud means OMIG investigators frequently do not receive the information or the cooperation afforded to the law enforcement community. As a civilian enforcement agency conducting law enforcement activities, the OMIG is not well received in the law enforcement community.

A resolution to this problem would be to grant Police/Peace Officer status to OMIG investigators, granting the investigators the ability to investigate Medicaid fraud with the statutory authority of the Criminal Procedure Law. If this is accomplished, OMIG investigator staff would be required to attend Peace Officer training as specified in the Criminal Procedure Law and as regulated by the Division of Criminal Justice Services. This is an established program and would grant BIE investigators the same status as Police officers. This would also be a good way to establish working contacts with MFCU investigators.

Conclusion

The 423 members of the OMIG staff appreciate the opportunity to address New York's Medicaid fraud, waste and abuse problems. We end our first year having made significant structural and process changes as well as having identified numerous new strategies to control fraud, waste and abuse.

We look forward to building on these efforts and continuing to meet the challenges of controlling Medicaid fraud, waste and abuse in the upcoming year.

Appendix

Operational Statistics

Appendix – Operational Statistics

2006 Investigations by Region and Provider Type

2006 Downstate Investigations				
Provider Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Diagnostic And Treatment Center	3	4	$ 2,543,584	$ 205,354
Dentist	0	1	0	0
Home Care Agency	1	1	32,000.00	32,000
Long Term Care Facility	1	1	794,077	407,297
Pharmacy	10	8	420,474	9,750
Physician	0	1	140,472	8,000
Nurse	0	1	0	3,470
Transportation	1	6	763,232	612,248
Total	**16**	**23**	**$ 4,693,839**	**$ 1,278,119**

2006 Upstate Investigations				
Provider Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Physician Group	1	0	$ 0	$ 0
Diagnostic & Treatment Center	0	1	110,000	0
Home Care Agency	0	0	0	477,063
Pharmacy	323	72	2,347,418	100,240
Physician	1	1	2,000	2,000
Nurse	0	1	0	0
Transportation	0	1	0	1,105
Total	**325**	**76**	**$ 2,459,418**	**$ 580,408**

2006 Total Investigations				
Provider Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Physician Group	1	0	$ 0	$ 0
Diagnostic & Treatment Center	3	5	2,653,584	205,354
Dentist	0	1	0	0
Home Care Agency	1	1	32,000	509,063
Long Term Care Facility	1	1	794,077	407,297
Pharmacy	333	80	2,767,892	109,990
Physician	1	2	142,472	10,000
Nurse	0	2	0	3,470
Transportation	1	7	763,232	613,353
Total	**341**	**99**	**$ 7,153,257**	**$ 1,858,528**

2007 Investigations by Region and Provider Type

January – June 2007 Downstate Investigations				
Provider Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Physician Group	1	1	$ 1,248	$ 1,248
Diagnostic & Treatment Center	0	1	780,908	459,537
Long Term Care Facility	0	0	0	179,408
Pharmacy	0	5	3,000	500
Physician	0	1	140,472	4,000
Transportation	6	7	545,068	181,677
Total	**7**	**15**	**$ 1,470,696**	**$ 826,369**

January – June 2007 Upstate Investigations				
Provider Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Physician Group	0	1	$ 5,047	$ 5,047
Home Care Agency	0	1	1,445,539	10,491
Pharmacy	2	112	574,633	345,050
Physician	1	1	0	0
Transportation	5	5	17,950	7,750
Total	**8**	**120**	**$ 2,043,169**	**$ 368,338**

January – June 2007 Total Investigations				
Provider Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Physician Group	1	2	$ 6,295	$ 6,295
Diagnostic & Treatment Center	0	1	780,908	459,537
Home Care Agency	0	1	1,445,539	10,491
Long Term Care Facility	0	0	0	179,408
Pharmacy	2	117	577,633	345,550
Physician	1	2	140,472	4,000
Transportation	11	12	563,018	189,427
Total	**15**	**135**	**$ 3,513,865**	**$ 1,194,708**

2006 Investigations by Source and Region

2006 Investigations						
Source	Downstate		Upstate		Totals	
	Initiated	Completed	Initiated	Completed	Initiated	Completed
BIE - Self Generated	713	339	866	446	1579	785
CMS	0	0	7	6	7	6
Correspondence	18	15	76	52	94	67
DOH - Other Than BIE	2	1	20	17	22	18
Enrollment	29	2	117	9	146	11
EOMB	15	14	28	31	43	45
Exec, Leg, Admin	1	1	10	14	11	15
HHS	0	0	0	1	0	1
Hotline	95	74	453	445	548	519
Internet	2	7	25	24	27	31
Law Enforcement	1	2	6	6	7	8
Local District	0	0	6	1	6	1
Medicaid Fraud Control Unit	2	4	44	14	46	18
Office of Professional Discipline	2	0	3	2	5	2
OHIP (OMM)	2	1	20	12	22	13
OMIG Audit	0	0	0	1	0	1
Other	2	6	6	9	8	15
RRP	0	0	2	2	2	2
Shop/CVR/Comp Target	6	5	21	4	27	9
SURS	8	4	35	7	43	11
Telephone Call	4	3	9	5	13	8
Total	**902**	**478**	**1754**	**1108**	**2656**	**1586**

2007 Investigations by Source and Region

January – June 2007 Investigations						
Source	Downstate		Upstate		Totals	
	Initiated	Completed	Initiated	Completed	Initiated	Completed
BIE - Self Generated	362	560	344	478	706	1038
CMS	1	0	5	4	6	4
Correspondence	10	12	65	54	75	66
County Demo Project	0	0	1	0	1	0
CSC Fraud Unit	1	0	0	0	1	0
DOH - Other Than BIE	4	2	24	27	28	29
Edit 1141	2	0	0	0	2	0
Enrollment	19	42	74	159	93	201
EOMB	16	12	20	14	36	26
Exec, Leg, Admin	1	3	12	13	13	16
HHS	1	1	0	1	1	2
Hotline	36	42	174	256	210	298
Internet	13	2	38	32	51	34
Law Enforcement	6	3	1	0	7	3
Local District	0	0	2	3	2	3
Medicaid Fraud Control Unit	0	0	19	9	19	9
Office of Professional Discipline	0	1	0	1	0	2
Office Of Prof. Medical Conduct	0	0	1	0	1	0
OHIP (OMM)	1	1	9	4	10	5
OMIG Audit	4	3	11	3	15	6
Other	5	3	1	5	6	8
RRP	0	1	0	0	0	1
Shop/CVR/Comp Target	1	1	14	5	15	6
SURS	0	2	22	6	22	8
Telephone Call	3	2	11	10	14	12
Total	**486**	**693**	**848**	**1084**	**1334**	**1777**

2006 Summary of Civil Recoveries

Project Type	Identified	Recoveries
Credentials	$ 229,442	$ 43,992
DME and Orthopedic Shoe Vendor	716,588	96,747
DME Mailouts	105,547	18,625
Eye Care	86,867	62,503
Free Standing Clinic	585,930	35,319
High Ordering Providers	4,050,194	99,116
NAMI	166,025	81,855
Pharmacies	2,120,983	995,526
Physician Reviews	844,191	185,485
Podiatrists	68,416	468
Radiology	455,270	207,464
Transportation	28,525	0
Total	**$ 9,457,980**	**$ 1,827,099**

2006 Provider Audits by Type and Region

2006 Downstate Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Commission On Quality Care	0	0	$ 0	$ 376,083
Credentials	0	1	0	0
Dentist	1	0	0	39,000
Diagnostic and Treatment Center	18	17	2,348,992	2,821,222
DME and Orthopedic Shoe Vendor	5	4	106,981	125,391
High Ordering Providers	0	3	74,020	48,972
Hospital Outpatient Department	19	3	1,117,664	19,369
Inpatient Billing	0	2	0	0
Laboratories	3	6	112,923	153,850
Nursing Reviews	0	2	27,876	0
OASAS	6	0	0	21,330
Ob/Gyn Services	59	48	989,751	411,230
OMH	19	10	276,508	434,666
OMH Outpatient	0	0	0	51,749
OMRDD	1	0	0	0
Other	0	1	1,040	0
PCAP	0	52	2,900,133	2,992,627
Pharmacies	17	4	365,739	292,915
Pharmacy Excessive Quantity	0	0	0	3,227
Physician Reviews	7	20	367,002	949,991
Radiology	0	4	344,454	0
Self Disclosure	56	38	3,490,824	3,837,666
TBI	0	1	3,147	3,147
Transportation	5	2	4,250	55,027
Total	**216**	**218**	**$ 12,531,304**	**$ 12,637,462**

2006 Upstate Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Diagnostic and Treatment Center	8	2	$ 207,957	$ 42,998
DME and Orthopedic Shoe Vendor	1	6	296,247	20,812
Hospital Outpatient Department	0	12	528,555	79,693
Nursing Reviews	0	1	0	0
OASAS	5	5	352,762	75,893
Ob/Gyn Services	16	14	126,670	94,249
OMH	10	2	508,706	523,947
PCAP	0	16	514,048	579,050
Pharmacies	12	3	688,543	341,124
Physician Reviews	0	1	10,773	27,892
Self Disclosure	21	17	469,114	536,938
TBI	1	5	25,919	17,432
Transportation	0	0	0	3,058
Total	**74**	**84**	**$ 3,729,294**	**$ 3,043,086**

2006 Western Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Dental Clinic Services	0	1	$ 12,996	$ 12,996
Diagnostic and Treatment Center	3	1	55,062	55,062
DME and Orthopedic Shoe Vendor	1	3	88,922	123,646
Hospital Outpatient Department	2	9	131,783	64,160
Laboratories	2	0	0	0
OASAS	2	0	0	101,215
Ob/Gyn Services	28	20	100,827	87,840
OMH	8	5	467,639	347,108
OMRDD	0	1	12,967	12,967
PCAP	0	26	794,234	682,747
Pharmacies	12	10	2,765,950	687,775
Physician Reviews	0	4	49,028	38,161
Self Disclosure	15	14	637,501	707,468
TBI	2	3	112,044	112,044
Transportation	1	0	0	0
Total	**76**	**97**	**$ 5,228,951**	**$ 3,033,189**

2006 Provider Audits Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Commission On Quality Care	0	0	$ 0	$ 376,083
Credentials	0	1	0	0
Dental Clinic Services	0	1	12,996	12,996
Dentist	1	0	0	39,000
Diagnostic and Treatment Center	29	20	2,612,011	2,919,282
DME and Orthopedic Shoe Vendor	7	13	492,150	469,850
High Ordering Providers	0	3	74,020	48,972
Hospital Outpatient Department	21	24	1,778,002	663,222
Inpatient Billing	0	2	0	0
Laboratories	5	6	112,923	153,850
Nursing Reviews	0	3	27,876	0
OASAS	13	5	352,762	198,437
Ob/Gyn Services	103	82	1,217,248	593,319
OMH	37	17	1,252,853	1,305,720
OMH Outpatient	0	0	0	51,749
OMRDD	1	1	12,967	12,967
Other	0	1	1,040	0
PCAP	0	94	4,208,415	4,254,424
Pharmacies	41	17	3,820,232	1,321,814
Pharmacy Excessive Quantity	0	0	0	3,227
Physician Reviews	7	25	426,802	1,016,044
Radiology	0	4	344,454	0
Self Disclosure	92	69	4,597,438	5,082,072
TBI	3	9	141,110	132,623
Transportation	6	2	4,250	58,085
Total	**366**	**399**	**$ 21,489,548**	**$ 18,713,737**

2007 Provider Audits by Type and Region

January – June 2007 Downstate Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Commission On Quality Care	0	0	$ 0	$ 51,233
Death Match	88	45	98,289	72,202
Dental Clinic Services	6	0	0	12,238
Dentist	2	0	0	4,837
Diagnostic and Treatment Center	18	8	176,476	442,591
DME and Orthopedic Shoe Vendor	13	3	31,363	70,311
High Ordering Providers	2	0	0	2,315
Hospital Outpatient Department	0	12	3,253,959	2,978,041
Inventory Audits	0	1	0	0
Laboratories	0	4	30,560	29,069
OASAS	5	1	33,266	41,801
Ob/Gyn Services	0	45	616,219	441,430
OMH	10	13	546,698	201,666
OMH Outpatient	0	0	0	29,903
OMRDD	1	0	0	0
Other	1	0	0	0
PCAP	0	6	179,695	22,927
Pharmacies	0	0	0	74,078
Physician Reviews	0	1	4,593	66,881
Radiology	21	7	24,013	12,374
Self Disclosure	23	36	388,399	388,399
Transportation	2	2	2,326,959	9,522
Total	**192**	**184**	**$ 7,710,488**	**$ 4,951,818**

January – June 2007 Upstate Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Death Match	9	6	$ 1,828	$ 1,828
Dental Clinic Services	0	2	37,250	37,250
Dentist	1	0	0	0
Diagnostic and Treatment Center	5	9	739,698	276,487
DME and Orthopedic Shoe Vendor	1	3	352,505	109,046
Free Standing Clinic	0	1	10,349,250	0
Hospital Outpatient Department	1	3	71,305	71,305
OASAS	3	3	69,653	98,902
Ob/Gyn Services	0	10	111,266	57,621
OMH	5	10	245,006	216,396
PCAP	0	1	37,228	7,795
Physician Reviews	0	1	0	2,815
Radiology	3	0	0	0
Self Disclosure	5	11	479,636	654,659
TBI	0	0	0	8,899
Transportation	1	0	0	211
Total	**34**	**60**	**$ 12,494,624**	**$ 1,543,214**

January – June 2007 Western Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Death Match	4	3	$ 0	$ 0
Dental Clinic Services	1	0	0	0
Diagnostic and Treatment Center	0	2	259,893	119,010
DME and Orthopedic Shoe Vendor	4	0	0	13,235
Hospital Outpatient Department	1	5	895,193	895,193
Laboratories	0	1	36,968	36,968
Nursing Reviews	2	0	0	0
OASAS	5	4	120,171	93,418
Ob/Gyn Services	0	20	109,791	77,757
OMH	6	8	326,392	54,443
Pharmacies	4	0	0	86,972
Physician Reviews	0	0	0	4,764
Radiology	4	2	32,226	14,710
Self Disclosure	9	10	122,736	174,837
TBI	2	1	17,481	17,481
Total	**42**	**56**	**$ 1,920,851**	**$ 1,588,787**

January – June 2007 Provider Audit Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Commission On Quality Care	0	0	$ 0	$ 51,233
Death Match	101	54	100,116	74,030
Dental Clinic Services	7	2	37,250	49,488
Dentist	3	0	0	4,837
Diagnostic and Treatment Center	23	19	1,176,067	838,088
DME and Orthopedic Shoe Vendor	18	6	383,868	192,592
Free Standing Clinic	0	1	10,349,250	0
High Ordering Providers	2	0	0	2,315
Hospital Outpatient Department	2	20	4,220,457	3,944,539
Inventory Audits	0	1	0	0
Laboratories	0	5	67,528	66,037
Nursing Reviews	2	0	0	0
OASAS	13	8	223,090	234,121
Ob/Gyn Services	0	75	837,276	576,808
OMH	21	31	1,118,096	472,505
OMH Outpatient	0	0	0	29,903
OMRDD	1	0	0	0
Other	1	0	0	0
PCAP	0	7	216,923	30,722
Pharmacies	4	0	0	161,050
Physician Reviews	0	2	4,593	74,459
Radiology	28	9	56,239	27,084
Self Disclosure	37	57	990,771	1,217,895
TBI	2	1	17,481	26,380
Transportation	3	2	2,326,959	9,733
Total	**268**	**300**	**$ 22,125,963**	**$ 8,083,820**

2006 Rate Audits by Type and Region

2006 Downstate Region Rate Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Adult Day Care	1	0	$ -	$ -
Bed Reserve	28	15	912,457	861,018
Clinic - Diagnostic And Treatment	0	3	650,151	-
Home Health Care and Long Term	0	0	0	22,261
Managed Care	169	171	24,524,530	24,794,126
Medicare Crossover	5	2	334,232	469,759
Medicare Maximization	0	1	10,700	0
Other	5	6	2,684	2,684
Skilled Nursing Facility Audits	108	118	41,927,952	22,120,507
Transportation	0	16	49,887	97,391
Total	**316**	**332**	**$ 68,412,593**	**$ 48,367,746**

2006 Upstate Region Rate Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Bed Reserve	1	4	35,110	35,110
Managed Care	54	55	2,631,844	2,450,959
Other	1	0	0	0
Skilled Nursing Facility Audits	31	54	6,992,980	6,627,962
Transportation	0	14	69,821	52,808
Total	**87**	**127**	**$ 9,729,755**	**$ 9,166,839**

2006 Western Region Rate Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Bed Reserve	1	0	0	$ 0
Home Health Care and Long Term	0	3	783,451	22,424
Hosp Inpatient	0	1	98,570	0
Managed Care	61	66	1,067,458	1,062,702
Medicare Crossover	0	1	5,215	0
Personal Care	0	3	382,197	0
Skilled Nursing Facility Audits	99	118	17,452,802	13,872,806
Transportation	0	16	43,555	9,314
Total	**161**	**208**	**$ 19,833,248**	**$ 14,967,247**

2006 Rate Audit Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Adult Day Care	1	0	$ 0	$ 0
Bed Reserve	30	19	947,566	896,127
Clinic – Diagnostic & Treatment Center	0	3	650,151	0
Home Health Care and Long Term	0	3	783,451	44,685
Hosp In-patient	0	1	98,570	0
Managed Care	284	292	28,223,831	28,307,788
Medicare Crossover	5	3	339,447	469,759
Medicare Maximization	0	1	10,700	0
Other	6	6	2,684	2,684
Personal Care	0	3	382,197	0
Skilled Nursing Facility Audits	238	290	66,373,734	42,621,275
Transportation	0	46	163,263	159,513
Total	**564**	**667**	**$ 97,975,595**	**$ 72,501,832**

2007 Rate Audits by Type and Region

January – June 2007 Downstate Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
ALP/Inpatient Crossover	16	17	$ 87,899	$ 63,453
Bed Reserve	4	4	474,765	250,094
Home Health Care	0	0	0	16,696
Managed Care	77	93	5,616,647	10,681,376
Medicare Crossover	0	1	135,527	0
Other	1	0	0	0
Skilled Nursing Facility Audits	33	54	13,670,922	15,624,085
Transportation	174	69	485,231	72,526
Total	**305**	**238**	**$ 20,470,990**	**$ 26,708,230**

January – June 2007 Upstate Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
ALP/Inpatient Crossover	17	15	$ 36,082	$ 36,986
Managed Care	23	22	414,767	543,572
Skilled Nursing Facility Audits	25	16	6,277,265	3,003,537
Transportation	77	33	152,377	145,812
Total	**142**	**86**	**$ 6,880,491**	**$ 3,729,907**

January – June 2007 Western Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
ALP/Inpatient Crossover	18	17	$ 62,785	$ 64,420
Managed Care	19	30	201,390	250,501
Medicare Crossover	0	1	42,981	4,179
Personal Care	0	3	0	0
Skilled Nursing Facility Audits	26	37	10,694,750	4,413,836
Transportation	45	13	5,164	35,661
Total	**108**	**101**	**$ 11,007,070**	**$ 4,768,596**

January – June 2007 Rate Audit Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
ALP/Inpatient Crossover	51	49	$ 186,765	$ 164,858
Bed Reserve	4	4	474,765	250,094
Home Health Care	0	0		16,696
Managed Care	119	145	6,232,804	11,475,449
Medicare Crossover	0	2	178,508	4,179
Other	1	0	0	0
Personal Care	0	3	0	0
Skilled Nursing Facility Audits	84	107	30,642,937	23,041,458
Transportation	296	115	642,772	253,999
Total	**555**	**425**	**$ 38,358,551**	**$ 35,206,733**

2006 Medicaid in Education Reviews by Region and Type

2006 Medicaid in Education Downstate Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Pre-School	3	0	$ 0	$ 0
School Age	30	16	133,180	58,822
Total	**33**	**16**	**$ 133,180**	**$ 58,822**

2006 Medicaid in Education Upstate Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Pre-School	4	0	$ 0	$ 0
School Age	22	41	200,729	181,962
Total	**26**	**41**	**$ 200,729**	**$ 181,962**

2006 Medicaid in Education Western Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Pre-School	5	1	$ 31,690	$ 0
School Age	42	33	716,303	1,001,781
Total	**47**	**34**	**$ 747,993**	**$ 1,001,781**

2006 Medicaid in Education Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Pre-School	12	1	$ 31,690	$ 0
School Age	94	90	1,050,212	1,242,565
Total	**106**	**91**	**$ 1,081,902**	**$ 1,242,565**

2007 Medicaid in Education Reviews by Region and Type

January – June 2007 Medicaid in Education Downstate Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
School Age	23	12	$ 70,982	$ 131,564
Total	**23**	**12**	**$ 70,982**	**$ 131,564**

January – June 2007 Medicaid in Education Upstate Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Pre-School	5	1	$ 0	$ 0
School Age	8	23	277,889	587,472
Total	**13**	**24**	**$ 277,889**	**$ 587,472**

January – June 2007 Medicaid in Education Western Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Pre-School	2	1	$ 192,639	$ 223,100
School Age	14	26	602,972	765,102
Total	**16**	**27**	**$ 795,611**	**$ 988,202**

January – June 2007 Medicaid in Education Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Pre-School	7	2	$ 192,639	$ 223,100
School Age	45	61	951,843	1,484,138
Total	**52**	**63**	**$ 1,144,482**	**$ 1,707,238**

2006 Systems Match Recoveries by Region and Type

2006 Downstate Region Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	108	108	$ 2,303,738	$ 7,150
Duplicate Clinic Payments	88	88	3,222,073	2,789,057
Home Health	0	0	0	416,959
MC - Inpatient/Newborn	60	60	6,065,847	4,099,140
Medicare Part A	0	0	0	2,427,261
Net Available Monthly Income (NAMI)	0	4	765,896	-$1,075
Non Affiliated Inpatient/Clinic/ER	208	208	427,019	287,653
Outpatient	97	97	1,973,593	1,512,125
Podiatrists	0	0	0	11,213
Program Integrity/Third Party	0	0	0	80,740
Voluntary Refunds	5	5	39,925	39,925
WTC Disaster Relief Medicaid	0	0	0	4,281
Total	**566**	**570**	**$ 14,798,091**	**$ 11,674,429**

2006 Upstate Region Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	54	54	$ 373,118	$ 0
Dental	0	0	0	163
Duplicate Clinic Payments	17	17	111,837	108,579
Home Health	0	0	0	2,919
MC - Inpatient/Newborn	16	16	375,563	336,927
Medicare Part A	0	0	0	634,970
Non Affiliated Inpatient/Clinic/ER	64	64	391,049	51,137
Outpatient	50	50	205,729	188,263
Voluntary Refunds	10	10	1,984	2,714
Total	**211**	**211**	**$ 1,459,280**	**$ 1,325,672**

2006 Western Region Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	66	66	$ 431,492	$ 0
Duplicate Clinic Payments	25	25	152,049	138,242
Home Health	0	0	0	13,007
MC - Inpatient/Newborn	27	27	1,039,210	367,381
MC - Leakage	0	0	0	19,161
Medicare Part A	0	0	0	406,362
Non Affiliated Inpatient/Clinic/ER	54	54	82,329	34,157
Outpatient	63	63	284,360	211,704
Total	**235**	**235**	**$ 1,989,439**	**$ 1,190,015**

2006 Systems Match and Recovery Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	228	228	$ 3,108,347	$ 7,150
Dental	0	0	0	163
Duplicate Clinic Payments	130	130	3,485,958	3,035,878
Home Health	0	0	0	432,886
MC - Inpatient/Newborn	103	103	7,480,621	4,803,448
MC - Leakage	0	0	0	19,161
Medicare Part A	0	0	0	3,468,593
Net Available Monthly Income (NAMI)	0	4	765,896	-$1,075
Non Affiliated Inpatient/Clinic/ER	326	326	900,397	372,948
Outpatient	210	210	2,463,682	1,912,092
Podiatrists	0	0	0	11,213
Program Integrity/Third Party	0	0	0	80,740
Voluntary Refunds	15	15	41,908	42,638
WTC Disaster Relief Medicaid Inpatient	0	0	0	4,281
Total	**1012**	**1016**	**$ 18,246,809**	**$ 14,190,116**

2007 Systems Match Recoveries by Region and Type

January – June 2007 Downstate Systems Match and Recovery Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	0	$ 0	$ 915,605
Deceased Recipients	371	371	3,048,865	0
Duplicate Clinic Payments	0	0	0	168,447
Home Health	0	0	0	176
Home Health - Nursing Home	91	91	358,919	185,508
Inpatient/Ancillary/Lab	69	69	754,700	181
MC - Inpatient/Newborn	0	0	0	304,854
Medicare Part A	0	0	0	103,376
Net Available Monthly Income (NAMI)	0	2	792,127	125,510
Non Affiliated Inpatient/Clinic/ER	0	0	0	481
Outpatient	0	0	0	347,530
Podiatrists	0	0	0	468
Voluntary Refunds	8	8	18,399	18,399
Total	**539**	**541**	**$ 973,010**	**$ 2,170,537**

January – June 2007 Upstate Region Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	0	$ 0	$ 366,705
Deceased Recipients	48	48	387,856	0
Duplicate Clinic Payments	0	0	0	1,411
Home Health	0	0	0	981
Home Health - Nursing Home	34	34	35,136	11,429
Inpatient/Ancillary/Lab	44	44	246,221	2,369
MC - Inpatient/Newborn	0	0	0	9,115
Medicare Part A	0	0	0	2,461
Non Affiliated Inpatient/Clinic/ER	0	0	0	815
Outpatient	0	0	0	6,094
Voluntary Refunds	4	4	362	432
Total	**130**	**130**	**$ 669,575**	**$ 401,812**

January – June 2007 Western Region Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	0	$ 0	$ 391,060
Deceased Recipients	32	32	217,652	0
Duplicate Clinic Payments	0	0	0	6,357
Home Health - Nursing Home	45	45	31,060	19,867
Inpatient/Ancillary/Lab	55	55	376,033	301
Medicare Part A	0	0	0	9,227
Non Affiliated Inpatient/Clinic/ER	0	0	0	2,655
Total	**132**	**132**	**$ 624,745**	**$ 429,466**

January – June 2007 System Match and Recovery Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	0	$ 0	$ 1,673,371
Deceased Recipients	451	451	3,654,373	0
Duplicate Clinic Payments	0	0	0	176,216
Home Health	0	0	0	1,156
Home Health - Nursing Home	170	170	425,115	216,804
Inpatient/Ancillary/Lab	168	168	1,376,954	2,851
MC - Inpatient/Newborn	0	0	0	313,969
Medicare Part A	0	0	0	115,064
Net Available Monthly Income (NAMI)	0	2	792,127	125,510
Non Affiliated Inpatient/Clinic/ER	0	0	0	3,951
Outpatient	0	0	0	353,624
Podiatrists	0	0	0	468
Voluntary Refunds	12	12	18,761	18,831
Total	**801**	**803**	**$ 6,267,330**	**$ 3,001,815**

Cost Savings Activities

Activity Area	Jan-Dec 2006	Jan-Jun 2007
Pre-Payment Insurance Verification Commercial	$ 400,666,638	$ 180,699,314
Pre-Payment Insurance Verification Medicare	278,414,640	139,842,540
Pharmacy License Verification	37,144,994	30,618,937
Edit 1236/1238 - Order/Servicing/Referring Provider #	70,807,255	18,329,499
Clinic License Verification	151,671,280	22,952,468
Card Swipe Program	41,114,346	25,734,267
Post & Clear Program	52,295,213	28,542,059
Edit 939 - Ordering Provider Excluded Prior to Order Date	2,911,508	1,204,832
Edit 1342 &1343 - Part-Time Clinic	140,860,405	86,596,352
Pharmacy Prior Authorization (Serostim)	48,604,928	25,735,154
Forgeproof Serialized RX Edit 2002	0	61,016,087
Edit 1141	4,843,440	26,665,345
Edit 903	0	155,119
Recipient Restriction	75,425,701	40,335,968
Drug Utilization Review	144,939,824	68,876,765
Investigations	58,068,118	5,581,174
Status Changes	25,441,572	7,428,631
Enrollment and Reinstatement	52,309,498	27,081,452
High Ordering Providers	2,206,850	2,350,388
Total	**$ 1,587,726,210**	**$ 799,746,351**