New York State
Office of the Medicaid Inspector General

2007 Annual Report

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Governor

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Medicaid Inspector General

STATE OF NEW YORK

OFFICE OF THE MEDICAID INSPECTOR GENERAL

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Governor Paterson
Senator Skelos
Speaker Silver
State Comptroller DiNapoli
Attorney General Cuomo

It is my pleasure to submit the Office of the Medicaid Inspector General's 2007 Annual Report.

Public Health Law, §35 requires the Medicaid Inspector General to submit an annual report, prior to October 1, to the Governor, the Senate Majority Leader, the Speaker of the Assembly, the Comptroller and the Attorney General on activities undertaken by the Office over the course of the preceding calendar year.

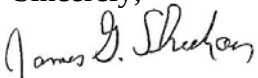
As required by Public Health Law, the attached report provides information about the audits, administrative actions, referrals and civil actions initiated and completed by the Office of the Medicaid Inspector General. Additionally, the report includes details about activities initiated and completed covering the outcome, region, and source of complaint and total dollar values identified and collected.

This report represents the first full year of operation of the Office of the Medicaid Inspector General. In 2007, we invested substantial effort to building systems and hiring staff to meet the ambitious goals outlined by the Governor, the Legislature, and the F-SHRP Agreement with CMS. In calendar year 2007, New York led the nation in identified Medicaid fraud and abuse recoveries. With your support, and cooperation from our agency partners and the Department of Health, we expect that New York will lead the nation not only in fraud and abuse recoveries, but also in program improvements to assure integrity in initial payments, provider enrollment, and quality of care for Medicaid enrollees.

During 2007, the Office of the Medicaid Inspector General identified four specific goals. First, to meet the requirements of the F-SHRP Agreement for 2008 – that is, identified recoveries of over $215 million through improvements in our audit process and staff. Second, to work closely with and provide support for, health care providers in developing their internal systems and controls, such as corporate compliance and voluntary disclosure in order to prevent improper payments. Third, to become the national Medicaid leader in the areas of data mining, integration and program measurement. Fourth, to develop a professional investigative unit capable of conducting and managing complex investigations, while supporting program integrity efforts.

The Office of the Medicaid Inspector General is well on its way to meeting these goals, and "to improve and preserve the integrity of the Medicaid program by conducting and coordinating fraud, waste and abuse control activities for all State agencies responsible for services funded by Medicaid." We look forward to continuing our work and partnering with you and other state agencies in the future. We welcome any questions you may have concerning items contained in this report or Medicaid fraud waste and abuse in general.

Sincerely,



James G. Sheehan
Medicaid Inspector General

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Office of the Medicaid Inspector General

On July 26, 2006, Chapter 442 of the Laws of 2006 was signed, establishing the Office of the Medicaid Inspector General (OMIG) as a formal state agency. The legislation amended several existing statutes, including the executive, social services, insurance and penal laws in order for the OMIG to accomplish the reform needed to effectively fight fraud, waste and abuse in the Medicaid system. The state made particular efforts to separate the administrative functions and program integrity while still preserving the single state agency structure required by Federal law. Although the OMIG remains a part of the New York State Department of Health, it is required by statute to be an independent office. The Medicaid Inspector General reports directly to the Governor.

OMIG's core function is to conduct and supervise activities to prevent, detect and investigate Medicaid fraud and abuse with the goal of assuring integrity in the Medicaid program. Fraud and abuse in the Medicaid program is defined by federal regulation (42 CFR 455.2). Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Abuse is defined as provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program. The definitions of "fraud" and "abuse" are analytically distinct, although the same provider submitting the same claim may engage in both.

Fraud focuses on the state of mind of the individual submitting the claim – that is, did they have the intention to deceive or misrepresent, with knowledge that the deception could result in an unauthorized benefit. Fraud detection and prevention activities focus on providers with bad intent; the goal is to prevent such providers from participating in Medicaid, and to deter them from fraudulent conduct by detection, investigation and prosecution.

Abuse focuses on the effect on the program, not on the state of mind of the person submitting the claim. A provider may have the best intentions, but if they fail to provide the services that meet "professionally recognized standards," or provide services that are medically unnecessary or inconsistent with sound practices, or result in unnecessary cost, the Office of the Medicaid Inspector General has a responsibility to take action involving that provider. Prevention and detection of abuse is more complex. Much abuse can be prevented by effective communication about program and professional standards and expectations. Providers who are likely to engage in abuse should be identified and educated. If providers are unable or unwilling to come into compliance with program and professional standards they should be sanctioned and potentially excluded from the Medicaid program. Providers should not receive payments for services which are not medically necessary, are excessive in cost or inconsistent with professional standards; and funds paid to providers for services defined as abuse should be recovered. Such non-payment or monetary recovery is not a

punishment; rather, it is recognition that services have failed to comply with a condition precedent to payment.

The Office of the Medicaid Inspector General is responsible for:

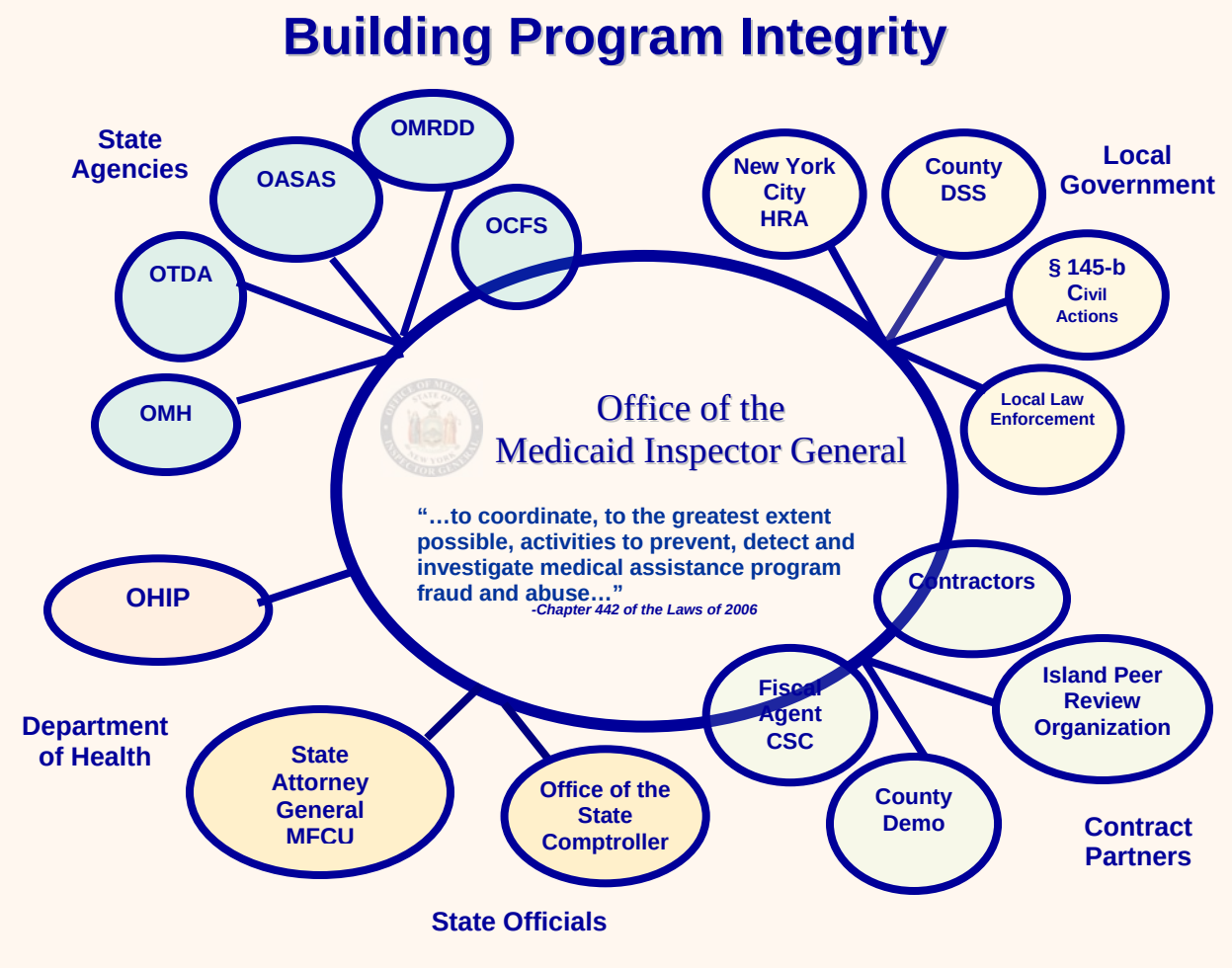
- coordinating fraud and abuse control activities with a number of partner agencies:
    - the Department of Health
    - the Offices of Mental Health, Mental Retardation and Developmental Disabilities, Alcoholism and Substance Abuse Services, Temporary and Disability Assistance, and Children and Family Services
    - the Commission on Quality of Care and Advocacy for Persons with Disabilities
    - the State Education Department
    - the fiscal agent—Computer Sciences Corporation (CSC)—employed to operate the Medicaid management information system
    - local, and county, governments and entities
- working in a coordinated and cooperative manner with, to the greatest extent possible,
    - the State Attorney General 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 available to appropriate law enforcement the information and evidence relating to potential criminal acts which may be obtained in carrying out duties
- receiving and investigating complaints of alleged failures of state and local officials to prevent, detect and prosecute fraud, waste and abuse
- performing any other necessary or appropriate functions to fulfill the duties and responsibilities of the office

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

OMIG Coordination with Medicaid Program Agencies

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, waste and abuse among various state and local agencies responsible for administering Medicaid services. The OMIG must also work cooperatively and in a coordinated manner with the New York State Attorney General's Medicaid Fraud Control Unit (MFCU), the New York State Comptroller, federal prosecutors, state district attorneys, the Welfare Inspector General, and the special investigative units maintained by each health insurer operating within the state.

During the first year of operation, the OMIG was focused primarily on establishing the agency and developing management systems to monitor activities and identify vulnerabilities. In 2007, OMIG undertook formal efforts to reach out to each of the agencies responsible for administering aspects of healthcare fraud investigation and enforcement. Through the efforts of newly formed Division of Legislative and Intergovernmental Affairs, the OMIG expects to further enhance its cooperative efforts with other state agencies. These efforts will be promoted further by the OMIG's hiring efforts to fill existing positions and the additional staff authorized for 2008-09.



Relationship with the Attorney General's Medicaid Fraud Control Unit

In order for the OMIG to be effective, it is vital that a high level of cooperation and coordination exist between the New York State Attorney General's Medicaid Fraud Control Unit (MFCU) and the OMIG.

In accordance with state law and federal regulations, OMIG must refer all cases of suspected provider and recipient fraud to MFCU (Public Health Law § 32(7), See 42 CFR 455.21). Referrals of providers to other law enforcement agencies for suspected fraud must be preceded by a ten day notice period to MFCU.

The OMIG continues to pursue activities that will improve and strengthen the relationship with MFCU. The OMIG meets with the MFCU on a monthly basis, and a single central coordinator from OMIG is assigned to ensure that referrals to and from the MFCU are appropriately addressed. In addition, the OMIG participates in joint meetings sponsored by the MFCU with the chief investigators of the MFCU, the Office of the State Comptroller,

Bureau of Narcotics Enforcement, and New York City Human Resources Administration. The purpose of these meetings is to discuss the investigations and trends in health care fraud that each agency has encountered.

The federal government requires that a memorandum of understanding (MOU) exists between the MFCU and the single state agency responsible for the administration of the Medicaid program. The existing MOU is being re-negotiated with the MFCU to reflect the current organizational responsibilities.

Office of Health Insurance Programs

The Department of Health, primarily through the Office of Health Insurance Programs (OHIP), is a critical partner in addressing Medicaid fraud and abuse, and in assuring program integrity. During 2007, the state established OHIP as the Medicaid program unit within the Department of Health, consolidating functions which had previously operated within a number of provider-specific units.

The new leadership at OHIP has supported and assisted OMIG efforts. Deputy Commissioner Deborah Bachrach and the Medicaid Inspector General participate in regular bi-weekly meetings to assure that the efforts of the two agencies are coordinated, that program and policy issues are promptly raised and addressed, and that OHIP can resolve program issues raised in the course of audits and investigations.

During 2007, OHIP has undertaken significant efforts to support the prevention, detection and investigation of Medicaid fraud and abuse including:

- OHIP staff referred 70 cases of potential fraud, waste or abuse to the OMIG;
- The Division of Managed Care referred 17 cases to the OMIG for further investigation;
- OHIP has worked closely with OMIG staff in developing major project areas for review and audit or enforcement;
- Computer Science Corporation (CSC), New York State's Medicaid fiscal agent, referred a total of 43 cases of potential Medicaid fraud, waste and abuse;
- OHIP staff worked with the OMIG to develop a number of system edits to identify potential fraud, and prevent improper payments;
- OHIP and OMIG worked closely with the Island Peer Review Organization to identify and recover overpayments to hospitals and nursing homes; and
- OHIP and OMIG collaborated on policy revisions and clarifications to assure that providers had sufficient guidance to fulfill their obligations.

Office of Temporary and Disability Assistance

The Office of Temporary and Disability Assistance (OTDA) undertook a number of program integrity initiatives that impact Medicaid enrollees. The results of those initiatives during the calendar year 2007 are summarized below:

Initiative	Cases Closed	
	Case Closing and Denials	Cost Avoidance
Automated Finger Imaging System – Identified instances of duplicate participation by enrollees through a finger print match	623	$ 4,246,368
Prison Match – Identified incarcerated recipients	912	6,679,680
Total	**1,535**	**$10,926,048**

Office of Alcoholism and Substance Abuse Services

During 2007, the Office of Alcoholism and Substance Abuse Services (OASAS) completed 10 provider investigations that involved Medicaid billing issues. Two of these resulted in issuance of Notices of Intent to Revoke with proposed fines totaling $336,500. Four cases were referred to OMIG for further audit/investigation. OASAS also issued one Notice of Revocation based on a previous enforcement action. OASAS estimates annual Medicaid cost savings associated with OASAS enforcement actions at $14.9 million.

Office of Mental Health

In 2007, within the not-for-profit sector, the Office of Mental Health (OMH) conducted 861 on-site inspection visits at programs for license renewal. OMH may withhold the renewal of a license until submission of an acceptable plan of corrective action (POCA) and subsequent on-site inspection is completed to confirm implementation of the POCA. Based on the findings from license renewal visits during the past year, 608 POCAs were required, 34 programs were placed in non-renewal status during the year, and one program had its license revoked. Forty-three programs were issued Tier 3 status last year, indicating the most minimal level of compliance by the program.

Office of Mental Retardation and Developmental Disabilities

For 2007 the Office of Mental Retardation and Developmental Disabilities (OMRDD) reported a total of $1.084 million in Medicaid dollars recovered through its Medicaid accountability activities.

During the 2007 calendar year, OMRDD's Bureau of Compliance Management conducted a total of 132 field reviews that comprised a Medicaid related review component or components:

Review Type	Total Reviews Conducted
Review of Allegations/Complaints	9
Due Diligence Review of Provider Self-Disclosures	4
IRA Full Month/Half Month Reviews	13
Limited Fiscal Review with Billing and Claiming Review Component(s)	93
Billing and Claiming Reviews and/or Expanded Billing and Claiming Reviews	13
Total	**132**

OMRDD also referred 17 providers to the OMIG in 2007 for further review/investigation of potential Medicaid fraud, waste, and abuse and/or systemic Medicaid billing issues.

Interagency Workgroup

OMIG established the Interagency Workgroup to help coordinate the Medicaid fraud, waste and abuse control activities of the state agencies with direct roles in administering the Medicaid program. Representatives from those agencies that play a part in the Medicaid program meet monthly to address issues, coordinate plans and foster the communication necessary to monitor program integrity an administer the Medicaid program. 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
- data issues pertaining to Medicaid payment systems

OMIG's Bureau of Investigation and Enforcement made a presentation to the group on the topic of OMIG investigations followed by an agreement to hold periodic meetings between various state agencies and the OMIG to discuss investigations. Other topics discussed include:

- the implementation of the OMIG statute
- OMIG systems initiatives
- eMedNY re-procurement
- OMIG advisory opinions
- consumer directed services
- assisted living programs
- developing a mechanism for resolving differences in regulatory interpretations among agencies

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
- Commission on Quality of Care and Advocacy for Persons with Disabilities

Data Mining

In 2007, New York led the nation in reporting fraud and abuse recoveries with $136 million of the $308 million national total[1].

Although these figures are impressive, the OMIG understands that a great deal more work needs to be done to identify fraud and abuse. Data mining is a cornerstone of the OMIG's efforts and goals to create higher program integrity and compliance standards in the future. Maximizing the return from data mining is a challenging task and requires attention from numerous perspectives. Outlined below is a summary of the different areas in which the OMIG is engaged in order to improve the state's return on data mining and related analyses.

Staffing and Organization

Data mining success of noteworthy scale and consequence requires competent, dedicated staff with a myriad of skills. Dedicating the staff resources, and acquiring and synthesizing the different skill sets are the greatest challenges to creating a culture of data mining excellence. Recognizing this, the OMIG has taken several steps to improve our staffing and organization.

The OMIG has formed a Business Intelligence Unit (BIU), currently staffed with 14 full-time employees, who service a spectrum of data needs to support the agency's mission. Their tasks include targeting, conducting provider analysis, supporting targeting tools, creating data match algorithms and providing pre-audit analysis and audit samples. The BIU's efforts are primarily focused on fee-for-service providers; however, an additional group with six full-time staff members provides similar data services for managed care and rate-based services.

[1] All referenced figures are based on self-reporting by states to CMS using CMS measurement protocols. These quarterly reports, known as CMS 64 reports, are publicly available. Form CMS-64 is a statement of expenditures for which states are entitled to Federal reimbursement under Title XIX (Medicaid) and which reconciles the monetary advance made by CMS to the state. The amount claimed on the Form CMS-64 is a summary of expenditures derived from source documents such as invoices, cost reports and eligibility records, as well as credits resulting from recovery efforts.

OMIG's long term goal is to integrate data analysis tools, capabilities and data access into the work of every employee who performs audit, investigative and program integrity functions. In an effort to promote the creativity and field knowledge of the program staff while simultaneously creating a center of data mining activities and strategies, OMIG established a data mining task force to help steer data mining efforts.

In addition to these efforts, the OMIG intends to augment the Federal Payment Error Rate Measurement (PERM) concept by perpetuating random sampling (every year, not just New York's cycle years) to create a continuous information stream for measuring the success of program integrity efforts.

The OMIG is continuing to invest in its pre-payment controls and monitoring. This includes legislative authorization to expand our Cardswipe and Post and Clear programs by adding 2,000 portable terminals across the state. The authorization includes increasing staff in the Cardswipe, Post and Clear and Pre-Payment Review (Edit 1141) units.

Tools

New York State leads the nation in the development and use of current data mining tools to identify patterns of improper payments, provider concerns, and enrollee issues. New York's leadership is due in part to the size of the program and the volume of claims (over $200 billion) stored in its data warehouse and available for analysis. Though New York leads the nation, the opportunities available based on analysis of this data, and data becoming available for integration from other sources, are just beginning. These opportunities extend beyond control of fraud and waste to disease management, medical error and unanticipated outcome detection, and assistance to patients in managing their medical conditions.

In the past year, the OMIG has received information from almost every leading organization in health care data mining about their capabilities, special uses of their tools and systems, and compatibility with existing New York systems in the past year. In addition, the OMIG has greatly expanded the staff and training for data mining within the organization.

In order to optimize the efficiency of the staff involved in data mining and promote increasingly complex data analysis, the OMIG has expanded the use of commercially available tools that specialize in areas of data mining. Examples of commercial products under active consideration include:

Desktop Graphical User Interface Tool. Following a successful joint pilot project, the OMIG and the Office for Health Insurance Programs are actively engaged in exploring procurement options for a data tool that presents ease-of-use through a graphical user interface, yet allows the user to make complex queries and effortlessly drill down into increasing levels of detail. This tool holds the promise of engaging a greater percentage of OMIG staff beyond the typical IT/power user audience.

IBM Entity Analytics Software (EAS). The OMIG recently conducted a pilot project with IBM to assess their EAS tool. EAS focuses on resolving entity relationships (i.e., identity

attributes) from disparate data sources. The pilot demonstrated the power of the tool in a number of areas. Using a partial set of data, it uncovered numerous instances of duplicate recipients in our enrollment file. Based on the sample we estimate that more than 22,000 duplicates are on file. The OMIG is currently pursuing purchasing the tool and related integration services.

Fraud Abuse Management System (FAMS). The FAMS sensitively ranks providers in relation to their peers within specific geographic regions, specialties and subspecialties, and any other parameters users choose to define. Results are displayed in a three dimensional graph format that readily identifies providers who fall outside norms. Numerous features and attributes can be measured and weighted to build complex models that assess behaviors in a selected peer group. FAMS supports further investigation by enabling users to drill down into detailed information on providers' claiming practices.

The OMIG has owned IBM's FAMS for more than ten years. However, this tool has not always suited the agency's needs. Based on a review of usage and some of the issues that have contributed to dissatisfaction with the tool, OMIG engaged IBM to address the concerns and customize the FAMS to better meet the agency's needs. Through a formal work engagement with IBM, the OMIG has asked the company to include an upgrade of several versions of the product, a switch from IBM's DB2 to an Oracle database (OMIG database administrators can now support it) and a more seamless ability to extract data from our data warehouse into the FAMS data format. In addition, we are making a more conscious effort to dedicate and train staff in the use of the product.

Data Sources

Though the New York State Medicaid data warehouse represents a huge investment and a powerful tool in support of data mining, it is essential that the OMIG acquire additional data sources in order to maximize our ability to find fraud and abuse. Recent efforts include obtaining upstate vital statistic records, and an agreement is nearing completion with New York City to receive this same information, workers' compensation data to aid the third party liability process and Medi-Medi initiatives.

Expert Services/Partnerships

New York State has created an innovative partnership with our counties through the Medicaid Fraud Waste and Abuse Demonstration Project. In 2007, 15 counties and New York City participated in the project. This partnership allows the counties, as agents of the OMIG, to pursue fraud and abuse through audits and investigations overseen by the OMIG.

After a request for proposal and competitive bid process, the OMIG awarded a contract to MAXIMUS, Inc. to complete a two-phase project called the Fraud, Waste, Abuse, Recovery & Detection (FWARD) project. In the first phase, which required no compensation and has been completed, MAXIMUS performed a complete review of the OMIG program and made a comprehensive set of recommendations.

The second phase provides remuneration as a percentage of actual recoveries. This phase directs MAXIMUS to perform data matches to complement the OMIG's own efforts in the data matching arena. Through the expansion of our own efforts in data matching and the MAXIMUS effort, the OMIG actively considers pre-payment edits to reduce the need for post-payment match activities. Though these efforts are sometimes successful, a number of cases remain where post-payment matches need to occur:

1. **Timing issues**. In many instances, a given match involves duplicate claims submitted by different providers. Though we have numerous edits that detect duplicate claims on a real-time basis, there are instances where the first claim received is the one in error but it has already been paid when the second, correct claim is received.
2. **Exceptions and complexity**. In other instances, the degree of complexity involved in identifying a billing issue is too convoluted or involves too many exceptions to be incorporated as part of the real-time edits in the claims processing system.
3. **Use of external data sources**. A number of the matches the OMIG uses rely on outside data sources which cannot be applied in a real-time manner. Examples of outside data sources used by the OMIG include vital statistics, workers' compensation, and Medicare data.
4. **Non-claim-related matches**. For some recoveries, the basis for claims recovery starts with conditions separate from the claims themselves. For example, the OMIG has recently performed data match analysis to identify duplicate enrollments for managed care recipients. Once the duplicates were identified, corresponding claims for managed care capitation payments were recovered.

The OMIG is currently contemplating the procurement of expert program integrity services in the areas of home health care, in-patient hospital reviews and pharmacies. The goals of the procurement include a full assessment of strategies in these areas and the feasibility of corporate-level detection, auditing and enforcement.

Quality of Care

Though the traditional monetary perspective on fraud and abuse remains a constant, the OMIG is incorporating quality of care considerations in its detection and enforcement strategies. These efforts will include assessment of interventions and outcomes, pattern outcomes (i.e. Epogen and cancer growth), tracking of "never" events, detection of unreported adverse events/outcomes and unanticipated deaths.

An essential part of the OMIG's efforts includes improving our program integrity functions through data-based activities.

Federal-State Health Reform Partnership

On September 29, 2006 the Centers for Medicare and Medicaid Services (CMS) approved New York State's request to enter into a waiver project to reform and restructure the state's

healthcare system. The approved project, entitled the Federal-State Health Reform Partnership (F-SHRP) took effect October 1, 2006.

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

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

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

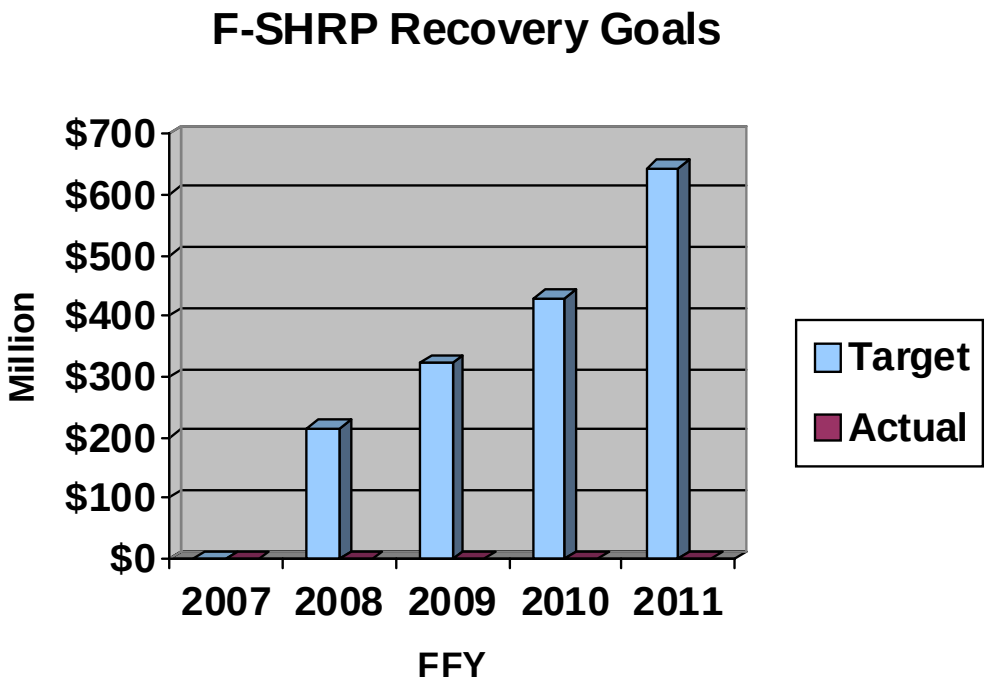
The conditions and required state milestones are clearly defined in the CMS agreement. The two conditions are:

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 have developed and submitted to CMS its plan for achieving this milestone by the end of the demonstration period, including details of Office of the Medicaid Inspector General (OMIG) staffing and new budget proposals to further enhance OMIG resources. This goal was accomplished.
- By December 31, 2008, for the period of October 1, 2007 to September 30, 2008, the state must demonstrate its annual levels of fraud and abuse recoveries are equal to .5 percent of total computable Medicaid expenditures for the federal fiscal year, or $215 million.
- By December 31, 2009, for the period of October 1, 2008 to September 30, 2009, the state must demonstrate its annual levels of fraud and abuse recoveries are equal to .75 percent of total computable Medicaid expenditures for the federal fiscal year, or $322 million.
- By December 31, 2010, for the period of October 1, 2009 to September 30, 2010, the state must demonstrate its annual levels of fraud and abuse recoveries are equal to 1 percent of total computable Medicaid expenditures for the federal fiscal year, or $429 million.
- By December 31, 2011, for the period of October 1, 2010 to September 30, 2011, the state must demonstrate its annual levels of fraud and abuse recoveries are equal to 1.5

percent of total computable Medicaid expenditures for the federal fiscal year, or $644 million.



Achievement of the above milestones will be assessed by CMS within 90 days of the end of each year in the demonstration. If the state does not meet the targets in any of the years, it will be required to repay funds to the federal government.

Work Plan

In April 2008, the OMIG issued its first annual work plan for State Fiscal Year 2008-09. Posted on the agency's Web site (www.omig.state.ny.us), the plan outlines work now underway as the OMIG's staff seeks to assure that providers meet program quality standards for Medicaid enrollees in a system free of waste, fraud, abuse and improper payments.

The plan serves as a roadmap for all activities within the agency, guiding each division through audit, investigative, surveillance and recovery activities across New York State.

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

enrollees have access to a quality health care system and enables them to receive appropriate services.

In 2007, OMIG made a decision to communicate risk areas to providers and to explain the agency's focus, culminating in the 2008 – 09 work plan. The document has proven useful not only for employees within state and federal government, but also for providers, accountants, compliance officers and other professionals involved in ensuring the integrity of New York State's Medicaid program.

Investigations & Enforcement

Functional Description

The Bureau of Investigations and Enforcement (BIE) conducts investigations of Medicaid providers and enrollees. 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). Additionally, referrals are 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 comprise the Downstate Region.

Investigators receive allegations from several sources including:

- the State Medicaid fraud hotline (1-877-87-FRAUD) or (212) 417-4570
- our partner state and federal agencies with a role in the Medicaid program
- the New York State Department of Health 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 enrollees

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

The OMIG is in the process of redesigning the in-house computer reference system known as Fraud Activity Comprehensive Tracking System (FACTS) to be more accountable for allegations received from all sources.

The New York State Medicaid Inspector General's website http://www.omig.state.ny.us and the New York State Department of Health's website http://www.nyhealth.gov/ contain information on how to file an electronic complaint directly on those sites 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 this 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 enrollees. 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 OMIG's 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. In 2007, 1,030 shops were conducted.

In April 2007, the OMIG unveiled a new shopper system as part of FACTS. This system has increased the efficiency of the program and provided new tools for its management. The new shopper system was on-line for nine months of 2007 and reported 491 shops with a final disposition for that time period. Examples of some of these dispositions include: five providers referred to MFCU; 16 providers referred to another BIE unit for further investigation; and two providers referred to OMIG Audit.

In 2007, more than 75 pharmacy shops were conducted at the request of the Enrollment Audit Review Unit. These shops provided useful information for the unit to use when deciding whether to approve or deny a pharmacy's enrollment in the Medicaid program.

Also in 2007, two investigations involving shoppers resulted in the termination of the providers. The cost avoidance associated with these two providers totaled $854,093.

As staffing levels increase, the number of targeted shops will increase. Staff continues to become more proficient with this system and its supporting organization, and results are expected to improve in coming years.

Enrollment, Audit & Review

The Enrollment Audit Review (EAR) Unit within the BIE works in conjunction with the Provider Enrollment Unit in DOH's Office of Health Insurance Programs (OHIP). 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 percent 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 Office of Professional Medical Conduct reports, as well as density criteria to determine existing levels of service availability.

Approximately 15 percent of the applications reviewed and processed by EAR result in a denial, netting a cost savings of approximately $52.2 million for 128 denials in 2007.

The unit conducts on-site inspections for durable medical equipment (DME) applicants and pharmacies.

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.

In addition, this unit is responsible for the High Ordering Practitioner Project. The unit identifies non-enrolled physicians and registered physician assistants who order in excess of 4,500 claims totaling $75,000. Non-enrolled practitioners include those who have never been enrolled in the Medicaid program or those who previously withdrew from the program either voluntarily or as a result of inactivity. In accordance with regulation 18 NYCRR 504.1(d)(19), these high-ordering individuals are required to enroll in the Medicaid program. Failure to comply with this requirement prohibits them from further ordering services. In 2007, four providers identified as high-ordering practitioners were placed on the exclusion list as a result of not enrolling in the Medicaid program. The associated cost avoidance totaled $2,350,388.

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 beneficiaries, with indicators of inappropriate utilization of Medicaid services, are restricted to specific primary providers. These actions reduce the cost of health care through the elimination of abusive or fraudulent utilization behavior of Medicaid enrollees and provide restricted beneficiaries with coordinated medical services.

Overall during 2007, the CMS certified Surveillance and Utilization Review Subsystem (SURS) prioritized and analyzed the utilization of more than four million enrollees, in order of the severity of Medicaid overuse and abuse. RRP placed special focus on controlled substances, forgery, dental, inpatient and emergency department utilization. Additionally, staff worked with the New York City Human Resources Administration's Bureau of Fraud and Investigations (BFI) staff resulting in 194 referrals being received by RRP and 123 cases being referred to BFI from RRP for action.

Overall, the RRP reviewed more than 7,500 recipient case records, completing 4,995 comprehensive cases resulting in 3,032 restrictions implemented by local social services districts. Of those restrictions, 1,630 were for instances including alcoholism and substance abuse services. Included in the total are more than 450 cases involving prescription forgeries, 215 hotline referrals, and more than 470 exclusive restrictions for dental services.

RRP activities resulted in annual cost savings of approximately $81.6 million in 2007.

Recipient Restriction Program Success Stories

In October 2007, OMIG RRP staff held two meetings to provide training and technical assistance to Medicaid program staff from Franklin and Clinton counties. RRP staff discussed various topics including OMIG's structure and priorities, the False Claims Act, RRP training materials, and district-specific enrollee and provider policy and program implementation issues.

Several Franklin County Medicaid program staff attended the meeting including the county's casework supervisor/RRP coordinator. After meeting with the coordinator, RRP referral procedures were established. A special meeting took place with the Franklin County District Attorney regarding the cooperative efforts of his office, the Franklin County Medicaid program staff and OMIG's RRP unit on a review of cases for possible inclusion in the RRP. Forty-eight cases of arrested and associated individuals were reviewed. The individuals were arrested in May 2007 as part of a multi-agency drug sting. Of those individuals, 16 had received Medicaid assistance; 11 enrollees have been identified for restriction. All 11 enrollees were indicted for selling drugs that were obtained using Medicaid. OMIG is also reviewing the prescribers in these cases.

Recipient Investigation Unit

The Recipient Investigation Unit first established a network of personnel involved with Medicaid recipient fraud in each of the 58 local districts in November 2007. Simultaneously, the unit initiated discussions on Medicaid recipient fraud with OMIG's Division of Counsel, and the following agencies:

- OHIP's Bureau for Medicaid/Family Health Plus Enrollment, and Office of Managed Care
- Office of Temporary and Disability Assistance's Program Integrity Unit
- Social Security Administration's Office of the Inspector General's, Office of Investigations
- NYS Office of the Welfare Inspector General
- NY Welfare Fraud Investigators Association
- the NY Public Welfare Association

Based on these discussions, the unit's first project was to develop a mutually beneficial approach to integrate OMIG into the areas of Medicaid recipient fraud investigations and the reporting of recoveries. The unit organized an eleven county workgroup and sent each member a series of specific subject questions in a February questionnaire. In March and April 2008 the Unit met face to face with the county workgroup to further discuss the subject. Based on the information and ideas gathered from the eleven workgroup members, the unit enlisted the participation of all 58 local districts. The project resulted in the creation of a quarterly fraud report of local district's Medicaid recipient investigations, prosecutions and recoveries.

The first quarter 2008 fraud report contained responses from 44 of 58 local districts (representing 76 percent). These local districts reported more than 4,500 investigations of Medicaid recipients and almost $3 million in recoveries. These numbers need to be reconciled and analyzed, but were very encouraging for a first reporting effort. The unit will continue to evolve and improve the report to develop a statewide knowledge of the investigations and prosecutions of Medicaid recipient fraud as well as an accounting of Medicaid recipient recoveries.

Drug Utilization Review Programs

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

At OHIP's request, the DUR programs were transitioned to OHIP at the end of July 2007. In 2007 (January through transition in July 2007), OMIG staff reviewed more than 3,500 cases.

Using retrospective DUR, intervention letters were sent to:

- 1,065 pharmacists serving the identified enrollees
- 4,206 treating prescribers

The total interventions attributable to BIE were 5,271.

Criteria for selection included drug to disease interactions (iatrogenic and exacerbation); drug interaction; over-utilization of therapy; and clinical appropriateness.

- Cost savings* attributed to retrospective DUR include $4,551,199.
- Cost savings* for prospective DUR accrued a gross savings of $87,546,656 due to the 1,199,105 net on-line rejects which were not overridden.

2007		
DUR Cases Reviewed	**DUR Cases Referred to RRP**	**Referrals Promoted to Full Case Review**
3,500	437	352

*Cost savings figures are reported through August 2007 due to a month's transition lag period.

Provider Surveillance Utilization Review System

The Provider Surveillance Utilization Review System (SURS) unit is responsible for evaluating the efficiency, effectiveness and utilization of the Medicaid program by Medicaid providers. The unit identifies duplicative, excessive or contraindicated care or services by developing control files for a variety of provider types. In addition, the unit develops *ad hoc* queries and uses predefined reports to monitor provider billings.

The Provider SURS unit works closely with the State Attorney General's Medicaid Fraud Control Unit (MFCU), the Office of Professional Medical Conduct (OPMC), the State Board for Education, the Bureau of Controlled Substances, OMIG Bureau of Medicaid Audit and other government agencies when quality of care issues or aberrant billing practices are noted. Referrals are also sent to the Recipient SURS unit.

Unit staff review medical records, issue draft and final reports and testify at administrative hearings.

The Provider SURS unit also provides support for central office (upstate) and metro regional office (downstate) investigative staff. This unit identifies providers in a variety of categories of service (COS) for investigative review. They review the results of explanation of medical benefit (EOMB) forms that are returned for quality of care as well as aberrant billing patterns. The staff assists the BIE investigators by reviewing medical records of all provider

types and providing written summaries of the review findings. The Provider SURS unit also offers technical support with Data Warehouse predefined and *ad hoc* reports.
The duties of the staff in this unit include, but are not limited to:

- Reviewing Medicaid claims and encounter data submitted by Medicaid-enrolled and non-enrolled providers
- Performing qualitative and quantitative provider reviews of providers enrolled in Medicaid using data available from eMedNY, Data Warehouse, Data Mart
- Reviewing medical records of beneficiaries to determine the appropriateness of services rendered by Medicaid-enrolled and non-enrolled providers
- Participating in meetings with providers and other representatives
- Providing nursing consultation related to review process and findings
- Testifying at administrative hearings.

The Provider SURS unit worked on a special project evaluating prescribing and dispensing patterns of Medicaid enrolled providers for the opiate based drug, Fentora. The review found that several enrollees did not meet the required criteria to receive Fentora, indicating that the drug was not being prescribed and/or dosed properly. As a result of this review, a clinical drug review is required prior to dispensing Fentora.

In 2007, the Provider SURS unit conducted 871 reviews. Of these reviews, 764 were closed with no further action taken, 39 were referred to the Attorney General's Medicaid Fraud Control Unit, two were referred to OMIG's Division of Audit and to the Office of Professional Medical Conduct. One resulted in a joint investigation with the federal Department of Health and Human Services, one resulted in a joint investigation with federal Immigration Customs Enforcement and OMIG's BIE Recipient Fraud Unit, and 64 resulted in further investigation by OMIG's BIE.

Joint Investigations with the FBI

Since its formation, the OMIG has had an ongoing working relationship with the Federal Bureau of Investigation's Health Care Fraud Unit. Our office has provided investigative and covert undercover support in the course of Medicaid fraud investigations. Notably, in two long-term investigations, our undercover investigators provided major contributions resulting in FBI enforcement, prosecutions and follow-up agency administrative actions.

In September 2006 three Medicaid providers were arrested and charged with conspiracy to defraud the United States and New York State of Medicaid funds and paying illegal kickbacks to Medicaid enrollees. During the course of this investigation OMIG undercover operatives made numerous visits to the office of one of the providers. The provider referred his patients to one of at least three pharmacies affiliated with his co-conspirators. It was

estimated that the pharmacies charged the New York State Medicaid Program approximately $1.2 million more in medications than the pharmacies had ordered from their wholesale drug distributors. The provider has pled guilty in the United States District Court and is currently awaiting sentencing.

Summary of Fraud Financial 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
2007	98	280	$2,229,991	$2,181,718

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 2007. The second table shows investigative referrals made to outside agencies other than MFCU.

Provider Type	2007
Dental Groups	1
Dentist	29
Diagnostic & Treatment Ctr.	11
Home Care Agency	11
Hospital	1
Long Term Care Facility	2
Medical Appliance Dealer	2
Non-Provider or Recipient	7
Nurse	9
Pharmacy	14
Physician	20
Physician Group	2
Transportation	9
Total	**121**

Agency	2007
Center for Medicare & MA	2
Law Enforcement Agency	1
Local District	315
OASAS	1
OMRDD	6
Off. of Prof. Discipline	13
Off. of Prof. Med. Conduct	5
Off. of Welfare Insp. General	6
Other	1
Other DOH Unit (not OMIG)	9
Other State Agency	5
Total	**364**

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 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.

The OMIG has incorporated into its audit process a review of medical necessity for services rendered to eligible enrollees and billed to the Medicaid program. The purpose of the medical necessity review is to determine if services are reasonable and necessary, and, therefore, reimbursable under the Medicaid program. The review focuses on clinical determinations as to the appropriateness of the services provided to Medicaid recipients, as defined in the Standards of Care NYCRR § 515.2(11) and (12).

In addition to its audit efforts with the above-referenced providers, the OMIG Division of Audit is also exploring new provider interaction avenues through projects such as the Medicaid Fraud Waste and Abuse Demonstration Project and fee-for-service system matches. As the responsible party for managing the demonstration project, the OMIG has entered into agreements with 15 counties and the City of New York to perform audits and/or investigations of Medicaid providers in selected ambulatory care areas. The OMIG staff work with the counties and/or their contractors to ensure the provider audit or investigation is conducted in the same manner to that of the OMIG. Audits and reviews of Medicaid providers are performed by state staff, augmented by outside contractors, and the local districts through the Medicaid Fraud Waste and Abuse Demonstration Project.

In the Systems Match and Recovery Program, the OMIG staff performs numerous post-payment data matches to identify systematic behaviors which result in recoveries from multiple providers. The systems match staff actively works with the audit review staff to solicit new ideas for data matches based on field experience.

The OMIG Division of Audit has made marked changes within the last year by shifting the focus of its provider interactions from education to collections. The activities of the Division of Audit focus on a diverse and deliberate group of Medicaid providers. This group includes, but is not limited to, adult day health care, ambulatory surgery services, assisted living facilities, diagnostic and treatment centers, durable medical equipment, home health services, hospice services, hospitals, laboratory services, nursing facilities, pharmacies, physicians, and transportation 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 2007, 15 pharmacy audits were opened and two were finalized with findings totaling $659,732.

In 2007, the OMIG initiated a comprehensive review of pharmacy audit protocols with expected completion and implementation by mid 2008.

Diagnostic and Treatment Centers

During calendar year 2007, 42 diagnostic and treatment center audits were opened; 22 audits were finalized, with findings totaling $1,447,111.

Outpatient Chemical Dependence Providers

The OMIG conducted audits of Office of Alcoholism and Substance Abuse Services (OASAS) outpatient chemical dependence providers. The OMIG reviewed case record documentation to determine compliance with OASAS regulations and Medicaid billing requirements.

During calendar year 2007, 24 outpatient chemical dependence audits were opened and 14 were completed with total findings of $53,674,755.

Outpatient Mental Health Services

Office of Mental Health (OMH) outpatient mental health services continued to be the subject of billing audits. During calendar year 2007, 27 outpatient mental health audits were opened and 10 were finalized. A total of $1,315,147 in findings resulted from these audits.

Utilizing the data warehouse, an 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 who exceeded treatment period requirements. Thirty-three final reports and stipulations were issued in 2007, with a total disallowance of $1,780,703.

Office of Mental Retardation and Developmental Disabilities (OMRDD)

In 2007, nine audits were opened and eight were finalized, with total findings of $619,462.

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 the OMRDD data analysis unit. OMRDD also utilizes a private contractor to conduct fiscal reviews.

Hospital Outpatient Departments (OPD)

Continued billing audits of hospital outpatient departments were undertaken. These audits involve ER/clinics, referred ambulatory services and laboratory services.

For calendar year 2007, five hospital outpatient department audits were opened and 24 were finalized, with total findings of $3,867,538.

Durable Medical Equipment

For calendar year 2007, 27 durable medical equipment (DME) audits were opened and 10 were finalized. Audit findings totaled $1,027,593.

A large percentage of the findings involved one audit with an identified overpayment of $761,049. The audit issues involved included billing prior to delivery of the DME, and billing for items from a location prior to properly enrolling that location. This enrollment issue has been somewhat unique to the DME program and continues to be a problem in current audits still in progress.

The balance of the audits involved projects identifying overpayment related to paid claims for individuals residing in assisted living facilities where these items were included in the facility's rate, and overpayments for billings of sterile gloves without the required prior approval.

Transportation

For calendar year 2007, seven transportation audits were opened and four were finalized with total findings of $2,345,055.

One of the affected providers was involved in an ambulette accident operated by an unlicensed driver that resulted in numerous Medicaid enrollee fatalities. The ambulette's driver was unlicensed, and a New York State Department of Motor Vehicle hearing subsequently found the provider to be out of compliance with New York State Vehicle and Traffic Law 19A requirements for the years 2005 and 2006. In April 2007, the OMIG took action to exclude this provider and imposed repayment of $2,261,193 following the provider's failure to disclose and comply with the furnishing of contemporaneous records. The case was brought to hearing and is pending a decision.

Obstetric and Gynecology Services

In the course of the Prenatal Care Assistance Program (PCAP) review, the OMIG identified improper Medicaid billings by physicians for obstetric and delivery services. The PCAP clinic rate includes routine anti-partum physician services. Physician billings for Medicaid coverage of anti-partum office visits, or the global delivery rate which includes anti-partum care, were considered overpayments. In addition, there were numerous instances of duplicate delivery charges for the same delivery.

In calendar year 2007, 78 audits were finalized with findings of $905,999.

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 pre-determined rate basis - for example, nursing homes and managed care plans. AMD auditors also conduct match projects to determine whether rates have been appropriately billed to Medicaid for certain beneficiary groups (e.g., incarcerated or deceased enrollees). OMIG staff routinely use the audits and desk reviews to make these determinations.

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. For nursing facilities, the base year for determining Medicaid rates are based on costs reported in 1983, trended forward to the current date to account for inflation. For nursing facilities built more recently or for those that have had a change of ownership, that base year is adjusted prior to the trend factor being applied. The same reported costs, with appropriate trend factors, are used for multiple years of reimbursement for the operating portion until a new base year takes effect; a new base year (2002) is slated to be applied as of January 1, 2009.

The 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 (rollovers).

Activity in this chart represents nursing facility audits issued in 2007.

Audit Type	2007	
	Audits Issued	Findings (millions)
Base Year	11	$ 4.0
Dropped Services	27	9.1
Medicare Part B	12	.3
Property	16	9.7
Rate Appeal	19	3.3
Rollover**	62	10.7
Total	**147**	**$ 37.1**

**Rollover audits for rate years 2005 and 2006 are currently in progress. Rollover audit reports for rate years 2002-2004 were issued in 2006 and 2007.
The NYS Department of Health will re-base all nursing facilities effective with the January 1, 2009 rate period. As a result, the OMIG staff will have to analyze more than 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 2007, the OMIG issued 147 audits and identified $37.1 million in overpayments.

In 2007, the OMIG initiated a comprehensive review of nursing facility audit protocols and programs. This review is expected to be completed and implemented by mid 2008.

Property Audits

Examples of property audits conducted include three residential health care facilities' records, which supported the capital (property) portion of each facility's Report of Residential Health Care Facility (RHCF-4) for the four years ending on December 31, 2002. The RHCF-4 reports served as the basis for the capital portion of each facility's Medicaid rates for the four years ending on December 31, 2004.

The audits identified significant issues, including:

- Under-funding of depreciation
- Unpaid interest expense
- Disallowance of working capital interest expense
- Disallowance of start-up cost amortization
- Disallowance of return on real property equity
- Unpaid mortgage interest expense
- Overstated shared hospital services expenses
- Underpaid Article 28-A fees
- Working capital interest expense held to the maximum allowed by regulations.

These audits resulted in the discovery of overpayments totaling $6,562,685, a significant portion of all overpayments discovered in this area.

Dropped Services Audits

An audit was conducted on a nursing facility's ancillary services for the three years ending December 31, 2004. The audit identified ancillary services which, subsequent to the base year, were dropped, but the facility's Medicaid rates still included the cost of the ancillary services. Ten ancillary services had been dropped. The audit resulted in an overpayment of $2,901,017. This audit is just one example of the dropped services audits performed in 2007.

Rate Appeal Audits

An audit of a residential health care facility's records, which supported both operating and capital portions of the facility's rates for the five years ending on December 31, 2001, identified the following two significant issues:

- Strategic shifting of base year costs between direct and indirect cost centers to maximize reimbursement
- Inflating base year costs by including expenses that belong to a different period, thereby maximizing reimbursement

The audit resulted in an overpayment of $1,784,544, just one finding in the rate appeal audit section for 2007.

Managed Care

The OMIG performs various match-based targeted reviews and audits in the area of managed care that identify and recover overpayments, in addition to submitting and implementing corrective action procedures that address system and programmatic issues/errors.

In 2007, the OMIG opened 216 new audits in nine project areas identifying potential recoveries of $51.2 million, and finalized 253 audits with $42.5 million in recoveries related to managed care audit projects. Following is a summary of the active projects in 2007.

Multiple Managed Care Capitation Payments Made on Behalf of Same Client

The OMIG, in a joint effort with the New York State Attorney General's Medicaid Fraud Control Unit (MFCU), identified and recovered $36 million in monthly capitation payments incorrectly paid to 34 managed care organizations (MCOs) on behalf of Medicaid enrollees who were already enrolled in the MCO under another client identification number (CIN). A workgroup was subsequently formed with staff from the MFCU, the New York State Department of Health's Office of Health Insurance Programs (OHIP), New York City Human Resources Administration (NYC HRA), and the OMIG to develop corrective action procedures to address and reduce the causes of duplicate CINs being issued.

The two basic problems identified as the major causes for issuance of multiple CINs were poor demographic matching at the point of eligibility and human error in data input. As a result, the scoring system allowing local district eligibility workers to override clearance

reports has become more restrictive. A team of HRA staff (SWAT) was formed to identify and close same client CINs in multiple plans. Additional training was given to county eligibility workers and policy changes were implemented to avoid duplicate CIN issuance as a result of supplemental security income (SSI) enrollment.

Improper Retroactive Supplemental Security Income Capitation Payments

The OMIG identified potential recoveries of $6,631,843 million related to enhanced supplemental security income (SSI) capitation payments made to six MCOs. The MCOs appeared to have submitted for a higher SSI premium retroactively to the enrollees' SSI eligibility date, which is not allowed in the MCO contract with New York State.

Family Planning Services to Managed Care Enrollees

Capitation payments to an MCO include costs associated with family planning services. The MCO is subsequently responsible for reimbursing their network providers for the family planning services provided to the MCO's Medicaid enrollees.

Family Planning Chargeback – MCO

Medicaid enrollees have the right to go outside their MCO to receive their family planning services. As part of the agreement between New York State and the MCO's, New York State DOH may recoup payment for services if the enrollee goes to a non-network MCO provider.

In this review, the OMIG:

- Identifies managed care enrollees who receive family planning services outside of their MCO; and
- Recovers the fee-for-service (FFS) payments made to the non-network MCO providers from the MCO.

In 2007, the OMIG finalized 31 audits with recoveries of $5.2 million.

Family Planning Chargeback – FFS

The MCO is responsible for reimbursing their network providers for the services provided to the MCO Medicaid enrollees. In this review, the OMIG:

- Identifies those managed care enrollees who received family planning services from a network provider that billed Medicaid, and not their MCO for the family planning services, and
- Recovers the FFS payment made to the network provider.

In 2007, the OMIG finalized 71 audits with recoveries of $918,000.

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

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

In 2007, the OMIG finalized 18 audits with recoveries of $2.7 million.

Premium Payments for Enrollees Under Six Months of Age

The OMIG finalized 32 audits and recovered $1.5 million in 2007 related to managed care enrollees who were six months of age or older and were billed by the MCO at the higher premium rate for a newborn who is less than six months old.

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

The New York State Office of Temporary Assistance (OTDA) provides local districts with monthly reports that contain matches of Medicaid enrollees who are incarcerated. The local social services districts (LDSS) are instructed to confirm the accuracy of the match information and, where appropriate, take action to close cases. In addition to closing the cases, the local districts are required to request that health plans repay any inappropriate capitation payments where the plan was not at risk to provide service to any enrollee due to an incarceration situation. The OMIG identifies the capitation payments made on behalf of managed care enrollees while incarcerated, not recovered by the LDSS, and pursues recovery of the payments from the MCO.

In 2007, the OMIG finalized 40 audits with recoveries of $939,000.

Duplicate Supplemental Maternal and KICK Payments

The OMIG identified instances where multiple supplemental newborn capitation (KICK) and/or maternity delivery payments were made under one client identification number. The MCO either had to provide documentation to support the payment or repay any inappropriate payments.

In 2007, the OMIG finalized 14 audits with recoveries of $485,000.

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

In 2007, the OMIG finalized 23 audits with recoveries of $476,000 from MCOs related to inappropriate capitation payments made on behalf of managed care enrollees for dates of service prior to the enrollee's month of birth.

Additional Payments to MCOs to Supplement Excessive Costs ("Stop Loss")

Capitation payments to MCOs are established by applying those costs associated with providing medical coverage to an individual based on the demographics of that individual. "Stop loss" is a type of reinsurance offered by New York State to Medicaid managed care plans and is intended to limit a plan's liability for enrollees when an episode of care includes excessive medical costs. Stop loss insurance will pay those additional costs incurred by the plan when the costs to provide the medical service exceed a certain threshold amount.

In 2007, the OMIG opened three audits to review the stop loss claims/payments submitted by the MCO. These audits were done to assure that the MCO met the threshold costs before submitting claims to Medicaid for reimbursement, and that the criteria to be paid were met. These audits are ongoing.

Assisted Living Facilities Billing for Residents During a Hospital Stay

Fifty-one assisted living facilities (ALF) were identified as having improperly claimed Medicaid reimbursement when their residents were in hospitals. Recovery letters were sent in February 2007 requesting repayment of the per diem rate paid to the ALF while the Medicaid enrollee was hospitalized, resulting in recoveries of $209,000.

Bed Reserve Payments to Nursing Facilities for Temporary Client Absence

A nursing home is eligible to bill a bed reserve fee for a Medicaid enrollee when the enrollee and nursing home meet specific requirements. The OMIG performs reviews to ensure that these requirements are met.

For 2007, 23 new audits were opened and four audits were finalized with recoveries of $648,000.

Medicaid Enrollees Spenddown Not Applied to Cost of Care

The OMIG identified a provider who properly billed the Medicaid enrollees for the amount of their spenddown, but failed to apply the spenddown amount to the enrollees' cost of care before billing Medicaid ($1,006,385). As a result, Medicaid was billed for the full amount of services provided. In addition, the audit identified $226,397 in unallowable costs that were included in the provider's rate methodology. After the provider appealed the audit findings the case went to hearing before the DOH Bureau of Adjudication. The hearing officer decided that New York State should be paid $1,023,924. After interest charges were added, the provider made full restitution of $1,470,593 in March 2007.

Voluntary Disclosure

The OMIG is responsible for the statewide provider "self-disclosure" process for all Medicaid providers regardless of provider type. The OMIG conducts active outreach with various provider associations, professional societies, other state agencies and the New York

State Bar Association to encourage providers to come forward when the provider identifies internal issues of fraud, waste, abuse and billing errors.

The OMIG requires providers to identify the reason for the disclosure as well as the scope and resulting potential financial impact. The OMIG's primary concern is to ensure the health and safety of Medicaid enrollees, and this is taken into account during the validation process. That process ensures that the parameters described are true and correct. Steps taken may consist of data analysis, matching claims, medical and/or billing record review, as well as the assessment of financial data.

The voluntary reasons for disclosures vary and include, but are not limited to: improper credentialing of professional staff, billing for services not included on the facility's operating certificate, incorrect rate codes billed and unbundling of physician services from the facility's rate.

Time Period	Cases Received	Cases Finalized	Identified Overpayment
2007	74	80	$10,268,010

Medicaid Fraud, Waste and Abuse Demonstration Project

The OMIG continues its responsibility for managing a demonstration project, authorized by the State Budget Bill of 2005. The project is aimed at providing counties with additional incentives to pursue Medicaid fraud, waste, abuse and improper billing. In 2007, 15 counties and the City of New York have entered into a partnership with the OMIG to conduct audits and/or investigations of Medicaid providers. Those counties include:

Albany	Monroe	Rensselaer
Broome	Nassau	Rockland
Chautauqua	Niagara	Schenectady
Dutchess	New York City	Suffolk
Erie	Onondaga	Westchester
	Orange	

Counties may use their own staff or may contract out for audit and/or investigative services. The OMIG works very closely with the counties by providing training and assistance when needed to ensure statewide consistency and application of audit findings. The OMIG provides statistically valid samples of a provider's cases or claims. Audit findings are then extrapolated over the universe of paid claims to identify potential overpayments owed by the provider.

County staff, or their contractors, must be prepared to testify in the event an audited provider requests an administrative hearing. Testimony would include a detailed description of the auditor's qualifications, how the audit was conducted, what documentation was reviewed and how the audit findings were reached. The OMIG legal staff prepares the county witnesses

for testimony. Assistance to the counties is also provided for investigative interviews, data analysis and surveillance. County investigations are summarized, discussed with and reviewed by the OMIG staff and, when warranted, referred to the New York State (NYS) Attorney General's Office for possible criminal prosecution.

During 2007, two pharmacies were excluded from the program. In addition, four audits initiated by the counties, but not finalized, have been referred to the NYS Attorney General's Office. County investigations resulted in one referral to the NYS Attorney General's Office.

2007 Demonstration Project Audits			
Audits Initiated	**Audits Finalized**	**Audit Findings**	**Audit Recoveries**
65	7	$6,733,125	$2,573,726

Systems Match & Recovery

The Systems Match and Recovery Unit (SMR) currently researches Medicaid policy and billing guidelines to create or modify existing and new criteria. SMR works closely with the Business Intelligence Unit (BIU) to write audit specifications. Once the BIU assembles the data, the SMR reviews the information to ensure all pertinent data is accurately included.

The SMR looks at all data within the payment system that appears to contradict acceptable conditions for payment. Often, other OMIG audit activities serve as the identifying sources for these reviews. Providers receive the results of reviews via mail and are required to substantiate the payments received or, where payments cannot be substantiated, return any overpayments.

Vital Statistics Match

Medicaid benefits cease upon an enrollee's death. Medicaid will not pay providers for services completed and billed after the recipient's date of death. All such claims will be denied.

In this review, the OMIG:

- Identifies fee-for-service claims submitted by Medicaid providers and matches these claims with files obtained from New York City and New York State vital statistics to identify dates of service completed and billed after the death of the recipient.

During 2007, the OMIG issued 451 reviews totaling $3,654,373.

Prenatal Care Assistance Program

This match addresses multiple issues of erroneous billings for Medicaid clients who are receiving prenatal care services (PCAP). Billing issues surrounding the PCAP program include clinic, physician, laboratory services, and ordered ambulatory services for clients

participating in the PCAP program. The match includes multiple initial visits; post-partum services billed at initial or follow up rates; PCAP service for inpatients; physician services; prenatal vitamins; laboratory services and ordered ambulatory services billed as fee for service which is included in the PCAP rate.

In this review, the OMIG identifies all PCAP recipients and matches information to ensure that all pregnancy related claims are billed within the scope of the PCAP program. Pregnancy-related claims billed as fee-for-service are disallowed.

During 2007, the OMIG issued 147 reviews totaling $3,527,770.

During 2007, a total of 1,033 provider reviews were initiated by SMR. Recovery activity totaled $8,603,975.

Medicaid in Education

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

Corrective action reviews (CAR) have been conducted 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 discovered the district or county is asked to void the inappropriate claims. A school district or county with a systemic error issue is required to review all claims in that service area retroactively to the date of the last federal audit.

Performing CAR rather than audits allows the OMIG to review more claims from districts and counties than would be possible using standard audits because of the lengthy administrative processes required for audits.

Districts and counties have not objected to self reviews of systemic error claim areas. They have voided inappropriate claims and reported the 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 91 reviews and completed 88, with findings totaling $2,227,408 and recoveries of $4,387,641 in calendar year 2007.

Summary of Audit Activities

2007 Audits				
Audit Dept.	**Audits Initiated**	**Audits Finalized**	**Audit Findings**	**Audit Recoveries**
Provider Audit Total	389	382	$ 78,314,783	$19,778,638
Rates/Audit Mgmt. & Dev. Unit	713	793	90,318,714	87,516,645
School Medicaid Program	91	88	2,227,408	4,387,641
Systems Match & Recovery Unit	1,033	987	8,594,803	8,603,975
Total	**2,226**	**2,250**	**$172,823,865**	**$120,286,899**

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 providers 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 provider who has:

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

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

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

There were 71 terminations and 802 exclusions for 2007. OMIG's current list of providers not eligible to bill the Medicaid program is maintained on its Web site (www.omig.state.ny.us) and contains 1,103 non-Medicaid provider exclusions, and 3,807 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) 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 percent 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 2007, a total of $1,170,035 in monetary penalties were issued to 286 providers.

Supervising Pharmacist Project

OMIG's Bureau of Investigations and Enforcement (BIE) conducted a project to identify non-compliance with the New York State Medicaid Supervising Pharmacist (SP) regulations [18 NYCRR 504.1 (b)(1)(2)]. The eMedNY system was used to download all SP information for pharmacy providers from June 1, 2001 to May 31, 2006. BIE identified approximately 300 pharmacies that appeared to be non-compliant with the program. The pharmacies did not identify an active SP with the Medicaid program during this period. As a result, the identified pharmacies received letters notifying them of OMIG's proposed agency action. BIE extensively researched all of the information received from the pharmacies replied to the notice. Those with valid and appropriate documentation had their penalty withdrawn. OMIG sent providers who did not respond were sent a final notice identifying the penalty owed.

On September 7, 2007, 127 providers who submitted arguments to the proposed agency action notice received final agency action notices. Of the 127 letters mailed, 110 letters were sent to pharmacies that responded but did not provide information that would lead to a

withdrawal of the penalty. The penalties associated with these pharmacies totaled $521,800. An administrative decision was made not to assess penalties with a proposed amount of $1,000 or less. As a result, 17 providers were sent penalty withdrawal letters. These 127 pharmacies were represented by attorneys and consisted of both independent and chain pharmacies. A total of 33 pharmacies have requested hearings in opposition to the OMIG imposed penalties. OMIG representatives continue to negotiate the penalties in the process to settle these cases while simultaneously preparing for potential hearings. OMIG has settled the majority of the outstanding cases in lieu of going to hearings.

Social Services Law §145-b

Social Services Law §145-b(5) addresses the right of the state or local social services district to recover damages from providers who knowingly make false statements or representations, or who deliberately conceal material information to obtain payment from Medicaid. Simple billing errors by the provider do not rise to the level of fraud and would be excluded from any Section 145-b investigative action.

Cases of suspected fraud are to be referred to the OMIG in the event of possible criminal intent. The OMIG would generally forward such cases to the New York State Attorney General's Medicaid Fraud Control Unit for potential criminal prosecution.

During 2007, the OMIG had ongoing discussions with the New York State Association of Counties about protocols for pursuing investigative actions under this section of the law. Several counties have expressed interest in pursuing Section 145-b investigations. The OMIG has partnered with one county in an ongoing investigation. This partnership has involved assistance with interviewing and data collection as well as discussions with the provider's legal representatives. That investigation continues.

Attorney General Civil Collection Efforts

The Collections Management Group has been established as the single point of contact to the New York State Office of the Attorney General Civil Recoveries Bureau for referral of uncollectible accounts and is responsible for the referral, follow-up and tracking of these accounts. OMIG anticipates that future referrals to the Civil Recovery Unit, within the OMIG's Collection Management Group, will increase as collection efforts become increasingly proactive.

The unit, with assistance from the Attorney General's Civil Recovery Bureau, conducted an extensive review of all OMIG collections that are potentially active civil recovery files. The review of the 130 files that were referred to the Civil Recovery Bureau prior to 2007 resulted in:

- 12 open and active civil recovery files
- 60 closed files
- 27 Affidavits of Uncollectability filed
- 16 files pending for Affidavits of Uncollectability to be completed

- 15 files with actions yet to be determined

Civil Affirmative Proceedings

The OMIG has the authority to initiate or participate in civil proceedings, including actions at law or in equity in order to recover any overpayments where the action or proceeding would be more efficient, effective or in the best interests of the program. No OMIG court actions were filed in 2007.

Administrative Hearings and Article 78 Proceedings

All OMIG final determinations are subject to administrative review and, if necessary, judicial review. Administrative review of certain OMIG final determinations are considered by administrative law judges at hearing. Judicial review of OMIG final determinations are commenced in Supreme Court pursuant to Article 78 of the Civil Practice Law and Rules (CPLR).

During 2007, 78 providers requested administrative hearings. 172 cases were pending, 28 cases were resolved with settlement agreements, 16 providers withdrew their hearing requests and three administrative decisions were rendered during this time period. The three decisions upheld the OMIG's original determinations.

During 2007, 11 Article 78 proceedings were filed. At the conclusion of the reporting period, five proceedings were closed. Of the five closed proceedings, two cases were withdrawn, one case was dismissed, one petitioner had the case denied, and OMIG received a favorable decision on the final case.

Appellate Reviews of Immediate Exclusions

Certain provider circumstances, such as a provider's criminal conviction of health care fraud, may result in the OMIG taking immediate action to exclude providers from participating in the Medicaid program. These providers are afforded the opportunity to appeal this decision by providing written documentation and argument to OMIG's Division of Counsel.

During 2007, 67 appeals were filed, 74 appeals were pending, and 65 appeals were decided. Of the 65 decided appeals two exclusions were reversed, one resulted in a stipulation agreement, two appeals were not filed in a timely manner and were dismissed, six appeals were withdrawn, and 54 appeals affirmed the OMIG's initial determination to exclude the provider.

Accomplishments

Third Party Activities and Medicaid Program Integrity

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.

Two main methods for determining if an enrollee has third party insurance coverage are:

1. the 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 district level. Applicants for Medicaid complete paperwork at the local social services district (LDSS), and identify any third party health insurance coverage they may have, including policy information. In addition, a state contractor routinely processes matches with the Centers for Medicare and 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's eligibility file.

Application of Third Party Insurance

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

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

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 (HMS and UMASS) who test claims for the existence of responsible third party payors. The availability of third party insurance for the specific services provided is verified and, where determined appropriate, Medicaid recovery activities are undertaken.

During the past year, OMIG, through its vendor HMS, initiated 6,559 third party reviews, with recoveries totaling $104,663,628.

Home Health Care Demonstration Project

OMIG continues to work with CMS and the State of Connecticut and Commonwealth of Massachusetts under a pilot demonstration project. The project utilizes a sampling approach to determine Medicare's share of the cost of home health services claims for dual eligible (i.e., both Medicare and Medicaid) enrollees that were inadvertently submitted to and paid for by the respective state's Medicaid agencies.

Findings from data analysis of the HHA demonstration project paid claims universe reveal an overlap of Medicare and Medicaid coverage. The OMIG is beginning to examine these "overlapping payment" universes that are excluded from the demonstration project. Medicaid is paying an excessively large portion of the home health aide services - services that represent the highest utilization dollars in most cases. A probe review of three certified home health agency providers was initiated with 10 home health care cases per agency to show the highest utilization cost to Medicaid, while also under a Medicare Prospective Payment System payment(s). OMIG will use these findings to refine review protocols. Future reviews will be targeted based on the information provided from the demonstration project, and requests for provider specific detail will be made through the Medi-Medi project.

This demonstration project replaces previous third party liability (TPL) audit activities of individually gathering Medicare claims from home health agencies for every dual eligible Medicaid claim the state has possibly paid in error. This is an enormous administrative savings in resources for the home health agencies (HHA), the regional home health intermediary (RHHI) and for the participating states. During the past year, this project recovered $75,618,895.

During the past year, OMIG received referrals identified by CMS that impact the NYS Medicaid program and require investigative action and/or audit. These issues are directed to the Bureau of Investigation and Enforcement for "joint investigation" and/or further referral to the Division of Audit when necessary. Issues of fraud are referred to the NYS Office of Attorney General's Medicaid Fraud Control Unit for potential prosecution if criminal action is identified.

OMIG staff also worked with CMS contract staff to identify potentially inappropriate billings to the Medicaid program. Data mining of Medicare data is requested and used to verify Medicaid billings for dual-eligible recipients.

OMIG is creating a system for tracking referrals between the various bureaus in order to capture the activities and the associated recoveries to the Medicaid program that result from data mining, investigations and audits.

Cost Savings Initiatives

The OMIG undertakes a variety of program integrity initiatives which result in significant cost savings to the Medicaid program. These initiatives are done in conjunction with OHIP. OMIG and OHIP believe it is more effective to build program integrity in on the front-end through these cost savings initiatives. 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 the eMedNY Third Party subsystem prior to inclusion in monthly retroactive recovery projects. This places the emphasis on the prospective cost avoidance of the insurance information while recovery efforts continue.

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

For 2007, 200,655 insurance policies were added to eMedNY. Estimated cost savings for those policies is $623,283,030**.**

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. Developed collaboratively by staff of OMIG, the Office of Health Insurance programs (OHIP), and the DOH fiscal agent, Computer Sciences Corporation (CSC), edits serve to meet budgetary goals, as well as aid in controlling fraud, waste and abuse as identified by audits and investigations.

During 2007, 13 evolution projects proposed in prior years were implemented, and an additional 3 projects were initiated. Savings attributable to these projects totaled $11,450,429 for calendar 2007.

One edit project implemented in 2007 includes a collaborative effort with the Bureau of Narcotics Enforcement. In 2005, all prescriptions written in New York State required the use

of official prescriptions – i.e. serialized forms with numerous watermarks that resist tampering and forgery. Medicaid required use of these forms for its prescriptions, and developed editing that requires pharmacies to report the serial numbers of prescriptions when they dispense drugs. Additionally, when prescribers report the theft or loss of their prescriptions, alerts are transmitted at point of service to pharmacists when one of these lost or stolen prescriptions is presented for dispensing. Since implementation on May 25, 2007, 3,717 alerts have been sent to pharmacies.

Pre-Payment Review Process (Edit 1141)

Edit 1141 is a pre-payment review function that historically has generated substantial cost savings to the Medicaid program, and is a strong fraud, waste and abuse detection tool that also has substantial value as a gatekeeper.

In order to identify, review and process suspected claims for designated providers, OMIG's review staff must have a working knowledge of the Medicaid program, claims processing procedures, and also must be able to communicate with providers orally and in writing. It is helpful to employ medical professionals in this function, though all staff are not required to have medical knowledge to review documents submitted by providers. It is estimated that each reviewer is able to concurrently handle, on average, 30 provider reviews. At present, 10 staff are dedicated to this function.

Reviews are initiated on designated providers who are selected based on criteria established through queries of the claims data warehouse. These include:

Paid claims information:

- High use of facility IDs to identify prescribers
- Large number of claims submitted after 90 days of service date
- Changing the order date on prescriptions that expired
- Using expired and invalid billing codes
- Licensed practical nurses billing in excess of 16 hours per day
- Transportation providers billing units in excess of daily frequencies or norms
- Durable Medical Equipment providers billing large numbers of shoe inserts and orthotics

Denied claims information:

- Review of denied claims that later were paid after changes were made.
- Attempts to circumvent editing
- Assess overall practice by combining denied and paid claims information

Other Sources:

- Use of data mining tools

- Querying data warehouse
- Newspaper articles (e.g., arrested enrollees)
- Referral from other organizations (e.g., Medicaid fiscal agent, Preferred Drug Program, Audit, Post and Clear unit, Restricted Recipient Program, Investigations, etc.)

For 2007, cost savings totaled $24.6 million.

Edit 1141 Success Stories

Inappropriate Use of Rate Code 2877 (Ambulatory Surgery - Hospital Based)

The Medicaid fiscal agent, Computer Sciences Corporation (CSC), maintains a helpline available for providers to call when they have questions regarding claims, claim denials, or other issues that affect their ability to obtain payment. CSC's Provider Services staff answer the helpline and if they suspect fraudulent activity on the part of the caller, they alert the CSC Fraud Unit. The fraud unit performs an initial review, and if the concern is substantiated, the situation is referred to OMIG. The helpline received several calls that raised questions of potentially inappropriate use of a specific payment rate code used by some out-of-state hospitals participating in the New York State Medicaid program. Pre-payment review staff contacted the Department of Health's Medicaid Rate Unit, and determined that it was inappropriate to use this rate code when none of the procedures submitted are listed as a Product of Ambulatory Surgery (PAS) procedure code.

In April of 2007, staff identified eight hospitals using this rate code, and pre-payment review criteria were developed to pend all such claims submitted by these out-of-state providers. Staff reviewed the submitted claim information to determine if any of the procedure codes performed met the criteria for payment. As of June 2008, an additional 24 hospitals were added to the review, with average monthly claim denials totaling $300,000. In addition to the monthly Medicaid savings generated, this review has been successful in re-training hospital billing personnel to identify the correct rate code to be used for the services provided.

Prior to identification of this issue, claims utilizing this rate code were paid. Edit 1141 staff identified 32 providers who billed using this rate code, and placed them on pre-payment review. In June 2007, information was sent to the OMIG's Division of Audit regarding this issue and these providers. Audit staff has been assigned to review the cases and address the recovery of funds associated with these billings.

Orthopedic Shoe Dispenser Improperly Billing for Shoes

According to the Durable Medical Equipment (DME) Provider Manual:

"Reimbursement for orthopedic footwear is only available to providers who possess, or employ others who possess, certification from the American Board for Certification in Orthotics and Prosthetics, the Board for Certification in Pedorthics, or the Board for Orthotist Certification. Orthopedic footwear must be dispensed by those holding the certification."

Staff selected a DME dealer who was increasing their shoe activity and pended their shoe claims to determine if they were in compliance with the policy. Staff discovered that the DME dealer did not have a certified shoe fitter dispensing shoes and all of their pended shoe claims were denied. This provider was referred to the Bureau of Investigation and Enforcement (BIE) for investigation and for recovery of the previously paid claims. In total, the OMIG realized a recoupment of over $70,000 in inappropriate payments for orthopedic shoes.

Edit 1141 staff extended this review to cover all DME dealers who dispensed shoes in SFY 2006-2007. First, these providers received a letter requesting that they send proof that their fitters had the required certifications. If a provider was unable to provide the proper certification, Edit 1141 criteria was set to deny all shoe and orthotic insert claims submitted by that provider. To date, orthopedic shoe and insert claims for 36 DME dealers are being denied. These providers were placed on pre-payment review and a list will be referred to OMIG's Division of Audit for recovery of previously paid claims.

Edit 1141 staff extended the review of DME dealers with certified fitters to review the records supporting the orthopedic shoe service. Documents include the actual doctor's order and the fitter's record of the service. Staff has discovered that many of the DME dealers are not dispensing custom-made shoes and orthotic inserts as required by Medicaid policy, but rather are dispensing "street" shoes, but billing Medicaid for custom-fitted orthopedic shoes. In 2008, four of these providers were referred to OMIG's BIE for investigation.

Clinic Providing Excessive, Poorly Documented Physical Therapy Services

A particular clinic was targeted for prepayment review for billing an all-inclusive rate code for physical therapy procedure codes that were not payable by Medicaid.

The provider was placed on Edit 1141 in December 2006. A total of 16 beneficiaries' claims were culled from the pended claims and a request for medical records was sent for all dates of service between January 1, 2007 and April 20, 2007.

The records provided by the clinic in response to the request were printouts of alleged computerized medical records. They all state at the top of the note the beneficiary's name, date of birth, visit date, provider and location of service. Our investigators immediately noted that about half of the records were labeled with a different clinic's name and location. The other clinic is not an enrolled Medicaid provider. A summary of findings from the record review are listed below:

- A statement at the top of each record notes that "This note has not been signed and may be incomplete."
- No physician, podiatrist or physical therapist signatures appear on any of the records.
- There is an unusual number of clinic visits, as often as three to four times a week for many of the enrollees. Most visits are for physical therapy services and these continue for months.

- Some claims for services do not have corresponding notes in the records.
- The physical therapy notes are nearly identical, most often with just a change in the date of service at the top of the note.

The OMIG's New York City office was asked to interview the beneficiaries whose medical charts were reviewed. Seven of the 16 enrollees were interviewed:

- All enrollees interviewed stated they did receive services at the clinic
- They all indicated that staff at the facility would not allow them to see more than one doctor on any given day.
- One enrollee was told that he needed to visit the clinic at least three times a week in order for them to get paid.
- One enrollee stated she saw doctors at this clinic as well as at the clinic that is not enrolled in Medicaid.
- One enrollee stated she was being harassed via telephone by clinic staff to set up more appointments.

Following the interviews, the prepayment review was continued for this provider. After medical records were requested, the clinic stopped billing for physical therapy services for the months of May and June, and instead billed office visit codes, even though the practitioner providing the services was a physical therapist.

This provider was referred to OMIG's BIE for further action. This referral resulted in proposed exclusion of the provider for five years, as well as recovery of $1,300,000.

Reviews of Inappropriate Dental Billing Practices

OMIG is conducting pre-payment reviews on approximately 30 dentists and dental groups. When a provider is under pre-payment review, staff manually adjudicates every claim submitted by the provider. The enrollees' dental services history is analyzed during the pre-payment review to determine the appropriateness of the service billed. The providers are also asked to provide dental records for a sample of beneficiaries to determine the necessity of the claimed services.

Dental pre-payment reviews have identified numerous improper and fraudulent billing practices, including, but not limited to:

- billing for services not performed
- billing for services previously performed by the provider or other providers
- billing restorations on teeth previously extracted by the provider or other providers
- billing too early in process for multi-step procedures
- significantly exceeding service frequencies
- poor and incomplete documentation of services in dental records

In addition to denying inappropriate claims on the 30 dentists, four providers have been identified as candidates for exclusion from participation in Medicaid. In these cases, the level of questionable dental procedures and billing practices has been deemed to be too egregious and beyond remediation. These providers were paid a total of $3.2 million by Medicaid in the year prior to being put on pre-payment review.

Card Swipe Program

The OMIG designates providers, based on various criteria, to become a mandatory "swiper" as part of the Card Swipe program. 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.

For 2007, OMIG initiated a project to use cardswipe technology to validate home health services and non-emergency transportation trips. Home health providers will be required to swipe their client's Medicaid card when they start providing a billable service, and again when they complete providing service that day. When fully implemented, data analysis will validate the duration of home health visits, and verify that services billed for were actually provided. Similarly, non-emergency transportation will be verified as being provided as claimed. It is anticipated that this project will be fully implemented in late 2008 or early 2009.

For 2007, cost savings totaled $25.7 million.

Post and Clear Program

Posting is a program that allows providers to electronically communicate with pharmacies or laboratories. Posting establishes a record of the care, services or supplies ordered by the provider, and enables the OMIG to verify that the order has been requested by the ordering physician before paying a provider who submits a claim for furnishing the service. Orders entered by a designated provider must be "cleared" off the Medicaid Eligibility Verification System (MEVS) by the lab or pharmacy rendering the service.

Providers are selected for reviews in various ways, including, but not limited to:

- Referrals from other agencies and OMIG Bureaus, such as the DOH Bureau of Narcotics Enforcement and OMIG BIE
- Providers who generate large numbers of orders, or bill for a high volume of patients Providers whose ordering and/or billing exceed $500,000 are generally considered high orderers/billers
- High volume prescribing of drugs that are often abused and/or marketable on the street for resale
- Providers whose prescribing patterns fall outside of their specialty (i.e. a dermatologist who prescribes medication for acid reflux)

- Providers treating patients who fall outside the expected age group of their specialty (i.e. pediatricians treating adults)
- Pharmacy errors – when copies of prescriptions are reviewed forgeries and incorrect information are revealed
- Enrollees who patronize several pharmacies for prescriptions ("pharmacy hopping"), often as an attempt to fill the duplicate prescriptions and/or obtain early refills

When a provider is selected for the Posting Program there is no implication that he or she may be engaged in illegal or inappropriate behavior. The program actually serves to protect both the provider and the Medicaid program – the provider because he or she is fiscally responsible for orders filled under their license/provider identification number and Medicaid because it does not pay for orders the provider did not request. Utilizing the Post and Clear system helps to ensure that only the services and supplies requested by the posting provider are furnished. 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 prescription or fiscal orders. Some providers have recognized the benefits of the Posting Program in protecting the integrity of their medical practice and have voluntarily requested to be included in the program.

Once in the program, there is no time limit on how long providers will remain in the program. OMIG maintains a minimum of one year of inclusion, after which the providers can send a letter stating the reasons they would like to be removed and requesting that a review be conducted.

During calendar year 2007, 69 practitioners were designated as posters.

Program Initiatives

State requirements under Social Services Law §363-d

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 the statute, the OMIG is in the process of drafting regulations and creating compliance guidelines that will assist providers in the development and implementation of their own compliance programs. The OMIG expects to promulgate regulations in 2008 establishing those providers who are subject to §363-d(4) of the Social Services Law. The OMIG anticipates 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, reduce provider costs in the long run as provider operational systems are made more effective and efficient.

OMIG established an advisory committee of stakeholders involved in hospital operations to assist in identifying best compliance practices to include in the guidance to be issued by OMIG. This guidance will assist hospitals in complying with their obligations in the Medicaid program, reflecting the requirements of Section 363-d of the Social Services Law. The advisory committee met over a three-month period in late 2007, and final hospital compliance guidance is expected to be issued in 2008. OMIG plans to create additional advisory committees and issue compliance guidance documents for various provider classifications in 2008.

Deficit Reduction Act of 2005

Section 6032 of the Deficit Reduction Act of 2005 (Act) added a new section, §1902(a)(68), to the Social Security Act. Under this new provision, entitled "Employee Education About False Claims Recovery," certain covered entities 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. The OMIG has responsibility for state oversight of provider compliance of the Act.

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

OMIG will review the certifications of the providers, and will also review selected 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 Centers for Medicare and Medicaid Services may also, at its discretion, independently determine compliance through audits or other means.

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

OMIG received 1,188 certifications from Medicaid providers in calendar year 2007.

Collections

A centralized unit was created in the beginning of 2007 to increase the efficiency and effectiveness of Medicaid recoupments. The unit continues to make progress toward a proactive approach to collections, and has already made improvements in the speed and efficiency of the collection processes, as well as improvements in the clarity of the financial data being collected and reported.

The Collections Management Group started the following initiatives in 2007:

- FACTS Financial: The Collections Management Group has begun work with information technology staff to determine necessary changes to align the FACTS data system's financial capabilities with changing organizational needs and F-SHRP reporting.

- Open receivables: The unit has begun an extensive review of all OMIG open receivable files as noted on FACTS. More than 1,100 open receivable files with approximately $299.1 million due and owed to the state are available.

- Federal-State Health Reform Partnership (F-SHRP): The Collections Management Group has the task of tracking and reporting all sources of F-SHRP recoveries, including any amounts generated by the Attorney General's MFCU and other New York State Medicaid program agencies. Staff is making great progress in identifying all State sources of F-SHRP recoveries and coordinating the reporting from those sources, through the Department of Health's Financial Management Group (recoveries for inclusion on Line 9(c) of the CMS 64 form). A total of approximately $269.3 million in recoveries was reported for the first two F-SHRP quarters (October 1, 2007 to March 31, 2008).

- MFCU: The Collections Management Group is now established as the single point of contact pertaining to withhold requests from the New York State Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) in connection with their ongoing investigations of providers. Staff has made significant progress toward meeting F-SHRP goals with regard to reporting of settlements and court decisions resulting from MFCU investigations.

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 Payment Error Rate Measurement (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 in FFY 2007, and the remaining 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 five areas to be reviewed under PERM: fee-for-service (FFS) payments and managed care capitation payments. OMIG will provide the universe of claims for FFS and Managed Care capitation payments. The other three areas, Medicaid eligibility, SCHIP eligibility and SCHIP payments, fall under the Office of Health Insurance Programs (OHIP).

The first claim universes were due to the CMS contractor on April 30, 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 250 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 contact each of the providers in the sample and request a second copy of the documentation for in-house review. OMIG intends to review the documentation that providers will supply to CMS 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. A large problem in the FFY 2006 PERM states was the documentation received by the contractor from the provider was insufficient.

PERM +

The OMIG will leverage the resources dedicated to the PERM program to construct a new initiative, PERM +. PERM and PERM + staff will share information and resources. In the first year, the projects will establish a benchmark percentage of Medicaid claims paid in error

and also the percentage paid as a result of potential fraudulent activity. This in itself will be a useful tool to fight fraud and ensure program integrity in New York State's Medicaid program. As a result of these efforts, the state will have a standard against which to measure future Medicaid program integrity efforts.

PERM + goes beyond the scope of review in PERM to determine if any fraud or abuse not discovered in the PERM review actually existed. PERM + staff will analyze how the sample claim fits within the provider's overall billing pattern and the beneficiary's medical treatment. PERM + staff will contact beneficiaries to confirm the service was provided and, when necessary, use the OMIG's investigative staff for further review. Because PERM uses a statistically valid sample of Medicaid payments, any findings of potential fraud discovered through PERM + can be projected to estimate the percentage of Medicaid dollars spent on potentially fraudulent activities during the period under review. These estimates will also identify future Medicaid dollars lost to fraud waste and abuse if corrections are not made. Potentially fraudulent claims will be referred for investigation.

Additionally PERM + will provide the OMIG with another targeting tool. The State of California has been doing a statewide payment error rate and fraud analysis since 2004. California has used the results to target its fraud resources where they are the most beneficial to identifying fraud.

PERM + will be an important tool for the OMIG to determine the effectiveness of its own efforts, and the efforts of other State agencies to detect Medicaid overpayments and fraudulent activities. PERM + will measure the effectiveness of both the prepayment controls and the post payment audit and investigation efforts.

New York Fraud, Waste and Abuse Recovery and Detection Project

MAXIMUS, a private consulting firm, was awarded a contract after a 2005 request-for-proposal 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 is assisting in identifiying new activities not currently undertaken by the state Medicaid program to combat fraud, waste and abuse in health care programs. MAXIMUS provides the means to avoid inappropriate future payments, as well as to detect and recover overpayments.

Phase I of the contract consisted 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.

Phase II of the contract is 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 consists of the following project initiatives being implemented in order to enhance overpayment recoveries:

- Duplicate payments paid to the same provider for the same procedure code for the same patient on the same date of service.
- Ambulette/livery service for patients with no related inpatient or outpatient services billed for the patient.
- Ambulance service for patients with no related inpatient or outpatient services billed for the patient.

Problems and Concerns

At the time the OMIG was created, one of the primary issues in controlling Medicaid fraud waste 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.

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

New York 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, significant impediments to OMIG's success remain:

1. ***The complex structure of the New York Medicaid payment system, 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:*** Responsibility for Medicaid eligibility, enrollment, and disenrollment determinations is assigned to the Local Department of Social Services (LDSS) in 57 counties as well as the City of New York. LDSS staff is employed by their respective counties, not by New York State.

    - Medicaid enrollees who have died, moved out of state, are imprisoned, or have other changes resulting in ineligibility are often not removed in a timely manner from eligibility rolls by the LDSS, resulting in ongoing payments of monthly capitated rates for individuals enrolled in managed care and ongoing payments for individual services billed to the Medicaid program after eligibility expires.
    - One individual enrollee may be assigned to multiple Medicaid accounts. If the Medicaid accounts assigned are managed care programs, this duplicate assignment results in the state's making multiple capitated payments per month for the same individual. Duplicate identification numbers may be established by the LDSS—in error—if an enrollee loses his/her Medicaid card (in which case the LDSS should be, and is not always, closing the prior account) or if the enrollee moves (in which case the initial account should also

be closed). Even if duplicate identification numbers are assigned to enrollees in fee-for-service plans, the issuance of different identification numbers and multiple Medicaid accounts creates the potential for fraud and abuse within the Medicaid system.

- The Medicaid managed care contract (§3.6) contains a clause that prohibits the state from recouping duplicate capitated payments for the same enrollee if the managed care entity "was not at risk for provision of…" managed care services "at any portion of the payment period." A Medicaid managed care provider may argue and decline to return duplicate payments, even if they were improperly made, if the provider can show they were at risk during the payment period because the enrollee was assigned multiple managed care or fee-for-service accounts.
- The computer systems used by the LDSS employees do not allow them to view the aggregate of enrollees statewide. Although all data is ultimately aggregated at the Office of Temporary and Disability Assistance (OTDA) and fed into the state's payment system, LDSS employees using New York City's data system cannot see enrollee data from the rest of the state, and LDSS employees outside of New York City cannot see enrollee data from New York City. This deficiency results in the inability of LDSS employees to ensure that multiple Medicaid accounts are not assigned to the same individual.
- Enrollee appeals of Medicaid eligibility determinations and sanctions are handled by OTDA by means of a memorandum of understanding with the Department of Health.

Another weakness in the enrollment system involves the enrollment of providers. The OMIG is working cooperatively with the Department of Health to strengthen the provider enrollment process.

- Provider entities are being allowed to enroll in the Medicaid program using names other than their complete and accurate legal names. This may complicate OMIG's ability to exclude providers engaging in unacceptable practices, since the enrolled name is at times inconsistent with the legal provider entity.
- Provider entities are at times allowed to enroll in the Medicaid program even when the entity is owned or controlled by an individual or individuals who are excluded from participation in the Medicaid program at the time of enrollment.

Until recently, individuals enrolling in the Medicaid program were not required to disclose ownership of other Medicaid provider entities. The absence of this information made it difficult for OMIG to ensure that all affiliates of an excluded individual provider were able to be identified and appropriate action taken to exclude affiliated entities. This weakness was resolved in August 2008 when DOH added an ownership disclosure form as part of all individual provider enrollment applications.

The multi-layered eligibility and enrollment process poses a problem for enrollees and for the administration of the Medicaid program. This leads to differences in how the statewide program is administered depending on the county in which the enrollee resides; in addition, local enrollment and eligibility staff do not report to the Medicaid Director, but rather to the County Executive or, in the case of NYC, the Mayor. The establishment of the cap on local district costs as of January 1, 2007 is also changing the relationship between the local districts and the state.

The Office of Health Insurance Programs (OHIP) has begun a multi-pronged initiative to improve the accuracy, consistency and timeliness of eligibility determinations and renewals. This includes the development of a Commissioner's Dashboard - a joint effort of DOH and the Office of Temporary and Disability Assistance to provide reports on performance measures to Commissioners. In addition, OHIP has begun providing local districts with information on whether or not they are meeting federal and state rules regarding application and renewal processing timelines. OHIP staff reviews local district applications for accuracy. This effort is being increased as part of PERM.

As part of the effort to streamline and simplify the enrollment and renewal process, and to move toward an electronic process, OHIP has obtained legislative authority to develop a statewide enrollment center. The enrollment center will be operational in 2009 and, among its initial tasks will be the centralization of Medicaid renewals. Centralization can provide greater efficiency and consistency in renewals and should reduce churning (eligible enrollees being dropped at the time of their renewal and subsequently re-enrolling as new applicants a few months later.) The center should reduce the workload at local districts when enrollees renew in the Medicaid program so more attention can be focused on increasing enrollment and improving the quality of eligibility determinations.

3. ***The New York Medicaid data system, eMedNY***: The New York Medicaid data system is based on an older programming platform that is difficult to modify, and requires substantial time and effort to develop new edits.

   OHIP was established in 2007 to consolidate the responsibility for the public health insurance programs as well as the key operational components of Medicaid. Among OHIP's first priorities was to reduce the backlog of evolution projects and increase evolution projects going forward. Ongoing delays were compromising Medicaid program goals as well as day to day operations. In early 2007 OHIP's leadership met with the national leadership of Computer Sciences Corporation (CSC) to secure their commitment to address this problem.

   In 2008, a Project Management Office was established and CSC on-site leadership was replaced. The project management office is staffed jointly by OHIP and CSC staff. Weekly evolution meetings are held to provide detailed schedules of all evolution projects. Two additional development workspaces were established in order to increase project production. New technology was implemented to accelerate the

creation of new edits and system functionality. This technology permits simple edits to move through the evolution process quickly. Enhanced capabilities were also developed for more complex edits. A new Evolution Control Board was established to ensure appropriate prioritization of projects. OMIG anticipates that OHIP's continued progress and efforts will help to resolve the difficulties and backlogs previously encountered in the process of implementing fraud, waste and abuse edit controls.

4. ***The Issue of Measurement in Program Integrity***: The New York Medicaid program relies almost exclusively on the conduct of Medicaid enrollees and health care providers to assure program integrity. Of the more than $46 billion in payments and more than 500 million claims each year, only a fraction can be individually reviewed to assure that services were appropriately rendered and payable. With the advent of automated claim processing systems over the past 20 years, the program has evolved to a point where almost every claim passes through an electronic claim system without any human review.

   In 2005, as the result of a *New York Times* series, as well as investigations and hearings before both the New York State Legislature and the Congress, it became clear that New York's system for assuring program integrity was a failure. The passage of the OMIG statute in 2006 was a direct response to that system failure. In November 2006, the OMIG organization began.

   This report describes activities undertaken in 2007, the first full year of OMIG's operation. The most significant task faced by OMIG was developing measurements to determine the effectiveness of program integrity initiatives and actions.

   At the beginning of 2007, virtually no reliable measures were in place at the New York Department of Health to determine the effectiveness of program integrity efforts. As detailed in this report, a variety of measures are being established to determine program effectiveness.

   - F-SHRP NUMBERS: As previously stated CMS and the State of New York struggled to develop a technique for demonstrating that the significant health care modernization funds provided to New York would be revenue neutral, that is, they would result in savings equal to the $1.6 billion being spent. The technique they agreed upon resulted in the first measure the OMIG used to determine the success of program integrity efforts: the identified recoveries reported on Line 9(c) of the CMS 64 form each federal fiscal year. This number, known as the F-SHRP number, was the basis for specific targets over the next five years:

Timeframe	*Benchmark*
1st Year FY 2007 – ending September 30, 2007	No required Target
2nd Year FY 2008 – ending September 30, 2008	Target = $215 million
3rd Year FY 2009 – ending September 30, 2009	Target = $322 million
4th Year FY 2010 – ending September 30, 2010	Target = $429 million
5th Year FY 2011 – ending September 30, 2011	Target = $644 million

In FFY 2006, New York led the nation in reported recoveries of $103 million. In FFY 2007, New York again led the nation with recoveries of $130 million. Total recoveries for all Medicaid programs in the United States, according to CMS's figures, were $305 million in 2007 – less than the FFY 2009 goal for New York alone. Further investigation revealed that a number of major states had no reported recoveries at all.

In addition to the FSHRP goals agreed to by the negotiators from CMS and the State of New York, OMIG is required to address another specific external measure.

BUDGET PLAN: The New York State Constitution requires the state to have a balanced budget each year. In order to achieve this fiscal goal, the state expects OMIG to identify and report cash recoveries and cost avoidance savings resulting from its audit, investigative, third party recovery and other efforts for the state fiscal year. These activities are reported to the Division of the Budget and Legislature on a quarterly basis.

When OMIG began, the state had no consistent approach for capturing these numbers. A number of other agencies and private contractors had responsibility for collecting money and reporting data about their recoveries, which were included in F-SHRP, cash receipts, and budget plan calculations.

During 2007, and continuing to the present time, OMIG has invested significant time and effort into determining all sources of F-SHRP, cash receipts, and budget plan funds, and assuring that they are reported accurately and consistently. This work is ongoing. OMIG is determined, going forward, to report results which are based upon consistent rules and conventions, clearly articulated and enforced.

5. ***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. 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 OMIG 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.

OMIG is attempting to accomplish this result through standardized audit protocols and systems, and extensive education of providers and auditors.

6. ***Inconsistent capture of findings and recoveries***: OMIG has diverse reporting requirements found across the organization, which may lead to inconsistent capture of findings and recoveries. A Reporting Standards Workgroup has been created to better define and standardize reporting requirements. The group is making a concerted effort to match the organizational reporting requirements with the existing case management system (FACTS) which is, in most cases, the primary source of data used to report activities.

   The Medicaid program has had a long history of limiting recoveries of amounts due from providers to 10 percent of the amounts otherwise payable to the provider. As a result, some providers will not pay their existing obligations, including interest, for 20-plus years. During that time, any further audit, no matter how egregious the result may be, will not yield recovery until the prior obligation is paid in full. OMIG plans to propose changes to this practice going forward.

7. ***Recruitment, staffing, and promotion problems***: The OMIG has conducted and continues to carry out an aggressive campaign to recruit, hire and retain qualified staff for its various programs. The OMIG has hired 248 staff from June 2006 through May 2008. Additionally, during SFY 2007-2008, the agency hired 101 staff for its various programs. The OMIG has accomplished these goals despite a number of different barriers including a complex Civil Service appointment process that increases the difficulty to hire staff from outside of the state workforce; a state compensation system that often makes the agency's targeted job openings unattractive to qualified candidates; and the retention of qualified staff due to a workforce with many members eligible for retirement. For example, during the period April 1, 2007 through March 31, 2008, the agency hired 118 new staff. During the same period the agency lost 45 staff. Consequently, the agency experienced a net gain of 75 staff during the aforementioned period. The bulk of the attrition which occurred during this period can be attributed to the retirement of agency staff. This is and will be an ongoing problem given the fact that 50 percent of the agency's workforce are eligible to retire within the next two years.

   With regard to compensation, in the New York City (NYC) area where the agency has a significant number of staff, especially auditors, the existing salary structure makes it very difficult to attract qualified people. As an example, the following chart depicts current salaries offered for auditor positions in the NYC and Long Island areas:

Job Title	Salary
1st Year Auditor Trainee	$41,661
2nd Year Auditor Trainee	$46,234
Senior Auditor Trainee	$49,711 - $61,211

In comparison, in the private sector within NYC, the average starting salary for auditors is $50,710. The median salary for auditors in NYC is $70,200. In light of the above, the agency often experiences difficulty in attracting qualified auditor candidates for its entry-level positions in the NYC and lower Hudson Valley areas.

As outlined above, the agency experiences problems with regard to the Civil Service selection and appointment process. More specifically, the agency must utilize a New York State Civil Service examination and eligibility list process which can and has seriously restricted OMIG's ability to appoint qualified candidates. This is especially telling with regard to the appointment of entry-level auditor staff.

In the above situation, candidates for these positions must take a NYS Civil Service written examination, pass the examination with a score of at least 70.0 and then their names are placed on a Civil Service eligible list. A more specific example of this situation involves a recent examination that the Department of Civil Service administered for auditor trainee candidates in the NYC area. Approximately 21 candidates were scheduled to take the examination. Of this number, only 7 candidates attained a passing score of 70.0.

During the past year, the OMIG has requested that the Department of Civil Service establish 50 Medicaid investigator items at various levels to staff many office locations throughout the state. Both the Department of Civil Service and the Division of the Budget have approved the agency's requests, and the items are presently available to be filled. With the establishment of these items, the agency has embarked upon an aggressive campaign to recruit and hire qualified candidates. To date, the agency has been very successful in recruiting qualified candidates to fill the newly created items and has been engaged in appointing candidates to the aforementioned vacancies.

In addition to the above, the OMIG has been actively engaged in filling a number of vacant items in its various administrative support, information technology and legal divisions. These areas provide the necessary support that enables the agency to carry out its core programmatic functions. It is critical that these areas are fully staffed based on their role in assisting the OMIG in meeting its programmatic goals.

Taken as a whole, the OMIG has and continues to experience problems in fulfilling its staffing needs; however, the OMIG continues to strive to meet its staffing target of 753.

8. ***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.

OMIG has applied and received approval to be a sponsor of continuing education. OMIG became a continuing education sponsor on May 1, 2008 and will offer courses in the subject areas of accounting, auditing, taxation, advisory services and specialized knowledge and applications for continuing professional education credits.

In May and June 2008, OMIG conducted classes for fee-for-service work papers, new rate audit program and procedures, basic rate audit, pharmacy protocols, CPT/HCPCS training and ICD-9-CM and DRG training.

9. ***Establishment of the OMIG as a separate appointing authority.*** The Legislature recognized in OMIG's enabling statute the separate and distinct mission of OMIG from that of the remaining portion of the Department of Health (DOH); it also recognized the need for, and designated OMIG as, a separate appointing authority to accomplish OMIG's mission.

   During the period of this report, the OMIG's status as a separate appointing authority did not exist and OMIG's personnel and human resources functions have been governed by DOH policies and procedures. The OMIG has approached DOH to discuss the potential for establishing OMIG as a separate appointing authority to acknowledge the distinction between DOH and OMIG work activities and to accomplish the following:

   - Transfer staff from the DOH to OMIG in accordance with Section 70.2 of the Civil Service Law.
   - Establish the Medicaid Inspector General as the final authority for decisions involving hiring and firing, staff deployment, employee relations, staff development, labor management, etc.
   - Establishment of OMIG promotional and layoff units. The separation of employees into separate pools will allow the OMIG increased flexibility to manage its workforce and provide promotional opportunities needed to support effective management of the OMIG's activities.
   - Allow the OMIG to manage criteria for Civil Service titles and examinations and to manage eligibility list certification. Distinct OMIG titles and qualifications will allow the OMIG to build and organization with individuals possessing the skills needed to manage a state of the art program integrity operation.

   Representatives from DOH and the OMIG have been meeting to develop a Memorandum of Understanding (MOU) that will define OMIG as a separate appointing authority. The OMIG and DOH will jointly present and implement the MOU provisions in conjunction with the Department of Civil Service, the Governor's Office of Employee Relations, the Division of the Budget, the Office of the State Comptroller, along with the two unions (Public Employees Federation and the Civil Service Employees Association) representing OMIG's employees.

10. ***Fraud hotlines available to the public***: The public has at its disposal a number of toll-free fraud hotlines. The OMIG 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.

A number of other state and federal agencies also maintain 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
- the New York City Human Resources Administration

Multiple hotlines which are not coordinated can result in duplication of efforts and the potential for the complaint to "fall through the cracks" if it is not referred to the proper agency.

11. ***Peace Officer Status for Investigators***: OMIG investigators are subjected to many of the same high risk situations as police officers and peace officers affiliated with other agencies. OMIG investigators conduct 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 New York State insurance fraud investigators, New York State Attorney General's investigators, United States Office of the Inspector General, and other state and federal agencies, all of whom have Peace Officer status.

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

    - interviewing enrollees and complainants in high crime locations
    - undercover operations posing as a recipient in high crime locations
    - providing back-up to undercover shoppers wearing a "wire"
    - interviewing providers, or other persons of interest, who may be associated with organized crime
    - functioning in a high crime environment while conducting investigations
    - conducting investigative functions in locations where there is a high likelihood of being identified as law enforcement personnel

    Granting investigators peace officer status would enhance the working cooperation with other law enforcement agencies. Having sworn peace officer status would enable the organization to be identified as a law enforcement agency. This in turn would allow BIE access to both federal and state grants and funding for training, agency programs and equipment. Peace officer status would also provide access to

the criminal information network. Providing a law enforcement status, rather than regulatory status, to BIE investigators would greatly assist in these areas.

Conclusion

The 500 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.

As a staff, we have investigated potential fraud, waste and abuse on the part of Medicaid providers of all types and recovered millions of dollars for the State of New York. We have also formed partnerships with other state agencies to strengthen our abilities to find areas where our staff might be able to identify providers whose practices may be questionable, or who need to better control their Medicaid system.

We have conducted outreach to the public, legislators and policymakers to build transparency in our work. We insist on program integrity and quality from the state's Medicaid providers at all levels – whether physicians, dentists, nurses, pharmacists, rehabilitation professionals, home care providers, nursing facilities, hospitals, transportation providers, durable medical equipment vendors, adult day care providers – we demand the highest quality that your profession commands.

This has been a year of building, of laying the foundation for the significant amount of work ahead. While we have begun by putting in the cornerstone for this large structure known as the Office of the Medicaid Inspector General, this is just the beginning. We are committed to integrity, fairness, access and clarity. We strive to make our approach to ending fraud, waste and abuse in New York's Medicaid program the model that the rest of the nation will use when combating problems in their respective states.

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, and documenting further progress in next year's annual report.

Appendix

Operational Statistics

Appendix – Operational Statistics

2007 Investigations by Source and Region

Source	Downstate		Upstate		Totals	
	Initiated	Completed	Initiated	Completed	Initiated	Completed
BIE - Self Generated	592	737	586	789	1,178	1,526
CMS	6	5	3	1	9	6
Correspondence	132	109	40	23	172	132
County Demo Project	17	1	-	-	17	1
CSC Fraud Unit	-	-	4	1	4	1
DOH - Other Than BIE	30	42	8	4	38	46
Edit 1141	-	-	5	1	5	1
Enrollment	152	250	30	50	182	300
EOMB	28	27	30	23	58	50
Exec, Leg, Admin	13	17	1	3	14	20
HHS	1	2	1	1	2	3
Hotline	477	455	106	87	583	542
Internet	75	61	22	10	97	71
Law Enforcement	4	3	8	3	12	6
Local District	3	3	-	-	3	3
Medicaid Fraud Control Unit	7	4	-	-	7	4
Medi-Medi	2	1	1	-	3	1
Office of Professional Discipline	4	3	3	1	7	4
Office of Professional Medical Conduct	2	1	1	1	3	2
Office of State Comptroller	-	-	5	-	5	-
OHIP (OMM)	12	6	4	1	16	7
OMIG Audit	18	7	13	6	31	13
OMRDD	2	-	3	-	5	-
Other	1	6	5	8	6	14
Qui Tam	1	-	2	-	3	-
RRP	1	1	-	1	1	2
Shop/CVR/Comp Target	26	7	2	1	28	8
SURS	102	9	5	3	107	12
Telephone Call	22	22	9	3	31	25
Total	**1,730**	**1,779**	**897**	**1,021**	**2,627**	**2,800**

2007 Fraud Financial Investigations by Region and Project Type

2007 Downstate Fraud Financial Investigations				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Annual Ambulette Survey	7	7	$ 0	$ 500
Billing Issue	0	0	0	1,641
Diagnostic And Treatment Center	0	0	0	85,540
Duplicate Billing	1	0	0	0
Fraud and Abuse	1	0	0	0
No Supervising Pharmacist	0	30	0	51,855
Nursing Home	0	0	0	94,500
Other	6	3	13,200	525,156
Personal Care	0	0	0	274,815
Pharmacy	0	71	0	250,403
Physician Reviews	0	0	0	4,000
Self-Disclosure	1	1	1,247	1,247
Service Not Rendered	1	1	518,668	153,635
Transportation	27	27	13,200	40,500
Unlicensed Provider	1	0	0	0
Total	**45**	**140**	**$ 546,315**	**$ 1,483,792**

2007 Upstate Fraud Financial Investigations				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Annual Ambulette Survey	8	8	$ 8,800	$ 374
CVR – Transportation - Vehicle	1	0	0	0
No Supervising Pharmacist	0	18	0	46,523
Ob/Gyn Services	0	1	5,047	5,047
Other	4	3	4,750	5,250
Personal Care	0	1	1,445,539	15,628
Pharmacy	3	75	215,140	598,854
Psychiatric Clinics	1	0	0	0
Service Not Rendered	1	0	0	0
Transportation	35	34	4,400	26,248
Total	**53**	**140**	**$ 1,683,676**	**$ 697,924**

2007 Total Fraud Financial Investigations				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Annual Ambulette Survey	15	15	$ 8,800	$ 874
Billing Issue	0	0	0	1,641
CVR – Transportation – Vehicle	1	0	0	0
Diagnostic & Treatment Center	0	0	0	85,540
Duplicate Billing	1	0	0	0
Fraud and Abuse	1	0	0	0
No Supervising Pharmacist	0	48	0	98,379
Nursing Home	0	0	0	94,500
Ob/Gyn Services	0	1	5,047	5,047
Other	10	6	17,950	530,406
Personal Care	0	1	1,445,539	290,443
Pharmacy	3	146	215,140	849,258
Physician Reviews	0	0	0	4,000
Psychiatric Clinics	1	0	0	0
Self-Disclosure	1	1	1,247	1,247
Service Not Rendered	2	1	518,668	153,635
Transportation	62	61	17,600	66,748
Unlicensed Provider	1	0	0	0
Total	**98**	**280**	**$ 2,229,991**	**$ 2,181,718**

2007 Summary of Civil Recoveries

Project Type	Identified	Recoveries
Credentials	$ 72,290	$ 1,092
Dentist	121,217	61,797
DME and Orthopedic Shoe Vendor	527,222	220,353
DME Mailouts	127,980	79,235
High Ordering Providers	4,291,925	176,764
Nursing Reviews	34,944	1,491
Pharmacies	2,253,499	995,526
Physician Reviews	1,179,413	360,882
Podiatrists	9,643	468
Radiology	2,125,022	348,708
Transportation	6,603	0
Total	**$ 10,749,758**	**$ 2,246,316**

2007 Provider Audits by Type and Region

2007 Downstate Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Commission On Quality Care	0	0	$ 0	$ 51,233
Death Match	88	64	128,772	117,705
Dental Clinic Services	6	3	14,245	14,245
Dentist	4	1	14,018	9,517
Diagnostic and Treatment Center	32	9	341,662	1,032,349
DME and Orthopedic Shoe Vendor	16	8	891,028	242,432
High Ordering Providers	1	0	0	2,315
Hospital Outpatient Department	0	17	2,388,744	3,297,372
Laboratories	2	0	0	0
OASAS	7	3	52,948,593	255,788
Ob/Gyn Services	0	47	635,872	587,609
OMH	11	20	2,003,301	1,529,471
OMRDD	3	2	616,751	276,852
Other	0	0	0	0
PCAP	0	0	0	22,927
Pharmacies	3	1	521,648	77,236
Physician Reviews	1	0	0	71,094
Radiology	20	7	29,999	29,999
Self Disclosure	47	54	8,555,184	6,188,120
Traumatic Brain Injury	1	0	0	0
Transportation	3	2	2,326,959	75,654
Total	**245**	**238**	**$ 71,416,776**	**$ 13,881,918**

2007 Upstate Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Death Match	9	7	$ 3,190	$ 3,190
Dental Clinic Services	0	1	37,250	37,250
Dentist	1	0	0	0
Diagnostic and Treatment Center	9	11	845,556	565,620
DME and Orthopedic Shoe Vendor	2	2	136,565	244,584
Hospital Outpatient Department	4	3	583,601	233,172
OASAS	6	7	387,081	403,358
Ob/Gyn Services	0	11	121,553	94,653
OMH	7	12	684,540	684,540
OMRDD	2	2	499	499
Pharmacies	1	1	138,084	0
PCAP	0	1	(17,009)	35,487
Physician Reviews	0	0	0	3,740
Radiology	3	0	0	0
Self Disclosure	8	11	680,860	858,629
TBI	1	2	46,708	55,607
Transportation	2	1	1,234	1,789
Total	**55**	**72**	**$ 3,649,712**	**$ 3,222,118**

2007 Western Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Death Match	4	4	$ 2,424	$ 2,424
Dentist	2	0	0	0
Dental Clinic Services	1	1	3,190	3,190
Diagnostic and Treatment Center	1	2	259,893	259,893
DME and Orthopedic Shoe Vendor	9	0	0	26,122
Hospital Outpatient Department	1	4	895,193	895,193
Laboratories	0	2	78,354	81,376
Nursing Reviews	2	0	0	0
OASAS	11	4	339,081	341,115
Ob/Gyn Services	0	20	148,574	124,605
OMH	9	11	408,009	320,364
OMRDD	4	4	2,212	1,019
Other	4	0	0	0
Personal Care	2	0	0	0
Pharmacies	11	0	0	174,096
Physician Reviews	1	0	0	13,252
Radiology	4	3	45,145	25,220
Self Disclosure	19	15	1,031,966	374,884
TBI	2	1	17,481	17,481
Transportation	2	1	16,862	14,367
Total	**89**	**72**	**$ 3,248,384**	**$ 2,674,601**

2007 Statewide Provider Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Commission On Quality Care	0	0	$ 0	$ 51,233
Death Match	101	75	134,386	123,319
Dental Clinic Services	7	5	54,685	54,685
Dentist	7	1	14,018	9,517
Diagnostic and Treatment Center	42	22	1,447,111	1,857,862
DME and Orthopedic Shoe Vendor	27	10	1,027,593	513,138
High Ordering Providers	1	0	0	2,315
Hospital Outpatient Department	5	24	3,867,538	4,425,738
Laboratories	2	2	78,354	81,376
Nursing Reviews	2	0	0	0
OASAS	24	14	53,674,755	1,000,261
Ob/Gyn Services	0	78	905,999	806,867
OMH	27	43	3,095,850	2,534,374
OMRDD	9	8	619,462	278,371
Other	4	0	0	0
PCAP	0	1	(17,099)	58,414
Personal Care	2	0	0	0
Pharmacies	15	2	659,732	251,332
Physician Reviews	2	0	0	88,086
Radiology	27	10	75,144	55,219
Self Disclosure	74	80	10,268,010	7,421,633
TBI	4	3	64,189	73,088
Transportation	7	4	2,345,055	91,810
Total	**389**	**382**	**$ 78,314,782**	**$ 19,778,638**

2007 Rate Audits by Type and Region

2007 Downstate Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
ALP/Inpatient Crossover	16	16	$ 102,110	$ 102,110
Bed Reserve	23	3	474,765	626,743
Child Health Care Institute	1	0	0	0
Home Health Care	0	0	0	22,261
Managed Care	138	154	45,981,683	37,330,931
Medicare Part B	0	5	254,384	2,402,014
Skilled Nursing Facility Audits	42	60	17,765,866	24,735,789
Transportation	172	196	680,203	577,515
Total	**392**	**434**	**$ 65,259,011**	**$ 65,797,363**

2007 Upstate Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
ALP/Inpatient Crossover	17	17	$ 42,110	$ 42,110
Bed Reserve	0	1	173,166	0
Managed Care	43	45	4,447,637	4,444,629
Skilled Nursing Facility Audits	32	23	8,354,589	8,139,564
Transportation	78	87	246,626	202,607
Total	**170**	**173**	**$ 13,264,128**	**$ 12,828,910**

2007 Western Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
ALP/Inpatient Crossover	18	17	$ 62,785	$ 64,420
Managed Care	35	54	818,640	678,725
Medicare Crossover	0	2	47,160	47,475
Medicare Part B	0	7	82,086	94,586
Skilled Nursing Facility Audits	50	52	10,757,587	7,947,715
Transportation	48	54	27,319	57,453
Total	**151**	**186**	**$ 11,795,577**	**$ 8,890,374**

2007 Statewide Rate Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
ALP/Inpatient Crossover	51	50	$ 207,005	$ 208,640
Bed Reserve	23	4	647,931	626,743
Child Health Care Institute	1	0	0	0
Home Health Care	0	0	0	22,261
Managed Care	216	253	51,247,958	42,454,284
Medicare Crossover	0	2	47,160	47,475
Medicare Part B	0	12	336,470	2,496,600
Skilled Nursing Facility Audits	124	135	36,878,042	40,823,068
Transportation	298	337	954,148	837,575
Total	**713**	**793**	**$ 90,318,714**	**$ 87,516,646**

2007 Medicaid in Education Reviews by Region and Type

2007 Medicaid in Education Downstate Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
SSHSP*	24	27	$ 209,801	$ 234,567
PSHSP**	0	1	9,600	9,600
Systemic Review	1	0	0	1,505
SSHSP – ICF***	5	0	0	45,217
Total	**30**	**28**	**$ 219,401**	**$ 290,889**

2007 Medicaid in Education Upstate Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
SSHSP	12	20	$ 271,355	$ 1,031,476
PSHSP	7	4	12,144	12,733
SSHSP – ICF	8	0	0	177,128
Total	**27**	**24**	**$ 283,499**	**$ 1,221,338**

2007 Medicaid in Education Western Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
SSHSP	23	33	$ 1,516,877	$ 2,383,124
PSHSP	3	3	207,631	225,792
SSHSP - ICF	8	0	0	266,498
Total	**34**	**36**	**$ 1,724,508**	**$ 2,875,414**

2007 Medicaid in Education Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
SSHSP	59	80	$ 1,998,033	$ 3,649,167
PSHSP	10	8	229,375	248,125
Systemic Review	1	0	0	1,505
SSHSP – ICF	21	0	0	488,843
Total	**91**	**88**	**$ 2,227,408**	**$ 4,387,640**

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

2007 Systems Match Recoveries by Region and Type

2007 Downstate Systems Match and Recovery Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	71	$ 1,319,473	$ 1,319,473
Deceased Beneficiaries	336	250	1,443,011	1,452,866
Dental	14	5	22,103	22,103
Duplicate Clinic Payments	0	14	168,447	168,447
Home Health	0	1	878	878
Home Health - Nursing Home	86	71	193,268	193,268
Inpatient/Ancillary/Lab	60	57	218,085	218,085
MC - Inpatient/Newborn	0	10	350,088	350,088
Medicare Part A	0	6	103,376	103,376
Net Available Monthly Income (NAMI)	0	5	193,366	198,492
Non Affiliated Inpatient/Clinic/ER	0	2	481	481
Outpatient	0	1	347,530	347,530
PCAP – Prenatal Care Assist Program	82	62	1,662,273	1,662,273
Podiatrists	0	0	468	468
Radiology	79	22	326,753	326,753
Voluntary Refunds	10	10	19,545	19,545
Total	**667**	**587**	**$ 6,369,145**	**$ 6,384,126**

2007 Upstate Region Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	51	$ 369,923	$ 366,705
Deceased Enrollees	49	28	141,069	141,069
Dental	2	0	0	0
Duplicate Clinic Payments	0	1	1,411	1,411
Home Health	0	1	981	981
Home Health - Nursing Home	34	28	11,767	11,767
Inpatient/Ancillary/Lab	42	39	99,904	99,904
MC - Inpatient/Newborn	0	1	9,115	9,115
Medicare Part A	0	2	2,461	2,461
Non Affiliated Inpatient/Clinic/ER	0	1	815	815
Outpatient	0	2	6,094	6,094
PCAP – Prenatal Care Assist Program	26	20	411,920	411,920
Radiology	28	13	63,749	63,749
Voluntary Refunds	2	2	292	292
Total	**183**	**189**	**$ 1,119,501**	**$ 1,116,283**

2007 Western Region Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	65	$ 406,095	$ 406,095
Deceased Beneficiaries	32	18	74,515	74,515
Duplicate Clinic Payments	0	2	6,357	6,357
Home Health - Nursing Home	45	36	21,981	20,927
Inpatient/Ancillary/Lab	55	53	78,477	78,477
Medicare Part A	0	6	11,542	11,542
Non Affiliated Inpatient/Clinic/ER	0	2	2,655	2,655
PCAP – Prenatal Care Assist Program	34	21	410,819	409,280
Radiology	17	8	93,719	93,719
Total	**183**	**211**	**$ 1,106,160**	**$ 1,103,567**

2007 System Match and Recovery Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	187	$ 2,095,490	$ 2,092,273
Deceased Enrollees	417	296	1,658,595	1,668,450
Dental	16	5	22,103	22,103
Duplicate Clinic Payments	0	17	176,216	176,216
Home Health	0	2	1,859	1,859
Home Health - Nursing Home	165	135	227,015	225,961
Inpatient/Ancillary/Lab	157	149	396,465	396,465
MC - Inpatient/Newborn	0	11	359,202	359,202
Medicare Part A	0	14	117,379	117,379
Net Available Monthly Income (NAMI)	0	5	193,366	198,492
Non Affiliated Inpatient/Clinic/ER	0	5	3,951	3,951
Outpatient	0	3	353,624	353,624
PCAP – Prenatal Care Assist Program	142	103	2,485,012	2,483,473
Podiatrists	0	0	468	468
Radiology	124	43	484,221	484,221
Voluntary Refunds	12	12	19,837	19,837
Total	**1,033**	**987**	**$ 8,594,803**	**$ 8,603,974**

Cost Savings Activities

Activity Area	2007
Pre-Payment Insurance Verification Commercial	$ 343,738,271
Pre-Payment Insurance Verification Medicare	279,544,759
Pharmacy License Verification	33,866,448
Edit 1236/1238 - Order/Servicing/Referring Provider #	42,550,515
Clinic License Verification	23,000,382
Card Swipe Program/ Post & Clear Program	90,998,232
Edit 939 - Ordering Provider Excluded Prior to Order Date	2,798,896
Edit 1342 &1343 - Part-Time Clinic	138,893,397
Pharmacy Prior Authorization (Serostim)	51,992,187
Forgeproof Serialized RX Edits	75,616,063
Edit 1141	24,598,203
Edit 903 – Ordering/Referring Provider Number Missing	10,980,847
Recipient Restriction	81,600,361
Drug Utilization Review	92,097,855
Investigations	6,181,707
Status Changes	10,220,864
Enrollment and Reinstatement	51,820,142
Transportation Crossover Edit	86,356
Duplicate Clinic/Nursing Home Claim Editing	45,429
Edit 760 – Suspected Duplicate, Covered by Inpatient	77,438
High Ordering Providers	2,350,388
Total	**$ 1,363,058,740**