Office of the Medicaid Inspector General

2018 Annual Report

Andrew M. Cuomo
Governor

Dennis Rosen
Medicaid Inspector General

Protecting the Integrity of the Medicaid Program

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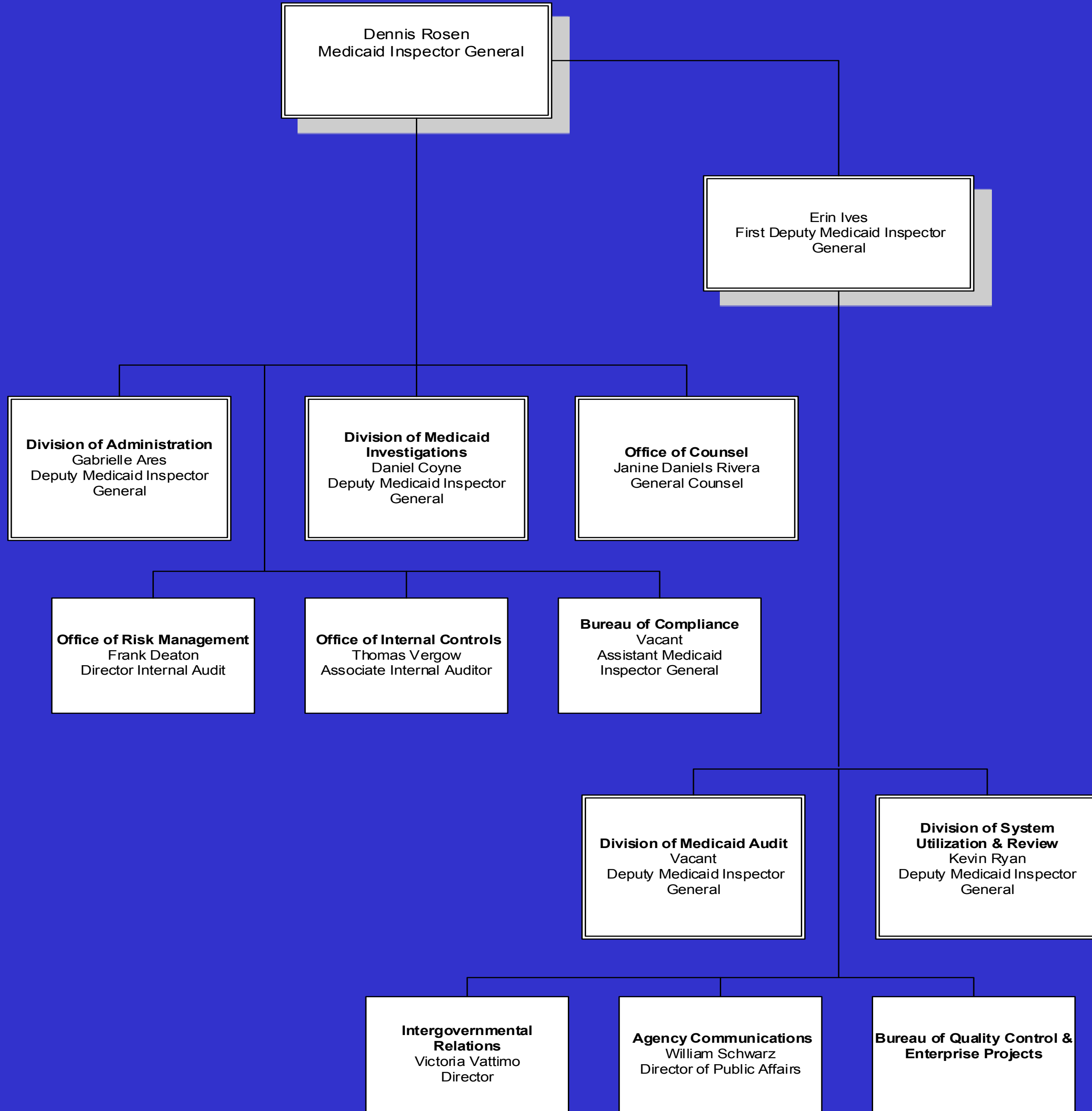
OMIG Organizational Chart



Message from the Medicaid Inspector General

I am pleased to issue the Office of the Medicaid Inspector General's (OMIG) 2018 Annual Report, which details the agency's initiatives and outcomes across all divisions and bureaus.

OMIG's investigative, auditing, cost-avoidance, and provider education efforts - coupled with its strong partnerships with law enforcement entities at all levels - resulted in more than $2.7 billion in Medicaid recoveries and cost savings in 2018.

OMIG is committed to building upon these 2018 achievements in support of its vital mission to protect the integrity of the Medicaid program.

Sincerely,

Dennis Rosen
Medicaid Inspector General

General Overview

History and Authority

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

OMIG is charged with coordinating the fight against fraud and abuse in the Medicaid program. To fulfill its mission, OMIG performs audits and reviews of Medicaid services and providers and works with other agencies that have regulatory oversight or law enforcement powers.

Mission Statement

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

Annual Reporting

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

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

2018 Program Integrity Activities

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

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

Executive Initiative: Opioid Epidemic

OMIG's Continued Efforts Related to the Opioid Epidemic

OMIG's Recipient Restriction Program (RRP) identified circumstances where a recipients' utilization did not meet the established restriction criteria. Data analysis showed multiple recipients had an accumulation of controlled substances. According to Title 10 of the New York Codes Rules and Regulations (NYCRR) §80.67 (c) – "Prescribing and Dispensing of Controlled Substances-Schedule II and certain other substances…No additional prescriptions for a controlled substance may be issued by a practitioner to an ultimate user within 30 days of the date of any prescription previously issued unless and until the ultimate user has exhausted all but a seven days' supply of that controlled substance provided by any previously issued prescription." As a result of the data analysis, RRP developed and issued Controlled Substance Accumulation Letters to notify prescribers of this potential overutilization and abuse of prescribed drugs. In 2018, OMIG sent these letters to alert the pharmacies and/or medical providers of the potential accumulation of controlled substances.

Additionally, RRP uses the Medication Therapy Review Form when a recipient's utilization of prescribed drugs does not meet the restriction criteria, yet there was an apparent therapeutic duplication or potential drug safety concern. The form contains recipient pharmacy claim information and any relevant clinical drug information pertinent to the apparent duplication/safety concern. An OMIG pharmacist may send a

Medication Therapy Review Form to a prescriber, which enables the prescriber to reconcile the recipient's medication list and identify potential forgeries or overutilization.

As part of its multifaceted response to the ongoing opioid crisis, OMIG continued to coordinate efforts to identify developing abuse patterns. This includes outreach and education at the county level. For example, is a presentation was delivered by an OMIG pharmacy consultant at the Franklin County Opiate Forum in Malone, NY. This forum was organized by the Franklin County Prevention Task Force in collaboration with the Franklin County Department of Social Services and Franklin County Community Services. The presentation focused on NYS Medicaid recipient utilization trends of opioids and gabapentin in Franklin County and across the state. The presentation also detailed observed trends from an enforcement perspective regarding the potential for misuse of buprenorphine medications (Suboxone, Subutex) and gabapentin. Additionally, the presentation highlighted the increased utilization of gabapentin within Franklin, St. Lawrence, and Clinton counties. One of the trends OMIG investigates includes recipients living in northern counties bordering Canada who travel to New York City (NYC) to obtain prescriptions for buprenorphine and gabapentin, rather than obtaining them locally.

Managed Care

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

Managed Care Audit Activities

OMIG's audit efforts include performing various match-based reviews utilizing data mining and analysis to identify potential audit areas/targets. These audits led to the recovery of inappropriate premium payments and identification of actions to address systemic and programmatic concerns. In 2018, these efforts resulted in 508 finalized audits with more than $117 million in identified overpayments. Highlights of managed care audit activities are described below.

Monitoring Retroactive Disenrollment Data

When a managed care monthly capitation payment is inappropriately made due to errors in determining eligibility or untimely eligibility file updates (e.g., death, incarceration, institutionalization, enrollees assigned more than one client identification number (CIN), enrollees who have moved out of state, etc.), NY State of Health (NYSoH), Local Departments of Social Services (LDSS), and the NYC Human Resources Administration (NYC HRA) are instructed to retroactively adjust the enrollee eligibility file, notify the MCOs to void the corresponding premium payments, and submit the retroactive disenrollments to OMIG. In turn, OMIG updates the retroactive disenrollment database with submissions received from these external agencies.

This database is used to perform a second-level review to determine if action was taken by the MCO in response to the external agency activities. OMIG semiannually issues a report of all submissions to each MCO that failed to void the premium payments after having been requested to do so by the external agency. If the MCO still fails to void the premium payments following the semiannual report, OMIG initiates the audit process. In 2018, OMIG finalized 363 audits and identified overpayments of more than $49 million.

Multiple Client Identification Number

Each Medicaid recipient is assigned a unique CIN for enrollment in the Medicaid program. In some cases, individuals may erroneously be assigned more than one CIN. This can result in overpayments if the CINs have overlapping enrollment. The LDSS, NYC HRA, and NYSoH perform initial reviews to identify

Medicaid enrollees with more than one currently active CIN. OMIG utilizes demographic data to conduct a second-level review to identify additional CINs that may not have been identified by the LDSS, NYC HRA, and NYSoH. The demographic information includes first name, last name, social security number, address, and date of birth. In 2018, OMIG coordinated efforts with the LDSS, NYC HRA, and NYSoH to review potential matches in order to confirm and resolve instances where an individual had more than one currently active CIN. After the review, incorrect CINs were deactivated. This resulted in 24 finalized audits and identified overpayments of more than $12.9 million.

Managed Care Project Teams

OMIG has six project teams, each tasked with the goal of improving and expanding the agency's program integrity work in Medicaid managed care. Staff from all OMIG divisions and regional offices participate on the teams; agency efforts are coordinated by the project management office. OMIG's six project teams oversee the following focus areas:

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

Here are highlights from some of the project teams:

Managed Care Contract and Policy/Relationship Management

In 2018, the MCCPRM Team proposed and negotiated amendments to the March 1, 2019 Medicaid Managed Care/Family Health Plus/HIV SNP/Health and Recovery Plan Model Contract (Model Contract) to address new federal regulatory requirements. Amendments include updated fraud, waste, and abuse referral requirements; compliance programs; and, the requirement that MCOs withhold payments from network providers who are the subject of a pending investigation of a credible allegation of fraud. In anticipation of the Model Contract being approved by the Centers for Medicare and Medicaid Services (CMS), MCCPRM began developing instructions and guidance for the MCOs related to the new/updated program integrity requirements that would be included in the Model Contract.

Managed Care Plan Review

Costs and utilization reported on the Medicaid Managed Care Operating Report (MMCOR) is used by DOH to develop the premium/supplemental payments that Medicaid pays to MCOs. The Managed Care Plan Review Team continues to perform MMCOR audits to ensure accuracy of the reported data.

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

Pharmacy

The Pharmacy Team's audit process utilizes pharmacy reimbursement amounts directly reported by pharmacies. The Team's review of this process model is ongoing and activities to refine the audit and recovery process are underway. Activities include a comprehensive review of the managed care pharmacy payment flow model, evaluation of available pharmacy data, determination of the need for access to additional encounter data fields and real-time point-of-sale transactional data, as well as data analysis of pharmacy billing trends.

Value-Based Payments

The VBP team's mission is to determine how value-based payment systems are being implemented, and to identify the rules and regulations that govern these payment structures. Members of the VBP team approached CMS to create a VBP-specific Technical Advisory Group (TAG) workgroup. The VBP TAG meetings are open to and comprised of state representatives from across the country interested in VBP. There have been presentations made by DOH, CMS, and other states related to their VBP programs. Additionally, VBP Team members participate in regular calls relating to the DOH VBP Pilot Program with members of the Pilot Program where information regarding challenges and successes pertaining to the implementation of VBP are discussed.

Audits

As part of OMIG's efforts to protect the integrity of the Medicaid program, staff conduct audits of services provided to beneficiaries. The objective of the audits is to assess providers' compliance with applicable federal and state laws, rules, and policies governing the NYS Medicaid program, and to verify that:

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

Fee-For-Service Audit Activities

In 2018, OMIG finalized 489 Fee-For-Service (FFS) audits that resulted in identified overpayments of more than $32 million. The most common audit findings identified were missing, late, or not properly authorized plans of care documentation, which reinforced to the providers the importance of maintaining proper documentation. These plans of care may have different titles across the various categories of service that OMIG audits, but they form the fundamental basis for authorized Medicaid services. Below are some examples of FFS audits.

Assisted Living Program

An Assisted Living Program (ALP) is an entity approved to operate in adult homes and enriched housing programs. ALPs provide long-term residential care, room, board, housekeeping, personal care, supervision, and provide or arrange for home health services to five or more eligible residents, unrelated to the operator. OMIG reviews service documentation to ensure that services provided are in line with plans of care.

In 2018, OMIG continued to conduct statewide audits of ALPs. Findings included missing information; e.g., a signature on the medical evaluation, the plan of care, and service documentation to support the claim. The audits also identified errors in personnel record keeping; e.g., missing health assessments, lack of tuberculosis tests, and missing annual performance evaluations. OMIG finalized six audits with identified overpayments of more than $9.7 million.

Pharmacy

In 2018, OMIG conducted audits of pharmacies where payments were made for emergency services due to override codes being used inappropriately. Claims submitted for prescribed drugs and durable medical equipment that do not meet the federal definition of an emergency medical condition should not be

reimbursed by Medicaid. In these instances, the provider must submit a letter of medical necessity to DOH explaining the rationale for how the claim meets the federal definition of an emergency medical condition, as stated in the 42 Code of Federal Regulations (CFR) §440.255(c). Once the pharmacy receives verbal and written notice of approval, the claim can be submitted using the appropriate override code as provided by DOH. OMIG finalized 50 audits where the override codes were used without the required approval, identifying more than $1.9 million in overpayments.

System Match and Recovery Projects

OMIG applies analytical tools and techniques to data mine large volumes of Medicaid data and identify improper claim conditions. The System Match and Recovery unit (SMR) finalized 164 audits with more than $12 million in identified overpayments. The following project contributed to these findings:

Transportation Claims

In a 2018 transportation services project, OMIG reviewed transportation claims for Medicaid recipients who, on the dates of the claims were in the hospital, and therefore could not have utilized transportation services. OMIG finalized 124 audits with identified overpayments of more than $6.2 million.

Rate-Based Audit Activities

OMIG conducts audits of Residential Health Care Facilities (RHCF) that are required to submit annual cost reports to DOH's Bureau of Long-Term Care Reimbursement. This information is then used to calculate daily Medicaid rates for each RHCF. OMIG audits these rates, which are comprised of operating and property components.

Beginning in 2012, a majority of the operating component of the rate was calculated on a regional basis. In 2018, OMIG completed six base year audits, and identified overpayments of more than $2 million. When a base year audit results in adjustments to the operating costs, these audit findings need to be integrated and carried forward into the rate calculation for subsequent rate years that use those operating costs as its basis. These projects are referred to as notice of rate changes. OMIG finalized 26 notice of rate change audits with identified overpayments of more than $3.1 million.

Additionally, OMIG conducts capital audits of RHCFs by verifying that the underlying costs that determine the capital component of the rate are accurate, allowable, and substantiated. Some examples of improper expenses that were identified as being included in the rate calculation are:

- working capital interest expense disallowances;
- sales tax disallowances;
- mortgage expense disallowances; and
- depreciation disallowances.

In 2018, OMIG finalized 25 capital audits that identified overpayments of more than $6.7 million.

Self-Disclosure

OMIG operates the statewide mandatory self-disclosure program, which provides a mechanism for Medicaid providers to report, return, and explain self-identified overpayments. The self-disclosure program is administered in accordance with the following statutory and regulatory authority:

- NYS PHL §32(18) – which states OMIG shall, in conjunction with the commissioner, develop protocols to facilitate the efficient self-disclosure and collection of overpayments and monitor such collections, including those that are self-disclosed by providers. The provider's good faith self-disclosure of overpayments may be considered as a mitigating factor in the determination of an administrative enforcement action.
- Affordable Care Act (ACA) of 2010 §6402 – which states that Medicaid and Medicare overpayments must be returned within 60 days of identification, or by the date any correspondence cost report was due, whichever is later.
- 18 NYCRR §521(7) – which requires the refunding of overpayments as part of provider's compliance program.
- Title 42 of the United States Code (USC) §1320a-7k(d)(1) & (2), requires a person who has received an overpayment to report the overpayment, the reason for the overpayment, and to return the overpayment within 60 days of identification or by the date the correspondence cost report is due, if applicable.

OMIG encourages providers to investigate and identify possible fraud, waste, abuse, or inappropriate payments through self-review, implementation of compliance programs, and internal controls. In 2018, OMIG's self-disclosure unit finalized 312 reviews with identified overpayments of more than $9.6 million.

2018 Initiated Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	7	3	17	0	27
Managed Care	348	82	113	0	543
Medicaid in Education	2	1	7	0	10
Provider	531	73	51	7	662
Rate	352	154	161	0	667
Self-Disclosure	123	95	102	2	322
System Match and Recovery	211	108	86	92	497
Total	1,574	516	537	101	2,728

2018 Finalized Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	8	1	4	0	13
Managed Care	324	77	107	0	508
Medicaid in Education	2	3	1	0	6
Provider	390	58	34	7	489
Rate	82	68	102	0	252
Self-Disclosure	115	89	106	2	312
System Match and Recovery	45	38	30	51	164
Total	966	334	384	60	1,744

2018 Overpayments Identified by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	$3,884,376	$187,269	$393,836	$0	$4,465,481
Managed Care	86,213,231	25,232,648	6,111,685	0	117,557,565
Medicaid in Education	18,509	59,221	2,567	0	80,297
Provider	26,127,659	3,395,432	2,492,314	183,719	32,199,123
Rate	4,208,628	4,166,318	5,003,601	0	13,378,547
Self-Disclosure	4,573,524	1,649,946	3,408,993	855	9,633,319
System Match and Recovery	7,979,581	2,139,736	1,086,458	1,688,178	12,893,952
Total	$133,005,508	$36,830,570	$18,499,454	$1,872,752	$190,208,284

2018 Overpayments Recovered by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	$2,520,080	$224,986	$222,146	$0	$2,967,212
Managed Care	80,333,420	22,635,357	5,286,677	0	108,255,454
Medicaid in Education	3,734	59,221	2,567	0	65,522
Provider	24,185,150	2,835,578	2,768,210	666,002	30,454,940
Rate	11,632,753	1,598,829	4,895,554	0	18,127,137
Self-Disclosure	7,236,186	2,164,490	3,042,400	855.28	12,443,931
System Match and Recovery	5,491,774	748,942	675,888	907,093	7,823,696
Total	$131,403,097	$30,267,402	$16,893,443	$1,573,950	$180,137,892

Data Mining and Technological Support

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

BBI utilizes resources such as eMedNY, Salient, and the Medicaid Data Warehouse (MDW), to extract, organize, analyze, and report data. The data analysis covers a wide range of provider types and program areas and supports the operation of all OMIG divisions. In addition, BBI frequently processes data requests from several federal, state, and county government entities to assist with program integrity efforts.

In 2018, BBI processed the following requests:

- 1,617 data requests, which consisted of Medicaid FFS and managed care data extraction and analysis in support of:
  - OMIG Division of Medicaid Audit (DMA), Bureau of Compliance (BOC), and Division of Medicaid Investigations (DMI) activities;
  - SMR audits;
  - CMS Payment Error Rate Measurement audit;
  - CMS Healthcare Fraud Prevention Partnership (HFPP) Data Analysis and Review Committee (DARC);
  - Office of the State Comptroller audits;
  - U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) audits;
  - Unified Program Integrity Contractor (UPIC) Audits;
  - United States Department of Justice;
  - District Attorney's Offices;
  - Department of Homeland Security;
  - Federal Bureau of Investigations (FBI); and
  - Self-disclosure reviews.
- 167 statistical samples created for DMA audits and DMI investigations, including:
  - County Demonstration audits;
  - UPIC audits;
  - Self-disclosure reviews;
  - Medicaid Electronic Health Record Incentive Program audits; and
  - Dental reviews.

Positive Provider Reports

During the audit process there are instances when OMIG determines that - for the audit period and objective reviewed - the provider has generally adhered to applicable Medicaid billing rules and regulations. In these cases, OMIG issues an Audit Summation Letter advising the provider that, pursuant to 18 NYCRR §517.3(h), the audit is concluded and no further action on their part is required. These reports are posted on the OMIG website as "Positive Reports."

Audit Summations	
Audit Department	**2018**
County Demonstration Program	9
Managed Care	9
Medicaid in Education	5
Provider	157
Rate	238
Total	**418**

Third-Party Liability

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

Medicaid Recovery Audit Contractor

Pursuant to the federal requirement under the ACA, OMIG has a Recovery Audit Contractor (RAC) to supplement the agency's Medicaid program integrity efforts. The RAC's mission is to: reduce improper payments through the efficient detection and collection of overpayments; to report suspected fraudulent and/or criminal activities; and implement actions that will prevent future improper payments. Data mining is used to identify possible improper payments and reviews are conducted via automated and complex assessments/analyses of medical and financial records. In 2018, $52.6 million in overpayments were recovered as a result of these efforts which was $28 million more than in 2017. The significant increase in 2018 can be attributed to the review of over 300,000 claims, which is more than triple the number of claims in 2017. The increase in claims is largely due to the addition of the Same Plan Overlap project. This project identified where insurers reimbursed Medicaid for premiums paid for recipients that had comprehensive health care coverage from an MCO, while also being enrolled in the Medicaid Managed Care or Family Health Plus product of the same MCO.

Home Health Care Medicare Maximization

The goal of the Home Health Care Medicare Maximization project is to seek the maximum allowable Medicare reimbursement for recipients who are eligible for both Medicare and Medicaid, and who have received home health care services paid by Medicaid. OMIG's contractor identifies home health providers that were reimbursed by Medicaid who have not billed Medicare for home health services. The provider is then directed to bill Medicare for those services. The contractor also pursues Medicare coverage through an appeal process for claims that were denied by Medicare upon initial determination. OMIG and its contractor successfully worked with CMS to resolve the appealed claims, recovering more than $100 million.

2018 Third-Party Liability and RAC Recoveries	
Activity Area	**Amount**
Third-Party Liability	$ 119,252,980
Casualty & Estate	105,139,585
Home Health Care Medicare Maximization Project	101,877,846
Recovery Audit Contractor	52,608,313
Self-Disclosed TP Health Insurance	2,257,829
Total	$ 381,136,553

Investigations

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

Investigative activities may involve partnering with a variety of law enforcement organizations and entities. The successes that are the by-product of these partnerships are often the result of years of work. As detailed in the examples below, the joint efforts over time by OMIG's investigative staff and other law enforcement agencies resulted in action against several individuals during the period covered by this report.

Referrals for Transitional Homes

In February 2018, the NYS Attorney General's Office announced the guilty pleas of two operators of "three quarter" homes that provided transitional housing for formerly homeless or incarcerated individuals. The charges related to a Medicaid kickback scheme that was uncovered by OMIG investigators and referred to MFCU. The scheme involved forcing residents to attend treatment programs regardless of need and billing the Medicaid program. On September 27, 2018, MFCU entered into a settlement agreement where the providers agreed to pay more than $1.8 million in restitution.

Credential Verification Reviews

OMIG conducts Credential Verification Reviews (CVR), which are random inspections of provider locations throughout NYS to ensure Medicaid providers are adhering to all requirements and regulations of the NYS Medicaid program. CVRs can be initiated as a response to an allegation received through OMIG's hotline or referrals from other agencies and are tailored to the specific provider type. These visits are conducted to assess such areas as:

- Provider and staff identification and credentials;
- Physical attributes and conditions of the place of business;
    - Offices are also inspected for public health and safety issues
- Recordkeeping protocols and procedures regarding Medicaid claiming.

A CVR can quickly yield additional and/or criminal findings as found in the examples below:

CVR Exposes Drug Diversion

OMIG conducted a CVR at a pharmacy, where the owner, who was also the supervising pharmacist, was present. The CVR identified expired, empty pharmaceutical bottles on the pharmacy shelves, and several clear plastic bags containing unknown drugs. Upon questioning, the owner admitted to buying and dispensing diverted drugs and stated that the expired, empty pharmaceutical bottles were used to create the appearance of having legitimate inventory. OMIG immediately notified MFCU, which executed a search warrant at the location on the same day. In January 2018, MFCU entered into a settlement agreement with the pharmacy and owner, in which they agreed to pay $76,500 in violation of the federal False Claims Act and NYS Social Services Law (SSL) for the illegal drug diversion scheme.

CVR Leads to Credible Allegation of Fraud

In October 2018, MFCU entered into a settlement with three pharmacies and their owner, in which the providers agreed to pay $250,000 in restitution for filing false claims to Medicaid. OMIG had conducted a CVR at one of the pharmacies, uncovering multiple findings including documentation in patient files for kickbacks for certain medications. Additionally, OMIG investigators observed books and manifests showing pills billed to Medicaid, but not dispensed. They also found paperwork and dispensed drugs from the two other pharmacies. As a result, OMIG referred the case to MFCU as a credible allegation of fraud. Subsequently, OMIG received a complaint from an employee of the pharmacy who alleged that the pharmacy was billing for dispensed medication not picked up by patients. The additional information provided by OMIG helped MFCU build the case resulting in the settlement.

Transportation CVRs

Medicaid transportation services are a critical component of the health care delivery system. NYS's Medicaid transportation sector is vast and continues to grow in response to increasing demands across the state. Providers who fail to meet necessary Medicaid transportation provider requirements can potentially endanger recipients and engage in fraudulent or abusive practices.

OMIG helps protect Medicaid recipients and the integrity of the Medicaid program by ensuring compliance with safety standards and all Medicaid rules and regulations (e.g., licensing of drivers, vehicle insurance, registration, inspection, billing practices, and service provision).

In 2018, OMIG conducted 143 on-site CVRs to assess compliance with program requirements and guidelines. After concluding a CVR, OMIG sends education letters to providers detailing their findings; 74 education letters were sent to transportation providers in 2018.

Pharmacy Investigations

In February 2018, the owner of two pharmacies was sentenced after pleading guilty to Grand Larceny 3rd Degree and Health Care Fraud 3rd Degree in Brooklyn Supreme Court. OMIG pharmacy consultants assisted MFCU investigators in the execution of search warrants at the two pharmacy locations, one in Brooklyn and the other in the Bronx. As a result, the owner was arrested and charged with buying prescriptions for HIV drugs from Medicaid recipients and then filing false claims with Medicaid for reimbursement.

The OMIG pharmacy consultants were specifically tasked with locating 16 prescriptions that undercover MFCU investigators had sold to the owner during the investigation, determining the indicia of drug diversion, and providing expert advice concerning pharmacy management and drug storage during the search operations. The pharmacy consultants located the prescriptions and identified a large quantity of expired narcotics, which were then seized by the investigators.

Investigation of Medically Unnecessary Treatments and Therapies

In March 2018, a therapy manager was sentenced for his role in a $55 million scheme to defraud Medicare and Medicaid at two Brooklyn medical clinics by having recipients subject themselves to medically unnecessary treatments and therapies provided by unlicensed staff. The therapy manager's co-defendant worked as a medical biller, and falsified patient charts and medical billing documents as part of this scheme.

OMIG collaborated extensively with HHS-OIG and the U.S. Internal Revenue Service Criminal Investigation Division on this case. An OMIG investigator fluent in Russian assisted throughout the investigation: conducting interviews and surveillance; providing results of OMIG data mining and assisting with undercover operations with cooperating witnesses. The investigator also provided translation during the arrests and interrogation.

The therapy manager was sentenced to three years in prison and three years supervised release, in addition to forfeiture of $270,604 and restitution payments.

As part of this scheme, the owner of a transportation company paid patients to persuade them to come to these clinics. In July 2018, the owner was sentenced to 46 months in prison for paying kickbacks to bring patients to clinics where they received no treatment, and Medicaid was billed. One of the clinic managers was sentenced to 18 months in prison. An associate of the defendants, whose role was to deposit checks and help launder money, received one year of probation with standard and special conditions after pleading guilty. Her sentence also included forfeiture of $21,688 and restitution of $433,775.

Recipient Investigations

An investigation by OMIG determined that a Medicaid recipient was providing in-home care services for other Medicaid recipients as a Licensed Practical Nurse and was paid in excess of allowed income limits to qualify for Medicaid benefits. In June 2018, the recipient pleaded guilty to Welfare Fraud in the 3rd Degree (D-felony) and was sentenced to five years' probation supervision. As a condition of the negotiated plea with the Erie County District Attorney's Office, the recipient signed a Confession of Judgement agreeing to pay back $25,111 in improperly paid Medicaid benefits.

In a different investigation, OMIG received a complaint from DOH stating that a Medicaid recipient was working as an IT Consultant and not reporting accurate income information in order to qualify for Medicaid. An investigation revealed that the subject and his spouse applied for Medicaid through NYSoH. Investigators obtained the recipient's application and discovered they were claiming earnings of $15,000 a year; however, investigators also obtained and reviewed their personal income tax returns that showed they claimed a federal adjusted gross income of $141,463 for 2016 and a federal gross income of $228,653 for 2017. A home visit was conducted to interview the recipients, and a call letter was left for the recipients to contact the investigator. As a result, a lawyer representing the recipients contacted OMIG, and the recipients signed a Voluntary Repayment Agreement for the full overpayment of $31,576.

Explanation of Medicaid Benefits

EOMBs continue to be used to confirm that recipients are receiving the services being billed to the Medicaid program. Each month 5,000 EOMBs are mailed out and list an array of services including transportation, medical, dental, and pharmacy, along with the date of the service. Recipients are asked to verify they received the service(s), and if there were any issues, to report them to OMIG by mailing back the completed EOMB.

OMIG uses EOMBs to substantiate allegations of fraud, as a tool to interview recipients who didn't receive the services listed or had other fraud issues to report, and as an investigative tool. Below are some examples of success in OMIG's use of EOMBs:

> A recipient called with an allegation that her Medicaid number was being used to bill for transportation trips she had not received. The supervising investigator ordered 298 EOMBs on the claims billed by the transportation company. As a result of these being sent out, twenty-five EOMBs were returned with allegations specific to the claims listed, which was a significant eight percent response rate. Many recipients stated that they never received the transportation services listed on the EOMB. Another recipient stated he was incarcerated during the time the transportation company billed using his Medicaid number. As a result of the information received from the EOMBs, the transportation company was referred to MFCU.

In 2018, a mother of a child who received home health services returned an EOMB questioning multiple dates of service listed on an EOMB when her child had not received services. The ensuing investigation found that the aide was billing NYS Medicaid in excess of 50 hours weekly when she never worked more than 24 hours in a week and had also billed when the child was a patient in Boston Children's Hospital. The aide was referred to MFCU.

In 2018, OMIG updated the EOMB template, which helped to improve the efficiency of this tool by making it more user friendly. OMIG staff also worked with staff at the MDW and the Office of Health Insurance Programs (OHIP) to ensure that services determined to be confidential are excluded from use with the EOMB tool in accordance with federal regulations and state policy. This helped to further refine the scope of categories for which EOMBs could be utilized.

Summary of Investigations by Source of Allegation and Region

Initial Source	Downstate		Upstate		Out of State		Totals	
	Opened	Completed	Opened	Completed	Opened	Completed	Opened	Completed
Anonymous	216	186	164	149	1	1	381	336
District Attorneys	5	13	0	0	0	0	5	13
Enrolled Recipients	67	59	37	37	8	9	112	105
Federal Agencies	47	33	4	2	0	0	51	35
Fiscal Agent Fraud Unit	2	3	0	0	0	0	2	3
General Public	173	132	105	103	4	4	282	239
Local Departments of Social Services	22	11	148	135	0	0	170	146
Managed Care Plans	246	116	181	156	31	12	458	284
Managed Long Term Care Plans	110	30	23	7	0	0	133	37
Non-Enrolled Providers	2	3	2	3	0	0	4	6
Non-Enrolled Recipients	40	36	38	39	0	0	78	75
Providers	111	40	51	46	0	0	162	86
State Agencies (including OMIG)	578	569	450	394	101	135	1,129	1,098
Total	1,619	1,231	1,203	1,071	145	161	2,967	2,463

Program Integrity Referrals to MFCU and Other Agencies

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

Referrals to MFCU	
Provider Type	**2018**
Billing Service Group/EMEVS	1
Chiropractor/Port-XRAY-SVC-QMB Services	1
Clinical Social Worker (CSW)	1
Consumer Directed Aide	24
Dentist	2
Diagnostic and Treatment Center	3
Home Health Agency	20
Home Health Aide	3
Long Term Care Facility	1
Medical Appliance Dealer	5
Multi-Type	4
Non-Enrolled Provider	44
Nurse	8
Optician	15
Optometrist	6
Personal Care Aide	5
Pharmacy	30
Physician	40
Physicians Group	6
Social Adult Day Care	1
Therapist	1
Transportation	22
Total	**243**

Referrals to Other Agencies	
Agency	**2018**
AG - Not MFCU	5
Centers for Medicare and Medicaid Services (CMS)	1
CMS - UPIC	6
Department of Justice	37
Internal Revenue Service	5
Law Enforcement Agency	71
Local Departments of Social Services	52
Local District Attorney	14
MAS - Medical Answering Service	5
NYC Department for the Aging	5
NYC Department of Buildings	1
NYC Department of Finance	5
NYC Department of Health	4
NYC Department of Sanitation	5
NYC HRA Bureau of Client Fraud Investigations	53
NYC Office of the Special Narcotics Prosecutor	16
NYS Bureau of Narcotic Enforcement	5
NYS Department of Environmental Conservation	5
NYS Department of Health	163
NYS Department of Taxation and Finance	5
NYS DOH Office of Professional Medical Conduct	7
NYS Office of Children and Family Services (OCFS)	1
NYS Education Department – Not Professional Discipline	19
NYS Education Department – Office of Professional Discipline	100
NYS Workers Compensation Board	3
Out of State	2
US Attorney	1
US Health and Human Services (HHS-OIG)	2
Total	**598**

2018 Recoveries

The chart below includes all OMIG recovery activities, which comprise audits, investigations, third-party payments recovered from other insurers, Medicaid RAC activities, and estate and casualty recovery projects. The recoveries represent both the Federal and State share of funds and equal the actual dollars recouped by OMIG during the reporting period. The recoveries reflect cash deposits and voids resulting from OMIG and contractor audits, less any refunds paid to providers. Some of these recoveries may also have appeared in charts earlier in this report.

2018 Recoveries	
Activity Area	**Amount**
Third-Party Liability	$ 119,252,980
Managed Care	108,255,454
Casualty & Estate	105,139,585
Home Health Care Medicare Maximization Project	101,877,846
Recovery Audit Contractor	52,608,313
Provider	30,454,940
Rate	18,127,137
Self-Disclosure	12,443,931
System Match and Recovery	7,823,696
County Demonstration Program	2,967,212
Self-Disclosed TP Health Insurance	2,257,829
Medicaid in Education	65,522
Investigation Financial Activities	(48,470)
Total	**$ 561,225,975**

Cost Savings

Cost savings activities prevent inappropriate, duplicate, or erroneous Medicaid payments from being made. OMIG's cost savings are calculated as estimates based on historical and current Medicaid claims data. Cost savings amounts are not monetary recoveries. Cost savings initiatives are intended to save taxpayer dollars proactively and protect the integrity of the Medicaid program. Each OMIG cost savings action or initiative has its own methodology for calculating program costs that are avoided. For example, OMIG utilizes program edits in the Medicaid billing system that deny provider claims, thereby preventing improper Medicaid payments from being made; those denied claims represent cost savings. In another example, when OMIG has an interaction with a provider, the agency will subsequently compare billing patterns prior to the interaction with those after to determine the cost savings attributable to OMIG's actions.

OMIG utilizes an internal workgroup of cross-divisional staff to develop, review, and approve its cost savings methodologies. This team reviews all cost savings initiatives on an ongoing basis to identify and assess variations in the savings amounts reported. Variations can occur naturally over time for any of OMIG's initiatives, and the workgroup ensures that methodologies are being reviewed on a timely basis and updated as needed. Throughout 2018, OMIG saved NYS taxpayers more than $2.1 billion as a result of these proactive efforts. Some examples of these activities are outlined below.

Pre-Payment Insurance Verification

OMIG's third-party liability vendor, Health Management Systems (HMS), performs pre-payment insurance verification (PPIV) services and third-party retroactive recovery projects. For this project, the contractor identifies and loads new third-party health insurance segments to the MMIS, establishing Medicaid as the payor of last resort to make sure the appropriate insurer will be billed first. In 2018, more than 630,000 new third-party health insurance (TPHI) segments (including medical, dental, pharmacy, and vision coverage) were identified and loaded. HMS also updated 156,000 TPHI segments in the MMIS that were no longer in effect, ensuring the records reflect accurate and updated information. Total PPIV cost avoidance for these projects during calendar year 2018 was more than $1.9 billion.

Enrollment Screening Activities

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

In 2018, EAR reviewed 1,492 new enrollment and reinstatement applications. These reviews resulted in 225 applications being denied, the cost savings associated with these denials was more than $18 million. Below is an example of an enrollment denial:

Pharmacy Enrollment Denials

An on-site inspection conducted at a pharmacy in Brooklyn found that the pharmacy was dirty and excessively cluttered. NYS law requires that all health facilities maintain adequate infection control and safety standards in the treatment of patients. Several expired medications were found on the shelves and OMIG staff found that the pharmacy refrigerator, which contained 36 medications, was frozen over. NYS pharmacy regulations mandate that a pharmacy must be equipped with storage facilities that provide for the safe storage of drugs to safeguard the purity and potency of drugs. This pharmacy was denied enrollment and was referred to the OPD.

Pre-Payment Reviews

OMIG's Pre-Payment Claims Review unit (PPR) utilizes the eMedNY system to monitor and, when appropriate, deny claims, preventing inappropriate payments from being issued. The PPR staff monitor and review the claim submissions of providers who demonstrate aberrant or inappropriate billing practices. As claims are reviewed, staff work with providers to obtain documentation to determine the appropriateness of the claim. This documentation review provides a wealth of information and, in many cases, produces evidence which can be used as a basis for further action. PPRs can be resolved manually, automatically, or a combination of both.

Staff often work joint cases with other divisions within OMIG, as well as MFCU, OPD, Department of Transportation (DOT), CMS, OHIP, and contractors. PPR staff work closely with DOH policy staff and statewide stakeholder associations as needed. The benefit of collaboration is effective program oversight with a corresponding increase in more compliant billing by providers. Upon request from another state, OMIG shared its pre-payment claims review process, best practices, and guidance.

The following list identifies ways the pre-payment reviews have been used in Medicaid program oversight:

- referrals of both dental and nursing providers to DMI for review and final action - including possible post-payment recovery, censure, and/or exclusion. Reasons for referral include excessive hours billed, upcoding of claims, and altering or falsifying documentation;
- prevention of payments to excluded providers until the enrollment status was updated;
- identification and processing of transportation claims for providers being investigated;
- identification and processing of claims for private duty nursing cases while the provider is being investigated;

- identification and processing of pharmacy claims while an OMIG audit was being conducted;
- monitoring the billing activity of enrolled providers with a limited enrollment status;
- reviewing providers with unusual billing patterns identified by the fiscal agent for NYS MMIS, including vision care providers, private duty nurses, and physicians;
- collaboration with OHIP Dental staff and reviewing provider billing patterns and practices;
- collaboration with OHIP Policy staff on program guidelines, manual updates, and program parameters.

In 2018, the Medical Pended Claims Unit had 446 cases under review; 95 fully active cases and 401 cases being monitored. The Dental Unit resolved 29,143 claims and reviewed 9,032 patient treatment records as part of their review process. These pre-payments claim reviews have resulted in several interagency collaborations, one targeted recovery, and the referrals of one transportation, two dental, and four nursing providers to DMI for further action.

Managed Care Cost Savings

OMIG launched a new project focused on Medicaid recipients using UPS Store mailboxes for their address. Letters were sent to 21 recipients requesting proof of residence to identify anyone using the store address to qualify for Medicaid, but not actually living in NYS. Sixteen recipients failed to respond and OMIG coordinated with DOH to close the Medicaid cases of eight recipients who failed to provide verification, generating an initial cost savings of $37,455.

2018 Cost Savings Activities	
Activity Area	**Amount**
Dental Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	$ 1,128,305
Enrollment and Reinstatement Denials	18,492,294
Exclusions/Terminations – Internal	9,670,080
Exclusions/Terminations – External	12,925,638
Managed Care Locator Code	2,292,993
Medical Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	3,664,876
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	15,767,646
Pre-Payment Insurance Verification Commercial	1,571,459,479
Pre-Payment Insurance Verification Medicare	412,168,351
Pre-Payment Review Sentinel Effect – Edit 1141	7,604,847
Recipient Medicaid MC Benefits - Case Closures for False Information	807,736
Recipient Restriction	97,099,243
Total	**$2,153,081,486**

Compliance Initiatives

Medicaid providers with compliance programs are better positioned to identify, correct, and prevent billing mistakes and fraud. NYS SSL §363-d and 18 NYCRR Part 521 (Part 521) detail NYS's requirements for what must be included in compliance programs. Medicaid providers who must maintain an effective compliance program are those who are subject to the provisions of NYS PHL Article 28 or 36; or those who are subject to the provisions of Mental Hygiene Law Article 16 or 31; or those for whom Medicaid is a substantial portion of their business operations. Substantial portion of business operations means any of the following:

- when a person, provider or affiliate claims or orders, or has claimed or has ordered, or should be reasonably expected to claim or order at least $500,000 in any consecutive 12-month period from the Medical Assistance Program;
- when a person, provider or affiliate receives or has received, or should be reasonably expected to receive at least $500,000 in any consecutive 12-month period directly or indirectly from the Medical Assistance Program; or
- when a person, provider or affiliate who submits or has submitted claims for care, services, or supplies to the Medical Assistance Program on behalf of another person or persons in the aggregate of at least $500,000 in any consecutive 12-month period.

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

Certification

Those subject to the mandatory compliance program requirements must complete a certification at the time of their enrollment in the Medicaid program and each December thereafter. Providers certify that they adopted, implemented, and are maintaining a compliance program that meets NYS's requirements. OMIG updated the certification form on its website for December 2018 to extend the certification so that the provider is expressly committing to maintain the compliance program until the following December certification period. OMIG requires that the certification be completed at the individual provider level, rather than at an enterprise (FEIN) level.

Monitoring and Enforcement

Similar to HHS-OIG, OMIG utilizes Corporate Integrity Agreements (CIA) as a way to monitor providers who have been determined to have engaged in one or more unacceptable practices that would otherwise warrant exclusion as a provider in NYS's Medicaid program. Although NYS's CIAs are patterned after HHS-OIG's CIAs, NYS focuses its monitoring and enforcement on areas related to the provider's unacceptable practice and other NYS-specific issues. OMIG's CIAs are for a five-year term and involve oversight and monitoring of not only the provider, but also the provider's Independent Review Organization's (IRO) reports and activities. The provider is required to contract with an IRO that is acceptable to OMIG, pay for the IRO, and make itself available to monitoring by the IRO. The IRO provides reports to OMIG on specific matters related to the unacceptable practice(s) that gave rise to the need for a CIA, as well as other matters specified in the CIA.

OMIG may impose stipulated penalties against the provider for any breach by the provider of the CIA's terms, with a material breach subjecting the provider to a potential termination of the CIA and exclusion by OMIG. In 2018, OMIG monitored two CIAs and recovered $62,500 in stipulated penalties against providers who were in breach of the terms of their CIA.

Education and Outreach

In response to questions received by providers subject to the compliance program and certification requirements, OMIG responded to over 1,400 telephone calls and 499 emails during 2018. OMIG, through these contacts and the compliance library on OMIG's website, offers guidance to providers, other agencies, and the public. OMIG's website includes a compliance tab that contains links to forms, guidance, alerts, and other resources. During 2018, there were more than 127,000 hits on the compliance tab.

OMIG Presentations

OMIG offers outreach and educational presentations about the Medicaid program to providers and the public. Below are some examples of OMIG presentations:

Association of Community Living Agencies in Mental Health Conference

OMIG staff were invited to speak at the 39th Annual Association of Community Living Agencies in Mental Health (ACLAIMH) Conference, regarding OMIG's Self-Disclosure process. The discussion encompassed the self-disclosure process and detailed how to submit a self-disclosure, what information needs to be provided, and repayment options. The presenters utilized the self-disclosure website to demonstrate how to submit a self-disclosure on OMIG's user-friendly system, provided examples of self-disclosures, and engaged the audience in an interactive format to encourage questions and answers throughout the presentation.

Medicaid Integrity Institute

During 2018, OMIG's Recipient Investigation Unit shared best practices and experiences in several national forums. In March 2018, OMIG staff served as faculty for the "Emerging Trends in Medicaid - Beneficiary Eligibility Fraud" seminar at the Medicaid Integrity Institute (MII) in Columbia, South Carolina. This was the first course taught at MII on beneficiary fraud and included participants from many states and Puerto Rico, as well as CMS. OMIG indicated that its recipient investigations focus on two main areas: eligibility fraud and drug diversion. For the purposes of the MII presentation, OMIG emphasized the best practices for investigating allegations of ineligible recipients. OMIG described two successful eligibility investigations, one resulting in a confession of judgement and another in a voluntary repayment agreement.

In April 2018, OMIG discussed its mission and operations, including OMIG's Opioid Project, at the HFPP Information Sharing Meeting held at MII. The presentation described how OMIG is working closely with law enforcement partners at all levels and, at the same time, tracking prescription drug arrests. OMIG focused its data analyses efforts to identify trends where recipients are obtaining dangerous combinations of prescription drugs. The combinations recipients sought - coupled with intel gathered from drug arrests - revealed the drugs were being used as potentiators, which are drugs used in combination with opioids as a means to enhance opiate effects, e.g., euphoric effects. Since potentiators can be either another controlled drug or a non-controlled drug, there are hundreds of potentiators that can be used in thousands of potentially deadly combinations. During the meeting, there were also presentations from the FBI, OMIG, and HHS-OIG, as well as breakout groups, to discuss best practices and areas of concern in the healthcare field. The topics were then discussed with the entire group, initiating discussions regarding solutions and how CMS can provide assistance.

Administrative Actions

Sanctions – Exclusions

Sanctions that can be imposed on a provider by OMIG include censure, exclusion, or conditional or limited participation in the Medicaid program (18 NYCRR §515). In 2018, OMIG may impose sanctions based upon any of the following:

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

In 2018, OMIG issued 794 exclusions and 135 censures. The NYS Medicaid Exclusion List contains 7,226 Medicaid and non-Medicaid provider exclusions. This list is updated daily (except holidays and weekends) and is available to the public on OMIG's website, www.omig.ny.gov.

Exclusions	
Reasons for Exclusions	**Number of Actions**
Affiliations – 18 NYCRR 504.1(d)(1)	105
Unacceptable Practice – 18 NYCRR 515.2	5
Indictments – 18 NYCRR 515.7(b)	129
Convictions – 18 NYCRR 515.7(c)	176
Imminent Danger – 18 NYCRR 515.7(d)	1
Professional Misconduct – 18 NYCRR 515.7(e)	115
Mandatory Exclusion – 18 NYCRR 515.8	263
Grand Total	**794**

Conclusion

OMIG appreciates the opportunity to share the results of its Medicaid program integrity activities for 2018. OMIG's provider education and outreach programs, coupled with its comprehensive audit and investigative efforts, and success in identifying and recovering inappropriate Medicaid payments, play a vital role in preventing and detecting Medicaid fraud and abuse, while promoting the delivery of high-quality care to millions of New Yorkers. OMIG's commitment to preventing, detecting, and rooting out fraud and abuse in the Medicaid program remains unwavering.

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