New York State
Office of the Medicaid Inspector General

2008 Annual Report

David A. Paterson
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 Smith
Senator Espada
Speaker Silver
State Comptroller DiNapoli
Attorney General Cuomo

It is my pleasure to submit the Office of the Medicaid Inspector General's 2008 Annual Report.

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

As required by Public Health Law, the attached report provides information about the audits, investigations, 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.

With your support, and the cooperation of our agency partners and the Department of Health, we expect that New York will continue to lead the nation in identifying and preventing fraud, waste and abuse in the Medicaid program, and promoting program integrity on the front end through cost avoidance, data mining and provider education.

The Office of the Medicaid Inspector General remains on track to meet 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

Executive Summary

Medicaid fraud, waste and abuse have been on the top of every state's agenda for the past four years. Each state is under pressure from its citizens to stop abuses and fraud in the Medicaid system.

New York State is no exception. At the end of 2006, the State established the Office of the Medicaid Inspector General as an independent entity to tackle the issue of fraud, waste and abuse within New York State's Medicaid program.

After two years of operation, the OMIG has successfully added staff to increase New York State's efforts at identifying and preventing Medicaid fraud, waste and abuse. During that time period, New York has led—and continues to lead—the nation in identifying and recovering improper Medicaid payments.

In 2008, the OMIG filled several key staff positions, enabling the agency to achieve success in their audits, investigations, audit findings and recoveries, and cost avoidance. Complete statistics are included as Appendix A in this document; however, the main highlights include:

- OMIG succeeded in saving the state **$1.66 billion** through cost-savings activities (including nearly **$134 million** in recipient restrictions) during 2008.
- During federal fiscal year 2008-09 (October 1, 2007-September 30, 2008), the OMIG met and exceeded federal identification and recovery requirements under the Federal-State Healthcare Reform Partnership (F-SHRP). The goal was $215 million, and, in collaboration with OMIG's state agency partners particularly the New York State Office of the Attorney General, New York reached **$551 million**.
- OMIG began 3,281 investigations in 2008; and completed 2,366.
- In 2008, 921 investigations began as the result of information the OMIG received from the fraud hotline.
- OMIG excluded 660 providers from participating in the Medicaid program in 2008, and terminated 39.
- OMIG referred 88 cases to the New York State Attorney General for potential prosecution as criminal cases; 72 were providers, while 16 were recipient cases.
- OMIG referred 531 cases to other state agencies; the vast majority of those (496) were referred to local social services districts for investigation at the local level.
- OMIG auditors initiated 2,532 audits and completed 1,738.

New York State leads the nation in Medicaid fraud, waste and abuse prevention and detection, and serves as a role model for other states to emulate. However, we cannot be complacent about our past accomplishments; rather, we must continue to make strides to increase audit and investigatory activities across the state. The OMIG continues to stress the importance of Medicaid program integrity at all levels of health care and will be adding more audit and investigative staff to ensure that the foundation that was built over the last two years remains solid and allows our expanded staff to intensify their efforts to promote and maintain Medicaid integrity in New York State on behalf of the State of New York.

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Office of the Medicaid Inspector General

On July 26, 2006, the Governor signed Chapter 442 of the Laws of 2006, 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, as defined in 18 NYCRR Part 515, is 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

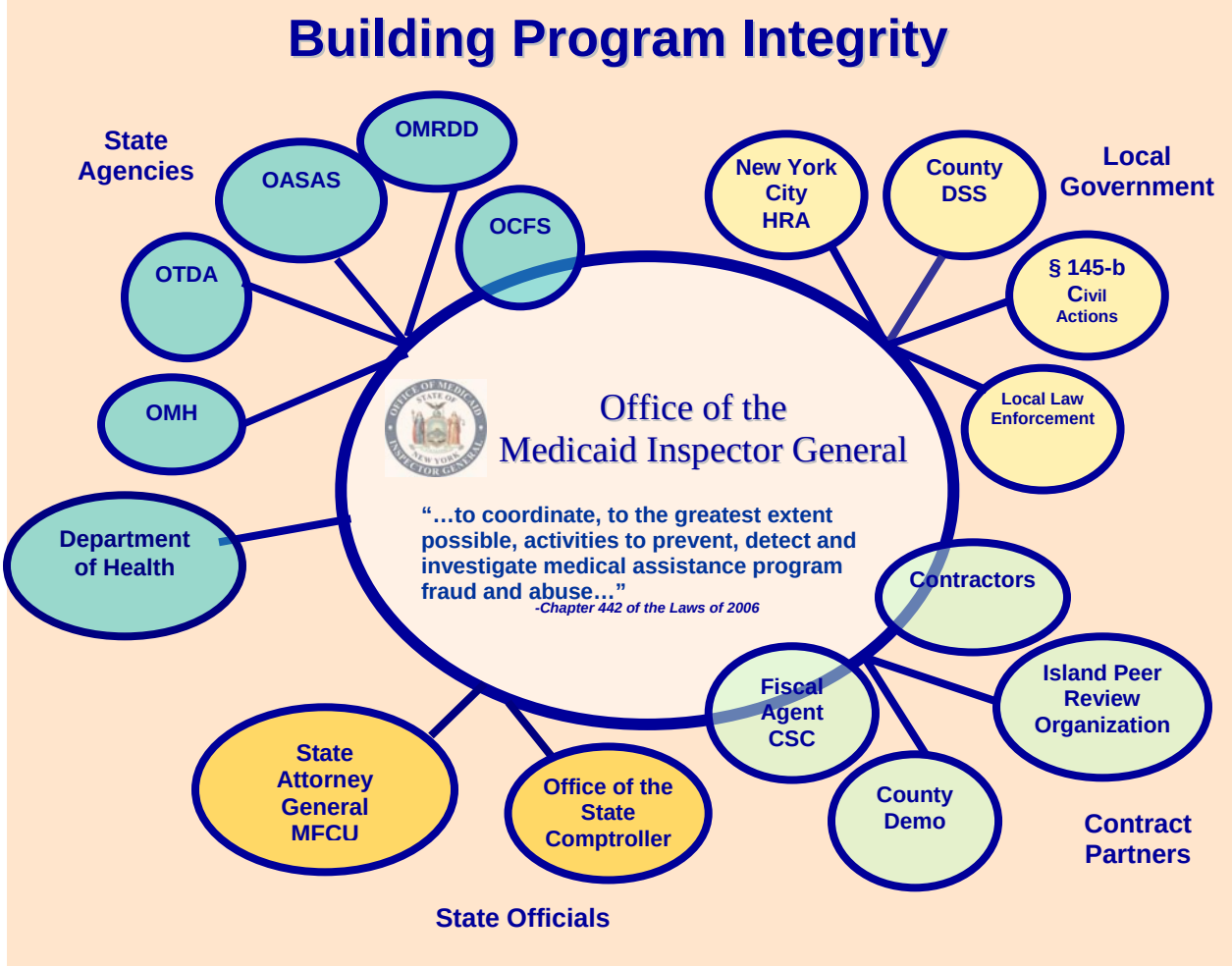
punishment; rather, it is recognition that services have failed to comply with a condition precedent to payment.

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 New York State Public Health Law §32, 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 focused primarily on establishing the agency and developing management systems to monitor activities and identify vulnerabilities. In

2008, OMIG solidified efforts to work with the agencies responsible for administering all aspects of healthcare fraud investigation and enforcement.

Also in 2008, the OMIG formed a new Division of Legislative and Intergovernmental Affairs to further enhance its relationship with the Legislature and further develop cooperation with other state agencies. Having a direct liaison between OMIG and members of the Legislature, federal government and state agencies expands the agency's visibility efforts with lawmakers and policymakers who play a crucial role in the state's Medicaid program.

These efforts will be promoted further by the OMIG's hiring efforts to fill existing positions and the additional staff authorized for 2008-09.

"New York led the nation in reporting fraud and abuse recoveries last year [2007], accounting for $136 million of the $308 million national total, according to an annual report on audits, administrative actions, referrals and civil actions from the office of New York State Medicaid Inspector General James Sheehan."
--Crains Health Pulse
October 6, 2008

Relationship with the Attorney General's Medicaid Fraud Control Unit

In order to maximize program integrity, the New York State Attorney General's Medicaid Fraud Control Unit (MFCU) and the OMIG must have a high level of cooperation and coordination. In accordance with State law and Federal regulations, the OMIG must refer all cases of suspected provider fraud to the MFCU (Public Health Law § 32(7) and 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 the MFCU.

The NYS MFCU was selected as the top Medicaid fraud control unit in the country for 2008 by the Department of Health and Human Services Office of the Inspector General. The MFCU obtained nearly 150 convictions in cases of Medicaid provider fraud and patient abuse, recovering over $263 million in civil damages and criminal restitution.

The OMIG continues its efforts to improve and strengthen this relationship with the MFCU. The OMIG meets with the MFCU representatives 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 US Department of Health and Human Services Office of Inspector General, the NYS Office of the State Comptroller, the NYS Office of the Welfare Inspector General, the NYS Bureau of Narcotics Enforcement, the FBI Federal Health Care Task Force, and the 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, discuss potential joint investigative efforts among the group, and share expertise and knowledge.

The federal government requires that a memorandum of understanding (MOU) exist between the MFCU and the single state agency responsible for the administration of the Medicaid program. At the end of 2008, the existing MOU was in the process of being re-negotiated with the MFCU to reflect current organizational responsibilities. This renegotiation has continued in 2009.

Interagency Workgroup

In 2006, the OMIG established the Interagency Workgroup to help coordinate Medicaid fraud, waste and abuse control activities of the state agencies with direct roles in administering the Medicaid program. 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.

Representatives from those agencies meet monthly to address issues, coordinate plans, and foster the communication necessary to monitor program integrity and administer the Medicaid program. In 2008, participants dealt with such issues as:

- Data mining tools, techniques, activities and issues
- OMIG Work Plan
- OMIG Exclusion Policy/Excluded Provider Match Project
- OMIG Audit Work Plan
- OIG audit initiatives
- Conflicts of interest/disclosure of confidential information
- Coordination of County Demonstration Project audits
- Third party liability
- Cost savings methodology
- OMIG Self Disclosure Program
- F-SHRP voids and recoveries
- External audits related to Medicaid
- Mandatory provider compliance programs

New York State Department of Health

Office of Managed Care

As part of the Department of Health's Office of Managed Care's (OMC)overall surveillance plan, managed care organizations (MCOs) are required to submit annually a Fraud and Abuse

Prevention Plan (FAPP), pursuant to 10 NYCRR §98-1.21. These plans capture information across all product lines including commercial, Medicaid, Family Health Plus, Child Health Plus and Medicaid Advantage. In addition to the annual FAPP reporting and referral process, DOH conducts onsite surveys of all certified MCOs. The surveys focus on fraud and abuse activities, deficiencies are noted and plans of correction are required.

In March 2008, OMC conducted a fraud and abuse conference with all Medicaid managed care plans. OMC outlined the State's initiatives, monitoring activities, reporting requirements and also clarified the State Agency referral process. OMC also collaborated with Florida's Office of the Inspector General and shared information regarding Medicaid providers, fraud and abuse detection, overpayment/recoupment in capitated arrangements and the reporting of fraudulent providers.

Office of Health Insurance Programs

The Division of Provider Relations and Utilization Review (DPRUM) collaborated with the Office of the Medicaid Inspector on the following initiatives:

- DPRUM staff referred 17 cases of potential fraud, waste or abuse to the OMIG
- Fee-for-service Provider Enrollment pended 737 enrollments to the OMIG for final determination
- DPRUM staff worked with OMIG to develop and/or modify system edits to identify potential fraud and prevent improper payments.

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 2008 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	506	$ 3,530,700
Computer Prison Match* – Identified incarcerated recipients	512	3,489,792
Total	**1,018**	**$ 7,020,492**

*****This match only reflects case closing for the first quarter of 2008. Effective with the second and subsequent quarters cases were referred to the Office of Health Insurance Programs for adjudication.

Office of Alcoholism and Substance Abuse Services

During 2008, the Office of Alcoholism and Substance Abuse Services (OASAS), Bureau of Quality Analysis and Enforcement (BQAE) conducted several investigations to prevent and detect Medicaid fraud, waste and abuse.

The BQAE completed four Quality Service Reviews of "high-risk" Medicaid providers. Quality Service Reviews assess the clinical appropriateness of services being delivered and billed to Medicaid by chemical dependence outpatient programs. Four provider targeted investigations, involving potential Medicaid billing issues, were conducted. One of these investigations resulted in the provider surrendering its Operating Certificate to OASAS; and another resulted in the issuance of a Notice of Revocation and proposed fine of $160,000.

The BQAE issued three Notices of Revocation based on previous enforcement actions: one resulted in the provider withdrawing from the Medicaid program; one provider agreed to terminate its OASAS Operating Certificate; and the third resulted in OASAS revoking the provider's operating certificate.

At the request of the OMIG's Division of Medicaid Audit, the BQAE completed three clinical/medical necessity reviews, which contributed significantly to OMIG's recoupments in 2008.

The annual Medicaid cost savings directly associated with OASAS enforcement and administrative actions in 2008 was approximately $9 million.

Office of Mental Health

In 2008, within the not-for-profit and proprietary sectors, as well as the state-operated outpatient and residential mental health system, the Office of Mental Health (OMH) conducted 709 on-site inspection visits at programs for license renewal. These reviews serve to help prevent and detect Medicaid fraud, waste and abuse. These visits assessed each licensed program's compliance with regulatory requirements pertaining to:

- appropriateness of admissions,
- treatment plans,
- case records documentation,
- evidence of active treatment,
- adequacy of staffing, and
- appropriateness of the treatment environment.

When an on-site inspection determines that a program is substantially non-compliant with regulatory requirements, or a pattern of uncorrected citations exists from previous surveys, OMH may withhold renewal of the license until submission of an acceptable plan of corrective action (POCA) and a subsequent on-site inspection is completed to confirm implementation of the POCA. Based on the findings from license renewal visits during the past year, 600 POCAs were required, 17 programs were placed in non-renewal status at some point during the year, and two programs had their licenses revoked.

For outpatient programs and adult community residence programs subject to OMH's Tiered Certification process, a Tier 3 status of the license indicates the most minimal level of compliance by the program, and usually results in a license being granted for not more than six months duration. A POCA is required and the program is re-visited during the next six months of the license. There were 22 programs that were issued Tier 3 status last year.

If a Comprehensive Outpatient Program Services (COPS) eligible outpatient program (i.e. – a program which receives supplemental medical assistance reimbursement) is notified of non-renewal, the COPS supplement is forfeited until the program receives at least a six month renewal license after submission of the POCA and subsequent on-site inspection. In 2008, seven programs had COPS payments withheld in this manner.

Several of these licensing visits uncovered Medicaid billing issues which ultimately resulted in self-disclosure of potential overpayments and documentation issues by the providers to the OMIG. In other cases, providers identified billing issues themselves, and after reviewing guidance posted on OMH's website which contains a link to OMIG instructions, made self-disclosures. OMH's website has also been updated to include a Medicaid Fraud and Abuse Notification, a notification to contractors with information regarding the federal False Claims Act and New York State False Claims Act, as well as other federal and state laws that aid in preventing fraud, waste and abuse.

During 2008, OMH undertook several actions to ensure that effective controls were in place for billing and receipt of Medicaid funds at OMH inpatient and outpatient mental health programs. OMH continued to review its billing systems as part of a routine internal compliance function, and engaged in several training sessions on services recording and timeliness of claims. Services recording guidance for clinicians and frequently asked questions were published on the OMH intranet website. Each month, actual revenue collections are compared with projections, and variations are investigated. A review of the OMH Reimbursing Receipts Account bank reconciliation process was performed to verify adequate controls. The review resulted in no major internal control issues.

Office of Mental Retardation and Developmental Disabilities

The Office of Mental Retardation and Developmental Disabilities (OMRDD) has invested considerable resources in the area of Medicaid accountability. Accountability functions are divided among the following OMRDD units:

- *The Medicaid Standards Unit:* issues Administrative Memoranda to both the State operations and not-for-profit agency providers establishing Medicaid billing and documentation standards. This unit also provides training on these standards.

- *The Bureau of Compliance Management (BCM):* conducts Limited Fiscal Reviews (LFRs) which include routine Medicaid Billing and Claiming reviews based on the standards established by the Medicaid Standards Unit. BCM also conducts special reviews of providers targeted by OMRDD's Medicaid Analysis Unit through data analysis activities and due diligence reviews of provider self-disclosures.

- *The Medicaid Internal Review Unit:* implements desk reviews of Medicaid paid claims, oversees provider voids on eMedNY and repayments to the Department of Health. The unit also oversees claim voids associated with BCM Medicaid Billing and Claiming reviews, and maintains an account of the dollar value of all voids/repayments to Medicaid. This unit is responsible for reporting F-SHRP recovery information to the OMIG on a quarterly basis.

- *The Medicaid Analysis Unit:* conducts Medicaid analyses required to support OMRDD's Medicaid accountability functions described above. The unit also identifies needed eMedNY edits and works with DOH on implementation.

Collaboration

OMRDD has been highly successful in implementing a comprehensive Medicaid accountability system. This system includes the establishment of clear billing standards, regular communication with and training for providers on these standards, field reviews that audit against the standards, routine desk reviews of Medicaid paid claims to identify inappropriate claims, and special targeted Medicaid field reviews based on eMedNY data analyses.

OMRDD has worked closely with the OMIG in all Medicaid accountability areas and this successful partnership has enabled OMRDD to maximize its effectiveness in preventing and detecting Medicaid fraud, waste and abuse. This ongoing collaboration has been a major factor in the success of the OMRDD's Medicaid accountability system. OMRDD and OMIG staff continue to meet on a quarterly basis to discuss the status of referrals made between the two agencies, as well as technical issues such as best practices in data mining.

For 2008 OMRDD reported a total of $3.69 million in Medicaid dollars recovered through its Medicaid accountability activities. During the 2008 calendar year, BCM conducted a total of 166 field reviews that comprised a Medicaid related review component or components:

Review Type	Total Reviews Conducted
Review of Allegations/Complaints	6
Due Diligence Review of Provider Self-Disclosures	15
IRA Full Month/Half Month Reviews	57
Limited Fiscal Review with Billing and Claiming Review Component(s)	64
Billing and Claiming Reviews and/or Expanded Billing and Claiming Reviews	22
Total	**166**

OMRDD also referred 15 providers to the OMIG in 2008 for further review/investigation of potential Medicaid fraud, waste, and abuse and/or systemic Medicaid billing issues.

Office of Children and Family Services

The Office of Children and Family Services (OCFS) will be auditing the Bridges to Health Home and Community-Based Medicaid Waiver program. This program is being phased in statewide over a three year period. Calendar year 2008 was the first year of the phase-in plan. OCFS's Office of Audit and Quality Control will begin audits of the program in 2009.

Commission on Quality of Care and Advocacy for Persons with Disabilities

The Commission's Fiscal Bureau consists of seven staff persons whose duties cover a broad spectrum of oversight mandates. Although there have been occasions where Medicaid claims audits have been performed, this function is tangential to the Commission's cost effectiveness reviews and not its primary responsibility. As such, for the 2008/2009 fiscal year, the Commission conducted and referred to the OMIG one Medicaid claims audit (North Shore Rehabilitation Center, Inc. – Audit #08-4458) which resulted in a recommended disallowance of $1.2 million.

New York Leads the Way

Data Mining

A cornerstone of the OMIG's strategy to detect and prevent fraud, waste and abuse in the Medicaid program, is to continually use technology to detect behaviors, control point of service transactions, review select claims and provide agency staff with critical support data.

Bureau of Business Intelligence

The OMIG continues to emphasize the creation of a center of expertise in the area of data mining and other data support functions. By consolidating with another unit, the Bureau of Business Intelligence (BBI) has grown to 26 staff members who provide support services to meet 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. In addition, the BBI performs hundreds of desk audits annually. These audits (a/k/a system matches) are based on algorithms designed with specific knowledge of various provider types and the guidelines that govern their claim submissions.

OMIG's long term goal is to integrate data analysis tools, capabilities and data access into the work of every employee performing 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. The key areas of OMIG's data mining focus over the past year are highlighted below.

Tools

Data Warehouse - New York State's Medicaid Data Warehouse continues to be our most valuable resource for data mining. The warehouse stores five years of Medicaid claims with payments exceeding $200 billion. Tools inherent within the system include a graphical user interface which assists users in the compilation of queries. More sophisticated users have access to the data through the use of structured query language which allows for more complicated queries. As the OMIG has expanded and matured the capabilities of the BBI, the bureau's ability to leverage this important resource has grown correspondingly.

Desktop Graphical User Interface Tool - Following a successful joint pilot project, the OMIG and the Office of Health Insurance Programs are engaged in exploring procurement options for a new data tool. This tool allows 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. Though we have incurred delays in the procurement of this tool, at this writing,

we have begun the formal procurement process and anticipate an implementation in late 2009 or early 2010.

IBM Entity Analytics Software (EAS) - The OMIG also conducted a pilot project with IBM to assess their EAS tool. EAS focuses on resolving entity relationships (link analysis) from disparate data sources. The pilot project demonstrated the power of the tool in a number of areas. Using a partial set of data, EAS uncovered numerous instances of duplicate recipients in our enrollment file. Based on the sample it is estimated that more than 22,000 duplicates are on file. The OMIG has purchased the tool and has an active procurement for expert services in progress to integrate the product and develop the data sources and linking logic.

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 additional data sources be acquired in order to maximize the OMIG's ability to detect fraud and abuse.

Recent efforts included projects utilizing full state vital statistics data. The OMIG is working with the Office of Health Insurance Programs, using state vital statistics data to make substantial improvements in the accuracy and timeliness of the State's processes for matching Medicaid recipients and providers to vital statistics death data.

The BBI continues to do Medicaid-to-Medicare matching through the federally sponsored Medi-Medi project. Through this project BBI identifies duplicate payments between the two programs.

The Bureau of Payment Controls and Monitoring, Medicaid System Controls, is also working with the New York City Taxi and Limousine Commission to match their data, which provides global positioning system (GPS) coordinates for the geographic start and end points of ambulette trips.

Collaboration

A key challenge to maximizing data mining efforts is to ensure that a two-way exchange of support between data mining staff and field staff from our Divisions of Audits and Investigations exists. Some key examples of this type of collaboration are outlined below.

Customized Audit Samples - To support our field auditors, BBI staff routinely prepare audit packages consisting of the audit sample, universe and provider-specific support data. In some cases, it is advantageous for audit and BBI staff to discuss the characteristics of certain audit universes. In a number of instances, staff have discussed audits and with the assistance of a peer expert in statistics, developed stratified audits to ensure that any associated findings result in a full and accurate projection of the overpayments owed to the Medicaid program.

General Clinic Match Project - Field auditors spoke with data mining staff about findings they encountered while performing Outpatient Department (OPD) audits. Based on these discussions, a systems match project was initiated. The auditors noted many instances where the provider was submitting separate claims for services that should have been provided as part of the patient's clinic visit.

Data mining staff created algorithms to identify these potentially inappropriate services. During 2008 BBI identified approximately $6 million of overpayments; of which, just over $1 million was recovered during 2008.

Dental Matches - Data mining staff, in conjunction with the dental unit in OMIG's Division of Medicaid Audit, developed several algorithms to identify inappropriate claims. These matches identified services such as radiography, cleanings, fillings and extractions for recipients without teeth. Medicaid claims should not be submitted for relines, rebases and repairs of dentures within the first six months the recipient has them. These services are included in the initial fee for dentures. The recovery estimate for these inappropriate payments is approximately $2.3 million.

Intensive Psychiatric Rehabilitation Treatment (IPRT) - The Office of Mental Health provides patients with a time limited intensive psychiatric rehabilitation treatment program, with active psychiatric rehabilitation designed to assist persons in forming and achieving mutually agreed upon goals in living, learning, working and social environments. Program guidelines limit reimbursement to 72 hours monthly or 720 hours yearly. Data mining staff identified instances where these limits were exceeded. This project identified approximately $150,000 in inappropriate claims.

Hospice Analysis - Audit staff requested analysis of the entire universe of Hospice billing. Data mining staff supplied data on multiple variables. From this analysis, a single Hospice provider was identified as an outlier in almost every dimension of analysis. Audit staff further collaborated with federal auditors to embark on a combined Medicaid/Medicare audit of that specific provider.

Net Applicable Monthly Income (NAMI) – OMIG's Division of Medicaid Audit requested assistance with the analysis of a Bronx nursing home's application of their residents' NAMI. Data mining staff did an extensive analysis of this provider which resulted in a referral to the New York State Attorney General. The outcome of this case is pending. With the knowledge learned during this analysis, staff applied the logic to all providers of this type. Further cases are being prepared and field work is expected to begin in 2009.

Investigations

Unraveling the complexities within the Medicaid program that can lead to fraud, waste and abuse requires an interwoven system of investigation. All Division of Medicaid Investigation (DMI) units and projects focus on four main areas that address the integrity of the Medicaid program: (1) fraud, waste and abuse; (2) cooperation with other entities; (3) deterrence; and (4) quality of care. Several forward thinking and unique projects are in process within DMI that demonstrate how New York leads the way.

DMI has an outstanding Provider Surveillance and Utilization Review System (PSURS) staffed with a certified coder, who utilizes complex computerized queries to compare providers to their peers, and medically trained experts, such as nurses and a dental hygienist,

that provide a unique skill set to detect fraud, waste, and abuse in providers that render and order services for Medicaid recipients. DMI's PSURS Unit fulfills the requirements of 42CFR 456.3 which states the Medicaid agency must implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; assesses the quality of those services; provides for the control of the utilization of all services provided under the plan; and provides for the control of the utilization of inpatient services.

The PSURS Unit identifies trends in the medical industry and specializes in off-label prescription use, learns about the latest trends in therapy that may not be approved, and detects quality of care issues. The PSURS staff members utilize their individual medical expertise and experience to look behind the billing and find providers who match certain criteria and may be more likely to commit fraud or provide poor quality of care. In 2008, 39 of these providers were referred to the DMI Provider Investigation Unit for further field work. Additionally, SURS referred three providers to the Attorney General's MFCU.

In 2008, the acquisition of a dental hygienist expanded the range of the PSURS reviews. For the first time, dentists treating recipients in a private practice and/or dental clinics were studied by a trained dental hygienist. Aberrant billing practices were subjected to the same analysis and investigative measures as other providers. Dental records, including radiographs, were examined to ensure that recipients are treated well and the quality of care meets professional standards.

Undercover investigations are an excellent tool for discovering and confirming suspicions of fraud, poor quality of care, and billing problems. The Undercover Investigations Unit's findings have resulted in arrests, prosecutions, exclusions, terminations, and penalties. Numerous groups, inside and outside the OMIG, rely on the Undercover Investigations Unit to assist in their investigations.

Undercover investigators seek services from Medicaid providers. They are equipped with pseudonyms, Medicaid cards to match the pseudonyms, and document the provider's conduct during the undercover operation (UCO). The provider's subsequent claims are reconciled with the investigator's written report. Differences between the evidence obtained by the undercover investigator and the provider's claims receive additional scrutiny.

Undercover operations are conducted based on information gleaned from various targeting tools such as Provider SURS, results of sending out explanation of medical benefits reports to recipients, telephone hotline calls, internet complaints, and anonymous reports. Information provided by the Enrollment Audit Review (EAR) Unit and Provider Investigations are also used to direct UCOs. During 2008, DMI undercover investigators conducted 2,192 UCOs.

During 2008, UCOs obtained evidence proving that some enrolled pharmacies and durable medical equipment (DME) providers wrongfully billed for services and products dispensed by non-enrolled pharmacies or DME providers. The act of claiming to have serviced recipients when another person or entity actually serviced the recipient is not permitted and is

considered an unacceptable practice, false filing, and potential fraud. Both enrolled and non-enrolled providers who participate in such schemes face exclusion or termination from the Medicaid program and criminal sanctions.

The OMIG excludes providers who pose a risk to the integrity of the Medicaid program. Protecting recipients from health care professionals who fail to provide appropriate care or fail to maintain the necessary standards prompts the OMIG to exclude individuals and entities from participating in the Medicaid program.

The OMIG takes action against individuals and entities for program-related criminal indictments, convictions, patient abuse or neglect, licensing board disciplinary actions, or for engaging in any practices considered unacceptable under the Medicaid program. Under certain circumstances, a lesser action is censure. The OMIG utilizes a consistent and fair approach to ensure a just outcome based on the individual facts surrounding the case.

Censured providers are monitored to ensure integrity in the Medicaid program. These providers are considered high-risk and the particular underlying issue that led to the censure is scrutinized along with other areas that are traditionally abused.

Various federal, state and local agencies provide information used to determine whether exclusion is warranted. The OMIG reacts rapidly to criminal indictments, convictions, and licensure actions to remove providers who defraud the system or provide poor quality of care. New York licensed providers who are excluded by other states are considered for exclusion from the New York State Medicaid program.

DMI identifies providers for potential exclusion by maintaining a cooperative relationship with district attorneys in New York State; conducting internet searches that reveal Medicaid and health care-related arrests; gathering information concerning investigations conducted by other agencies at various Health Care Task Force meetings and meetings with MFCU, OSC and other state agencies; and reviewing actions taken against health care professionals by the United States Attorneys.

When the Office of Professional Medical Conduct (OPMC) or the State Education Department (SED) takes an action, they provide the OMIG with consent orders on those cases. The OMIG obtains the full investigative file and considers the underlying facts to make an independent decision on whether exclusion is warranted. Clinical experts consult with the exclusion specialists as appropriate.

These and all other DMI programs combine to ensure the integrity of the Medicaid program, protect the most vulnerable population and the investment of New York State's taxpayers.

Medicaid Program Integrity and Third Party Activities

Traditionally, third party activities have been limited, by definition and scope, to the identification of a liable third party and the retroactive pursuit of recoveries. Below are

several examples, both current and future, of how the Bureau of Third Party Liability (BTPL) is expanding the scope of third party to specifically target payment initiatives.

Medi-Medi

The Medicare-Medicaid Data Match Program (Medi-Medi) is a partnership between Medicaid and Medicare that enhances collaboration and reduces fraud, waste, and abuse. This payment integrity initiative uses Medicaid paid claim data and Medicare (a third party payment source primary to Medicaid) paid claim data in order to identify improper billing and utilization patterns. It includes state, regional, and national efforts and requires collaboration among state Medicaid agencies, the Centers for Medicare and Medicaid Services (CMS), and state and federal law enforcement officials. BTPL will continue to target suspected Medicare zero-fill abusers through analysis of their billing patterns and running the targets through Medi-Medi. A "zero-fill" is the mechanism that allows claims to bypass certain third party liability edits that would otherwise reject the claim due to the existence of other coverage – in this case Medicare. This action affords the opportunity to bill multiple payors and create potential duplicate payment scenarios.

Credit Balance Reviews

OMIG third party payment integrity initiatives continue to expand. The BTPL Credit Balance Reviews are now predicated on integrating various aspects of the Medicaid Match and Recovery Program. More specifically, BTPL utilizes the following three-pronged approach:

- **Traditional Review -** Provider-generated reports drive the traditional credit balance review. Each account in "credit balance" status is manually reviewed.
- **Inter-Provider Review -** Provider specific issues can be identified during the course of a review. Potential issues are examined in a post-review environment to determine whether follow-up is needed.
- **Intra-Provider Review -** Detection of community wide issues that generally requires robust data mining capabilities. Targeted findings are reviewed with all providers.

Credit Balance Reviews play a crucial role in the BTPL's ability to effectively leverage data mining capabilities as well as improve the enforcement of New York's Medicaid billing and reimbursement policies. For example, a claim that is satisfied during one of the Third Party Reviews can be fed into the Credit Balance process for a secondary review if there is sufficient evidence to merit such review. Another example consists of analyzing payments and denials that are received as part of BTPL's Direct Billing to detect providers engaging in potentially fraudulent or abusive billing practices.

"E-audit" Expansion

The BTPL continues to work with commercial carriers and pharmaceutical benefit managers on suspected duplicate payment reviews using the carrier claim information as

source data. This "e-audit" initiative is a more in depth forensic analysis of the return information of the BTPL's routine third party reviews and direct billing efforts payments. This is a reverse engineering of the current process. In the future, BTPL hopes to expand this effort to include an analysis of Medicare reported amounts as well. These new initiatives are reshaping the thinking that these efforts are limited to third party work.

Home Health Aide Overlapping Payment Review

The OMIG continues to examine the "overlapping payment" universes excluded from the Home Health Aide (HHA) Demonstration project. Findings from data analysis of the Medicaid paid claims show that within the overlap of Medicare and Medicaid coverage, Medicaid is paying an excessively large portion of the HHA services - services that represent the highest utilization dollars in most cases. The OMIG initiated a probe review of three Certified Home Health Agency providers using 10 home health care cases per agency that showed the highest utilization cost to Medicaid while also under a Medicare prospective payment system payment(s). BTPL will use these findings to refine the review protocol. BTPL will target future reviews based on the information provided from the demonstration project and then request provider specific details through the Medi-Medi project.

Prescription Paid Claim Probe Review

The OMIG, through its vendor Health Management Systems, recently reviewed a select sample of "e-audit" Medicaid paid pharmacy claims. The review revealed a number of billing and reimbursement issues, including improper coordination of benefits and inaccurate billings.

The review covered 4,037 claims that Medicaid paid as the primary insurer on behalf of Medicaid enrollees who also had commercial insurance coverage at the time of service. These claims were selected based on a number of criteria including lack of third party payment information reported by pharmacies and denial reason codes that were obtained by HMS through a third party recovery project. Selected claims were mailed to dispensing providers along with instructions for responding to the review.

Based on the responses from pharmacies, BTPL identified the following issues:

- ***Lack of Coordination of Benefits*:** Some pharmacies failed to report *commercial payment* and *patient responsibility* amounts when billing Medicaid. Consequently, Medicaid paid the full *Medicaid Allowed Amount* rather than paying its true liability as a secondary payor.

- ***Balance Billing*:** Even in cases where providers billed Medicaid as the secondary insurer BTPL found that providers sometimes billed for the remaining balance and were paid up to the *Medicaid Allowed Amount*. More specifically, providers failed to report the full patient responsibility amounts

left over by the primary insurer; or, reported in such a way that those amounts were not recognized by eMedNY.

- ***Improper Use of Other Coverage Codes (OCC)*:** In most cases the lack of coordination in benefits and balance billing appear to be direct results of providers' improper use of OCC when billing Medicaid. Other situations of improper usage include where the commercial insurer paid $0 payment (100 percent co-pays/deductibles). Providers overriding third party edits rather than reporting third party co-pay and/or deductible amounts precludes eMedNY from calculating the correct Medicaid reimbursement amounts.

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.

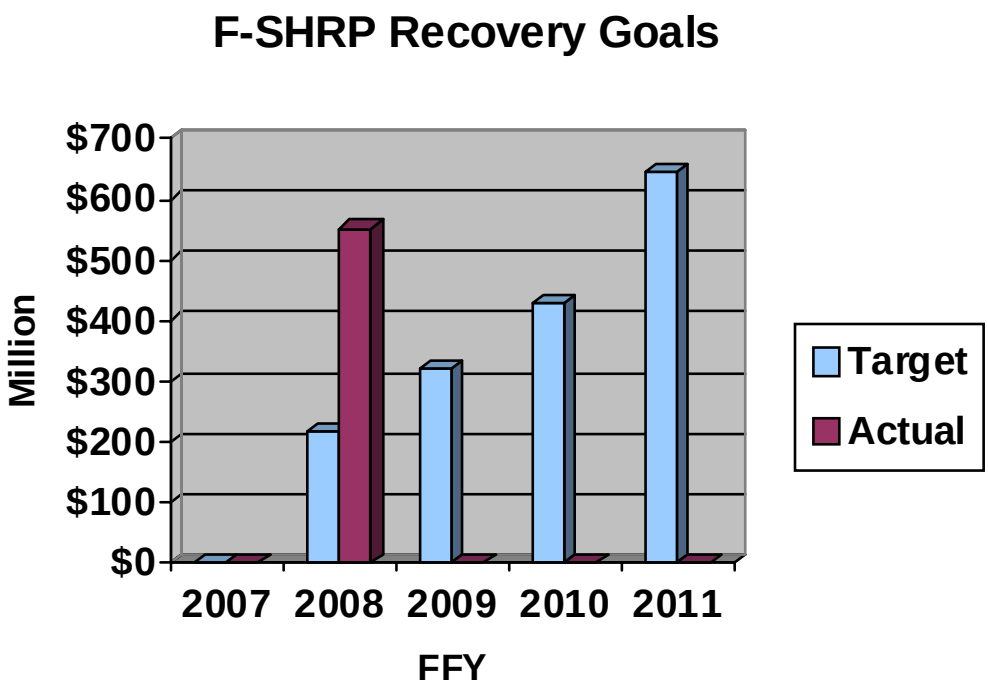
The conditions and required state milestones are clearly defined in the CMS agreement. The two conditions are:

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 was required to develop and submit to CMS its plan for achieving this milestone by the end of the demonstration period, including details of Office of the Medicaid Inspector General (OMIG) staffing and new budget proposals to further enhance OMIG resources. This goal was achieved.
- By December 31, 2008, for the period of October 1, 2007 to September 30, 2008, the state had to 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. The State's accomplishment for FFY 07-08 was $551.6 million, which exceeded the goal by $336.6 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 to the federal government the dollar difference between actual and target recoveries, whichever is less. This value can go up to, but not exceed, $500 million for the five year demonstration period. Additional funds that exceed single year targets cannot be carried over into the next year for use at meeting the subsequent year's requirements.

Work Plan

"State fraud-finder gears up: New York State Medicaid Inspector General James Sheehan has listed the targets in his quest to find fraud, waste and abuse in the state's $48 billion Medicaid program…Mr. Sheehan says that [New York] is "the first state to use this approach." The new 35-page plan by New York's Office of the Medicaid Inspector General is available to the public at www.omig.state.ny.us"

*--Crains Health Pul*se
April 23, 2008

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 promoting the integrity of New York State's Medicaid program.

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 validate 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. The plan communicates risk areas to providers and explains the agency's focus for the state fiscal year (April 1, 2008 – March 31, 2009).

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.

Division of Medicaid Investigation

Functional Description

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Providers are removed from the program or prevented from enrolling if their participation in the program would be detrimental to the system. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

The Provider Investigations Unit, Undercover Investigations Unit, Enrollment and Reinstatement Unit, Provider Exclusions and Censures Unit, Surveillance and Utilization Review System Unit, Prescription Forgery Project, Recipient Fraud Unit, and Recipient Restriction Program all focus on four main areas that address the integrity of the Medicaid program:

- Fraud, waste, and abuse
- Cooperation with other entities
- Deterrence
- Quality of care

Although DMI is divided into specific units, matters addressed by DMI impact every section of the division and the OMIG. Cases may begin in one unit but frequently involve several other units. Tracking providers to recipients then to providers and to other recipients helps DMI find those who seek to defraud the Medicaid program.

Any patient could be a DMI undercover investigator. Recipient and provider records are scrutinized through surveillance, forensic accounting of subpoenaed bank records and billings, medical record reviews, witness testimony, site visits, immediate demands for records, and computerized analysis, among other proven investigatory techniques.

The requirements of New York's Medicaid Program do not allow a recipient to be cut off from the program, no matter how egregious their behavior, as long as they continue to be eligible and have medical needs. Recipients who do abuse or misuse the program, however, are subject to restriction to a primary medical provider(s) and/or pharmacy to ensure that medically necessary care and services are provided and paid. In 2008, such controls resulted in an estimated $133,977,595 in annual program cost avoidance. Recipients and providers suspected of illegal activities are referred by the Recipient Restriction Program to appropriate internal and external entities.

Unlawful or improper behavior may also result in adverse administrative actions. Such actions against providers include excluding or terminating, censuring, imposing penalties, or

suspending privileges for a specified period of time. The OMIG notifies other governmental agencies including the Office of Professional Medical Conduct (OPMC), the Bureau of Narcotic Enforcement (BNE), State Education Department (SED) and the Health and Human Services' Office of Inspector General (HHS OIG), when appropriate.

After DMI identifies improper provider billing practices, the OMIG's Division of Medicaid Audit (DMA) may commence an additional review resulting in recoupment and systemic improvements. In 2008, nine such referrals were made from DMI to DMA.

Internal Workgroups

Enrollment and Undercover Investigations – Exclusions

In 2008, the Enrollment and Reinstatement Unit (EAR), in conjunction with the Undercover Investigations and Administrative Reports Tracking System (ARTS) Unit, began the process of excluding pharmacies that filled Medicaid prescriptions subsequently billed by other pharmacies. New York State regulations prohibit billing for a service that is not supplied by that provider. In requesting undercover operations (UCO) of pharmacies that were applying for enrollment in the Medicaid Program, EAR found several cases where a pharmacy, not yet enrolled in the program, filled a prescription presented by a Medicaid "recipient" (actually an undercover investigator) and then gave the prescription to an enrolled pharmacy to bill using the enrolled pharmacy's provider number.

The policy prior to 2008 was that the enrollment application of the pharmacy filling the prescriptions was denied, but no other action was generally taken on either the filling pharmacy or the enrolled pharmacy that billed for the prescription. In the second half of 2008, Notices of Proposed Agency Action calling for six-month exclusions were issued for three pharmacies that filled these prescriptions and for two enrolled pharmacies that billed for the prescriptions. Responses to the Notices of Proposed Agency Action were pending or under review at the close of 2008.

Provider Forgery Project

In September of 2008, the Provider Forgery Project was greatly expanded. The goal was to increase the number of forgeries the OMIG detected by using data-mining initiatives.

The Provider Forgery Project tracks the providers identified with forged prescriptions to prevent duplication. The project's database includes provider demographic information and data regarding the prescribing practices of providers who had been the victim of a forgery. The resultant early identification of forgeries stops recipients from refilling prescriptions and prevents other prescriptions from the identified pad from being filled.

Recipient Restriction Program

A planned agency wide review of all organizational units within the OMIG started in 2008 with the Recipient Restriction Program. The review identified methods to improve

efficiency, better understand the purpose and continued need for the particular functionality, analyze the resources needed to support the efforts and maximize impact each unit has on the integrity of the Medicaid program.

Fraud Hotline

A hotline complaint helped to confirm the findings of a joint OMIG, NYC Human Resources Administration's Bureau of Fraud Investigation, and FBI investigation of four pharmacies. The complainant reported that one of the pharmacies paid Medicaid recipients for their prescriptions and then sold the medications on the street. In addition, the complainant reported that a woman threatened the recipients for their prescriptions by stating she would call immigration. Although the joint investigation began in 2007, the complainant provided independent information that strengthened the case.

In addition to the hotline, this investigation ultimately utilized many of the OMIG's tools and areas of expertise. Time spent cultivating relationships with various health care and law enforcement agencies made this joint investigation possible. Eight OMIG investigators and three pharmacists participated. Two OMIG undercover operatives continuously provided compelling and credible evidence implicating the individuals and target pharmacies in major drug diversion, financial fraud and the misuse of Medicaid recipient identification cards. The flagrant fraudulent acts included:

- billing the Medicaid program for prescriptions that were never filled;
- giving recipients cash in lieu of medications;
- selling controlled substances without a prescription; and
- dispensing expired and diverted medications.

Subsequently, as a result of this long term joint investigation, the FBI arrested several individuals, the OMIG personally served Notices of Immediate Agency Action to all four pharmacies excluding the providers from the Medicaid program and the pharmacies were placed on 100% withhold. As of this writing, all four pharmacies have received Notices of Proposed Agency Action. Final Notices of Agency Action are pending.

Referrals to AG and Other Agencies

Pursuant to Public Health Law §32(7) the OMIG has been charged with coordinating, to the greatest extent possible, activities to prevent, detect and investigate Medicaid program fraud and abuse with other governmental agencies. As part of this effort, and in accordance with federal regulations, referrals are made to the New York State Attorney General's Medicaid Fraud Control Unit (MFCU), the United States Attorney, or local district attorneys for civil or criminal prosecutions, the Department of Health's Office of Professional Medical Conduct (OPMC), the Bureau of Narcotic Enforcement (BNE), State Education Department's Office of Professional Discipline (OPD) and the Health and Human Services' Office of Inspector General (HHS OIG), and others when appropriate. Recipient fraud cases are referred to local social services departments for appropriate action. Taking advantage of varying areas of

expertise, tools, resources and statutory approaches broadens the OMIG's response to fraud, waste, and abuse in the Medicaid program.

In the course of an audit or investigation, enough evidence may be gathered to suspect a provider of intent to defraud the Medicaid program. By statute, the OMIG 'shall refer suspected fraud or criminality to the deputy general for Medicaid fraud'. A total of 88 such cases occurred in 2008. Provider misconduct cases, where the provider's behavior may require a licensure action, may also be referred to either the OPD or the OPMC in addition to the MFCU. In 2008, eight cases were referred to OPD and five were referred to OPMC. OMIG referred 500 recipient cases to local districts in 2008. In total, there were 531 referrals to agencies outside the OMIG in 2008.

FBI Federal Health Care Task Force

During 2008, OMIG entered into a working relationship with the Federal Health Care Task Force (FHCTF) under the direction of the FBI. The mission of the FHCTF is to identify, investigate, and prosecute healthcare fraud perpetrated against the Federal Government, State of New York, City of New York, private sector sponsored health plans and private insurance companies of the greater New York City metropolitan area. The FBI has additional Federal Health Care Task Forces located in Albany, Rochester, Syracuse, and Buffalo. On January 28, 2009, the OMIG signed a Letter of Agreement formally joining the task force.

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, the United States Attorney's Office, Southern District of New York, arrested and charged Dr. Muhammad Ejaz Ahmad, Muhammad Nawaz Ahmad; the brother of Dr. Ahmad and co-owner of three pharmacies; and Mohammad Tanveer, a pharmacy employee 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. The three pharmacies involved were Nash Pharmacy, Stay Slim Pharmacy and ASA Pharmacy. It was estimated that these 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 are opened and closed by the OMIG and often result in referrals to other entities for closure. Some of these investigations can also result in dollar findings.

Investigations	Initiated	Finalized	Findings	Recoveries
2008	67	58	$3,936,265	$2,075,687

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 2008. The second table shows investigative referrals made to outside agencies other than MFCU.

Provider Type	2008
Capitation Provider	1
Clinical Psychologist	1
Dentist	7
Diagnostic & Treatment Ctr.	5
Home Care Agency	10
Hospital	1
Laboratory	1
Long Term Care Facility	1
Medical Appliance Dealer	2
Multi-Type Group	1
Nurse	10
Recipient/Other (Non-provider)	16
Pharmacy	14
Physician	8
Transportation	10
Total	**88**

Agency	2008
Center for Medicare & MA	1
Law Enforcement Agency	2
Local District	496
OMRDD	1
Off. of Prof. Discipline	8
Off. of Prof. Med. Conduct	5
Off. of Welfare Insp. General	2
Other DOH Unit (not OMIG)	11
Other State Agency	5
Total	**531**

Division of Medicaid Audit

Functional Description

The Division of Medicaid Audit (DMA) professional staff conducts audits and reviews of Medicaid providers to ensure compliance with program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; ensure the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and reduce the potential for fraud, waste and abuse.

DMA's field staff has a broad range of experience in health care programs. This affords the DMA the opportunity to organize and coordinate statewide projects to address the spectrum of Medicaid-covered services and the various program initiatives of the Department of Health (DOH), Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), and the Office of Alcoholism and Substance Abuse Services (OASAS). DMA's efforts are augmented by outside contractors, and staff from the local districts through the Medicaid Fraud, Waste and Abuse County Demonstration Project.

Pursuant to 42 USC § 1396(5); §§ 20, 34, and Article 5, Title 11 of the New York Social Services Law, and Chapter 436 of the Laws of 1997, DOH is the designated single state agency responsible for administering and supervising the Medicaid program in New York. That responsibility includes ensuring the quality of care within each facility, establishing the rates of payment to be paid to each facility for Medicaid-covered care (Public Health Law Article 28), validating the appropriateness of payments on delayed or denied claims, and the responsibility of assuring the accuracy of the promulgated rates of payment through the audit of cost reports (Social Services Law § 368-c). To carry out the latter responsibility, DOH conducts audits and reviews of various providers of Medicaid-reimbursable services.

Medicaid program participation is a voluntary, contractual relationship between the provider of service and the state (Social Services Law § 365-a; 18 NYCRR Part 504). Satisfactory compliance with program rules and regulations is a condition of continued participation in the Medicaid program.

By choosing to participate as a Medicaid provider, a participant assumes responsibility for meeting all requirements as a prerequisite for receiving payment and maintaining continued status as an enrolled provider (18 NYCRR Parts 504, 515, 517 and 518). Enrollment as a provider, along with participation and submission of billings certifying compliance with those rules and regulations (18 NYCRR §§ 504.3 and 540.7(a) (8)), connotes acceptance of the contractual responsibilities.

DOH regulations (18 NYCRR Subchapter E) define the requirements for participation, as well as the rules, regulations and statutes of general applicability to the provider type in

question. The rules governing the establishment of Medicaid rates by DOH are enumerated in 10 NYCRR Subpart 86-2.

Audit Process

> *Mr. Sheehan is making New York far more sophisticated about spotting abuses in the home care industry, he told an audience of home health agency managers at a compliance seminar organized by the Home Care Association of New York. "We want to make sure you understand the audit process and what the rules are," he said. The inspector's goal is to emulate the credit card industry, where front-end controls keep the loss ratio at 0.07 percent. That means catching fraud before it happens.*
>
> *--Crains Health Pulse*
> September 9, 2008

The Medicaid program requires participating providers to maintain adequate records to support their billings to the program. Cost-based providers must maintain financial and statistical records which are used for the purpose of establishing reimbursement rates. This includes all underlying books, records and documentation that form the basis for the financial and statistical reports which the provider files with the Bureau of Long Term Care Reimbursement (BLTCR). The BLTCR is responsible for establishing the payment rates.

Fee-for-service providers, who are paid in accordance with DOH-established rates, fees and schedules, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the Medicaid program. The provider must keep all records necessary to disclose the nature and extent of services furnished and the medical necessity of the service, including any prescription or fiscal order for the service or supply, for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later.

DMA's goal is to implement a system of paperless audits for rate-based provider audits. DMA chose the TeamMate audit software program to facilitate more efficient and consistent rate-based provider audits statewide. This program will be implemented in all rate-based provider audits during SFY 2009-10.

DMA publishes its work plan to assist compliance offices in developing their own organization-specific audit and monitoring activities.

Selection of Audit Subject Areas, Providers and Methods

DMA uses a variety of analytical tools and data mining techniques to identify providers for audit purposes. Successful initiatives in Medicaid program integrity in other states, current academic and public policy organization analyses of health care issues, and program ideas and directives from the CMS Medicaid Integrity Program, which has federal responsibility for guiding and overseeing OMIG's work, are all considered by DMA when preparing for an

audit. DMA works closely with the Department of Health, the Department of Law and the Office of the State Comptroller in identifying program vulnerabilities.

The Department of Health and Human Services' Office of Inspector General (OIG), oversight agencies, newspaper articles and OMIG's hotline all make recommendations to the OMIG. An integral part of the selection process is a review of oversight agency survey reports or other provider reviews. DMA uses this information to determine whether or not to perform an audit, and, if so, the type of audit to perform. For example, DMA has the option of performing a documentation and coding audit or a clinical audit of fee-for-service providers, or a combination of those audit approaches.

Project Notification

An on-site audit begins when DMA notifies a provider by sending out a project letter. In 2008, the OMIG revised the project letter to require providers to submit certain audit documentation to the OMIG within 30 days. This enables DMA to perform audit procedures prior to beginning the field audit. The information includes audited financial statements, tax returns, a list of related parties and selected analysis of work. In addition, the provider is directed to notify its outside accountants of the audit in writing, so that the DMA can gain access to their workpapers.

Entrance Conference

DMA conducts an on-site entrance conference with each individual provider to discuss the nature and extent of the audit. For rate-based audits, specific issues to be addressed in the audit are discussed based on pre-audit reviews of documents. For fee-for-service audits, DMA is able, in certain instances, to give providers the specific date of service or cases under review. In other instances, DMA gives the provider sample selections periodically during field work which may include ranges of dates of service.

Statistical Sampling

Accounting firms, national healthcare consulting firms, the Department of Health and Human Services, and the Office of the Inspector General (OIG) have historically used statistical sampling for audit purposes. In many instances, statistical sampling allows an audit of an account to be conducted that would otherwise be too voluminous or complex to audit in its entirety. Some of the sampling techniques generally used by auditors, including the DMA, are as follows:

- *Population or sampling frame* - the entire set, comprised of individual elements, under consideration. In the context of third-party insurer audits, the population might be the set of all claims made over a certain period of time or the set of all recipients of medical care.

- *Sampling unit* - the individual elements that comprise the population or sampling frame. In the case of an insurer audit, the sampling unit might be the insurance recipient or the individual insurance claim or transaction.

- *Probability sample* - a sampling procedure in which the probability that any member of the population will be included in the sample is known in advance. For example, in a simple random sample, each member of the population has an equal chance of being included in the sample. Valid estimation procedures require probability samples.

- *Random sample* - a group of sampling units from a population where each unit has an equally likely chance of being independently selected from the population or sampling frame.

- *Sampling procedure or technique* - the method used to select units for inclusion in a probability sample. For instance, choosing every tenth unit (systematic sampling), or using a random number table.

- *Estimator* - the mathematical rule by which an estimate of some population characteristic is calculated from the sample results.

- *Estimate* - the value obtained by applying the estimator to the random sample, and projecting it to the larger population. A **point estimate** is an estimate in which a single number is used as an estimate of a population characteristic. An **interval estimate** is one in which the estimate is given as a confidence interval within which the population characteristic will lie with a certain confidence level.

- *Unbiased* - an estimator is unbiased if the average value of the estimate, taken over all possible samples, is exactly equal to the true population value.

- *Confidence interval, confidence level* - the confidence interval is the range of values in which a population characteristic will lie with a given level of certainty (confidence level, expressed in percent). For example, we might be "95 percent confident" that the mean of a sampling frame is between two values, X1 and X2, which are the upper and lower bounds of the confidence interval.

DMA uses the services of a recognized statistician to assist in the development of sampling techniques and analysis and identification of the results of a statistical sample.

Audit Field Work

DMA's standard request for documents include audited financial statements, tax returns, information on related parties and access to the workpapers of independent certified public accountants. This information facilitates the review and, at times, enables DMA to reduce the audit procedure. The provider's compliance plans are reviewed, the compliance officer is

interviewed and, as necessary, auditing, monitoring and compliance committee reports are inspected. Additionally, DMA reviews enrollment records and annual certification for paper and electronic submission of claims.

DMA is streamlining the audit process based on comments from trade associations and providers. The goal is to share the preliminary findings, including work papers, during field work with the intent to resolve any differences before an exit conference.

DMA has incorporated into its audit process a review of medical necessity for services rendered to eligible recipients 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 through Medicaid. OMIG clinical staff has the requisite training needed to review clinical documentation and make determinations regarding the appropriateness of the services provided to Medicaid recipients.

Exit and Draft Reports

Upon completion of a field audit, DMA conducts an exit conference with the provider to discuss preliminary findings. Afterward, the DMA issues a draft audit report that identifies any proposed recoupment and the basis for the action. The provider has 30 days to respond to the draft audit report. If the provider objects to the draft audit report, the DMA considers the provider's response, including any supporting documentation, before issuing a final audit report. If the provider fails to reply within that time frame, the DMA issues a final report.

The provider has 60 days after receiving the final audit report to request an administrative hearing. If granted, the administrative hearing will be limited to only those matters contained in the provider's objection to the draft audit report. If the provider disagrees with the hearing decision the provider has the option to undertake an Article 78 proceeding

Provider Audit

DMA conducts billing audits of provider services rendered to eligible recipients paid on a fee-for-service (FFS) basis. These audits focus on ordering practices of hospitals, diagnostic and treatment centers, physicians and other health care providers. The division is responsible for coordinating all Medicaid-related "self-disclosure" cases. DMA also conducts audits to determine the medical necessity and quality of care rendered to eligible recipients.

Pharmacy Projects

In 2008, DMA developed audit protocols for application in all OMIG pharmacy audits including demo projects statewide. Throughout the year, DMA made presentations on the application of these protocols to audit staff statewide and various pharmacy associations.

During the year, 38 pharmacy audits were opened, while 22 audits were finalized. These audits had findings totaling $3,084,620 and recoveries totaled $866,566.

Self Disclosures

DMA 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 internal issues of fraud, waste, abuse and billing errors are identified.

DMA's disclosure process describes the steps a provider should follow to identify the reason(s) for the disclosure, the financial impact to the Medicaid Program as well as the corrective measures implemented to prevent the reoccurrence of the error. The DMA takes steps to ensure the parameters of the disclosure are true and correct through data analysis of the claims, medical and/or billing record review, along with assessing the financial data. If the provider contracts with an outside consultant to perform an internal review, the DMA requires that the disclosure include an engagement letter, a description of the methodology used to examine the provider's records, the sampling technique used to extrapolate findings and overpayments to include a universe of payments as well as the sample cases, and a description of the documents reviewed.

Self disclosures for 2008 have identified a number of issues that will lead to future statewide audits, to include reviews of: recipient spenddown not applied to home care services; teaching anesthesiologist claims for compliance to 10 NYCRR405.13; OMRDD day treatment services; and claims for traumatic brain injury services.

Time Period	Cases Received	Cases Finalized	Identified Overpayment
2008	59	41	$11,607,866

Diagnostic and Treatment Centers

During 2008, DMA conducted 17 Diagnostic and Treatment Center (D&TC) audits. Audit staff reviewed case record documentation to ensure compliance with applicable laws, regulations, rules and policies of the Medicaid program. The total findings for these audits are $8,472,232.

In 2008, DMA obtained electronic scanners which significantly reduced the amount of time auditors had to spend at the audit site. On average, an audit team consisting of four auditors now completes field work in half the time previously required. As a result, significant reductions in audit costs have been achieved. The electronic scanner also provides enhanced document security. The utilization of flash drive technology has eliminated the need to photocopy documents and the manual transfer of large boxes containing these documents on a daily basis during the audit process.

Outpatient Chemical Dependence Providers

DMA conducted audits and pursued recoveries of Office of Alcoholism and Substance Abuse Services (OASAS) outpatient chemical dependence providers. DMA reviewed case record documentation to determine compliance with OASAS regulations and Medicaid billing requirements. DMA Audits emphasized the clinical documentation to support the provision of patient-centered and clinically necessary services to demonstrate quality of care. Audit protocols were updated and revised.

During 2008, DMA conducted 21 outpatient chemical dependence audits were opened and 15 were completed with total findings of $2,050,539. Several audits that were not completed required the use of a clinical professional to evaluate services for medical necessity. It is anticipated that these will be completed in 2009.

Inpatient Chemical Dependence Providers

In 2008, DMA developed audit protocols for inpatient chemical dependence provider audits. Throughout the year, DMA made presentations on the application of these protocols to audit staff and various associations statewide. DMA shared this information with OASAS to ensure agreement with audit goals and objectives.

DMA also conducted audits and pursued recoveries of Office of Alcoholism and Substance Abuse Services (OASAS) inpatient chemical dependence rehabilitation providers. In 2008, three inpatient chemical dependence rehabilitation audits were opened and three others were completed with total findings of $1,354,869.

Outpatient Mental Health Services

Audits and reviews of providers of outpatient mental health services licensed by the Office of Mental Health (OMH) remain integral to DMA billing and documentation audit projects. During calendar year 2008, 44 outpatient mental health audits of not-for-profit agencies, hospital-based and county operated programs were opened and 16 were finalized. These audits resulted in findings totaling $2,127,954. Audit protocols were updated and revised.

In addition to audit activities to determine compliance with OMH regulations and Medicaid billing requirements, the OMIG added staff to assist in evaluating case record documentation to determine if appropriate medical necessity was documented and quality clinical care was provided. Some of the audits in process need clinical personnel to evaluate records for medical necessity.

OMH Rehabilitative Services

In 2008, the OMIG conducted audits of three OMH community rehabilitative services providers. This was the result of the HHS OIG state-wide audit of a NYS OMH Rehabilitation Program. More of these audits will be conducted in the future.

COPS/CSP-Overpayment Recoveries

The OMIG and the OMH performed a review of mental health providers who received COPS/CSP (community support programs) overpayments for the (4) four years ended November 30, 2005. COPS are supplemental payments in addition to the provider's Medicaid rate. The amount of COPS reimbursement that a provider can receive is limited to a threshold amount and any COPS received in excess of that amount can be recouped. CSP payments in excess of a formulated reimbursement rate are also subject to recovery. Recoveries of COPS and CSP overpayments are for the period of local fiscal year (LFY) 2002/03-2004/05 for New York City providers and county year (CY) 2003-2005 for the rest of the state. However, OMH has not determined recoveries for the subsequent period through 2008.

Office of Mental Retardation and Developmental Disabilities

In 2008, the DMA implemented audit programs, developed audit methodology protocols and created audit detailed findings, supported by regulations and other sources, for the Office of Mental Retardation and Developmental Disabilities' (OMRDD's) residential habilitation and Medicaid service coordination programs. These initiatives represent OMIG's increasing audit projects of OMRDD programs.

Additionally, OMRDD's Bureau of Fiscal Audit conducts limited fiscal reviews, which include routine Medicaid billing and claiming reviews as well as special reviews of selected OMRDD providers. Also, OMRDD fiscal units conduct claim-based audits of residential therapy, transportation and DME/OTC service providers that are opened and tracked for collection purposes through the OMIG's Fraud Abuse Case Tracking System (FACTS).

For calendar year 2008, 86 audits were opened and 11 were finalized with total findings of $434,907.

Hospital Outpatient Departments

Hospital outpatient department (OPD) billing audits continued in 2008. OPD audits include emergency room/clinics, referred ambulatory services and laboratory services.

During 2008, the Albany and White Plains regional offices audited OPD. For 2008, eight hospital outpatient department audits were opened and six were finalized, with total findings of $1,027,640.

Exception Code Project

The Medicaid program requires providers to submit claims within 90 days from the date of discharge (inpatient) or the date of service (outpatient). Unless an acceptable reason

for late submission exists, if the claims are not submitted within the prescribed time frames, the claims are ineligible for payment.

The OMIG's Exception Code Project involves audits and reviews of late claims submission to the Medicaid program. Providers are required to show documentation for specifically identified claims submitted beyond 90 days from date of service, with or without an exception code. If the provider has a valid reason for late claim submission no error is cited. If no valid reason for the late claim submission is demonstrated, the claim is denied.

During 2008, the OMIG sent letters to 28 providers requesting documentation to support their need for late claim submission for OASAS, OMH and hospital-based inpatient and outpatient services.

Dental

Two dental audits were finalized in 2008, with total recoveries of $119,930. In addition, 2008 recoveries from one on-going matching project totaled $368,195; for a 2008 total recovery of $488,125.

Four additional audits were initiated in 2008 and are continuing through 2009 with estimated recoveries totaling $5,642,538.

Patient Review Instrument

The Patient Review Instrument (PRI) is an assessment tool developed by the New York State Department of Health (DOH) to assess selected physical, medical, and cognitive characteristics of nursing home residents, as well as to document selected services that they may require.

During 2008, audit field work was completed for nine PRI reviews. All nine reviews are anticipated to be completed during calendar year 2009.

Project letters were sent to 30 selected facilities to be reviewed in calendar years 2009 and 2010.

Durable Medical Equipment

There were six DME audits finalized in 2008 with total recoveries of $125,961. Projects initiated in this period and finalized in 2009 have recoveries of approximately $4.9 million dollars. Major issues include incomplete information on fiscal orders and failure to produce documentation related to dual eligible recipients.

Home Health

In 2008, DMA developed audit protocols for Home Health audits. Throughout the year, DMA made presentations on the application of these protocols to not only audit staff statewide, and to various associations.

In 2008, DMA initiated audits in three project areas in the home health arena involving reviews of personal care, certified home health associations, and long term home health care providers. These comprehensive audits assess compliance with all regulatory requirements related to service delivery and requirements related to training and health and safety issues for direct care personnel.

Independent Laboratories

During this period, three reviews were completed with recoveries of $117,303. Projects for both independent and hospital based laboratories were initiated to ensure proper billing for dual eligible recipients.

Transportation

OMIG revised the transportation ambulette protocols in the latter part of 2008. Ambulette providers continued to be the main focus for reviews. For 2008, two transportation audits were finalized with total findings of $491,599.

Traumatic Brain Injury

During 2008, DMA conducted seven traumatic brain injury provider audits. Audit staff reviewed case record documentation to determine the adequacy of provider records in support of their claims to Medicaid and their compliance with applicable rules and regulations. The total findings for these audits are $1,008,301.

Rate Based Audit

The Rate Based Audit Management and Development (AMD) Bureau, within the Division of Medicaid Audit, is responsible for financial audits and desk reviews of cost reports used to set rates for Medicaid providers. AMD performs billing audits of Medicaid providers who are paid on a pre-determined rate basis - for example, residential health care facilities 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). DMA staff routinely use the audits and desk reviews to make these determinations.

Residential Health Care Facilities

Residential health care facilities (RHCFs) are reimbursed for covered services to eligible Medicaid recipients based on prospectively determined rates. Through 2008, the

prospective rates were comprised of two components - an operating component and a property/capital component.

The operating component was based on the 1983 reported costs of the RHCF, or the first full year of operation, whichever was later, or on a current basis to reflect, among other events, a change in ownership or construction of a new facility. The base year for the operating portion is fixed. The same reported costs, with appropriate inflation factors, are used for multiple years of reimbursement for the operating portion until a new base year takes effect.

The property/capital component is based on costs reported in each year with a two-year time lag. Mortgage expense is the exception and is based on rate year costs.

New York passed legislation in 2006 to rebase the 2009 operating component of the Medicaid rate from 1983 to the year 2002. The legislation takes effect retroactively to April 1, 2009. Effective April 1, 2010, the method used to reimburse RHCFs for services provided to Medicaid patients is scheduled to be revised. A regional base price with adjustments for RHCF-specific costs will then be used, based on 2007 costs.

AMD audits identify inappropriate or unallowable costs, services dropped by the RHCF, 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 residential health care facility audits issued in 2008. As designated in the chart, AMD issued 463 RHCF audits and identified $75.3 million in overpayments.

Audit Type	2008	
	Audits Issued	Findings (millions)
Base Year	19	$ 6.1
Dropped Services	25	6.1
Property	48	13.4
Rate Appeal	4	3.0
Rollover	367	46.7
Total	**463**	**$ 75.3**

Audit Process

In 2008, DMA developed audit protocols for application in all rate audits of RHCFs and made presentations on the application of these protocols to audit staff statewide, and to various RHCF associations.

DMA’s goal is to implement a system of paperless audits for rate-based provider audits. In 2008, a team of auditors instituted a pilot program utilizing electronic work papers and

chose the TeamMate audit software program to facilitate more efficient and consistent rate-based provider audits statewide. This program will be implemented in all rate-based provider audits during SFY 09-10. In conjunction with the implementation of the TeamMate software, AMD has developed a training manual and outline for all rate-based provider audits, with the implementation process slated for completion by July 2009.

Base Year Audits

Reported base year costs, with appropriate inflation factors, are used for multiple years of reimbursement for the operating and property component until a new base year is set. For example, an audit of base year costs for two RHCFs identified the following disallowances:

- unsubstantiated expense
- prior period expense
- non-patient care expense
- duplicate expense
- non-nursing facility cost
- non-approved building cost
- interest on excess borrowing

These two audits resulted in an overpayment of $1,804,619 in 2008.

Dropped Services Audits

An audit was conducted on a RHCF's ancillary services for the two years ending December 31, 2006. 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. Where Medicaid is paying the outside fee-for-service provider in addition to the RHCF for the same ancillary services, duplicate reimbursement occurs. Ten ancillary services had been dropped. The audit resulted in an overpayment of $2,250,756. This audit is one example of the dropped services audits performed in 2008.

Property Audits

Reported RHCF property costs are used as a basis for the property/capital component of the facility Medicaid rate on a two year lag basis. For example, property/capital audits of three facilities' costs identified significant issues, including:

- Disallowance of mortgage interest
- Disallowance of property/auto insurance
- Disallowance of related company expense
- Offset of investment income
- Disallowance of non-patient care cost
- Disallowance relating to inappropriate capitalization
- Application of working capital interest expense ceiling
- Disallowance of minor equipment depreciation

- Disallowance of unnecessary working capital interest expense
- Disallowance of overstated expense
- Disallowance of unsubstantiated expense
- Disallowance of duplicate expense
- Offset of extraordinary gains

These three audits resulted in overpayments totaling $4,861,178, a significant portion of all overpayments discovered in the property/capital area.

Rate Appeal Audits

RHCFs file rate appeals to contest their Medicaid rates as the result of a number of factors, including computational errors, additional costs, methodology issues, new services, new renovation projects, and new base years, among other issues. During 2008, DMA issued four audits totaling approximately $3 million. The primary reason for the rate appeal was a new base year.

Rollover Audits

Base year operating costs are increased by an inflation factor and used as a basis for RHCFs Medicaid rates for subsequent years. During 2008, the OMIG carried forward base year operating cost audit findings into subsequent rate years, primarily 2005 through 2007. The three largest Medicaid rollover facility impacts totaled $7,244,522.

Bed Reserve Payments to Nursing Facilities for Temporary Client Absence

Reviews continued in 2008 to determine if 18 NYCRR § 505.9(d) requirements pertaining to nursing facility vacancy rates are being met. A nursing facility's vacancy rate must be equal to, or less than, five percent at the time of a resident's temporary leave from the home. Written documentation must exist to support the expectation that the resident will return to the nursing home within 15 days of the date of transfer, thereby qualifying a nursing home to receive a Medicaid bed reserve payment. Three new audits were opened and 7 were finalized, recovering $3.8 million in 2008.

Managed Care

Managed care plans coordinate the provision, quality and cost of care for its enrolled members. In New York State, several different types of managed care plans participate in Medicaid managed care, including health maintenance organizations, prepaid health service plans, managed long-term care plans, primary care partial capitation providers, and HIV special need plans. The Medicaid managed care policy and billing procedures are found and referenced relative to the sections found in the Medicaid managed care/Family Health Plus contract. The managed care contract describes the responsibilities and agreements established between a managed care organization and the New York State Department of Health (Medicaid).

DMA 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 2008, 234 new audits were opened in eight project areas, and 230 audits were finalized, recovering $24 million related to managed care audit projects.

In October 2008, DMA established the Bureau of Managed Care Audit and Provider Review ("MCA&PR") to specifically address audit issues related to managed care, assure that managed care organizations are in compliance with program requirements, and identify and recover any overpayments. The bureau, in addition to its managed care related activity, is also responsible for assisting the division in other audit related functions. In 2008 46 audits were opened related to special project areas within the bureau and 9 were finalized; recovering $5 million.

Following is a summary of the project activity in 2008.

Improper Multiple Client Identification Numbers for One Enrollee Payments

DMA continued the recovery of capitation payments made incorrectly to managed care organizations (MCOs) for Medicaid enrollees who were already enrolled in the MCO under another client identification number (CIN). In 2008, 7 final reports were issued identifying $8.7 million in recoveries. A workgroup formed in 2007 with staff from the Attorney General's Medicaid Fraud Control Unit (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 continues to meet and develop corrective action procedures to address and reduce the causes of duplicate CINs being issued.

Improper Retroactive Supplemental Security Income Capitation Payments

In 2008, the DMA continued its review of retroactive Supplemental Security Income (SSI) capitation payments made to MCOs. The Medicaid managed care contract, Section 10.29, Prospective Benefit Package Change for Retroactive SSI determinations, states that, despite the fact that an enrollment status may be changed using retroactive dates, MCOs may not bill capitation payments retroactively to a listed date of SSI eligibility. Only prospective billing can be used from the date the plan is notified via the roster of the status change to SSI. In 2008, two audits were finalized recovering $546,000, and 15 new audits were opened for review.

Family Planning Chargeback – MCO

Medicaid enrollees have the right to go outside their MCO to receive their family planning services. In instances where the enrollee has chosen to go outside the health plan network for family planning services, those claims are identified on an annual basis and are recoverable from the MCOs, as stated in the managed care contract, Appendix C,

Part II, and Section 2b. In 2008 DMA opened 41 and finalized 35 audits in this area; recovering $6.7 million.

Family Planning Chargeback – FFS

MCOs are responsible for reimbursing their network providers for services provided to their Medicaid enrollees. In this review DMA identifies family planning services that were billed as a fee-for-service from a network provider of the MCO, and recovers the fee-for-service payment made by Medicaid to the network provider. In 2008, DMA opened 15 and finalized 46 audits in this area; recovering $1.2 million.

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 MCO enrollees who remain enrolled following the date of their 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 2008 DMA opened 70 and finalized 50 audits in this area; recovering $3.8 million.

Premium Payments for Enrollees Under Six Months of Age

DMA finalized two audits and recovered $192,000 in 2008 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")

In accordance with the Medicaid managed care contract, the OMIG identifies capitation payments made on behalf of managed care enrollees while they are incarcerated, and pursues recovery of the payments from the MCO. In 2008, DMA opened 35 and finalized 40 audits in this area, recovering $1,042,000.

Duplicate Supplemental Maternal and KICK Payments

DMA 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 2008, DMA finalized 26 audits, recovering $254,000.

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

In 2008, DMA finalized one audit for $5,125 related to inappropriate capitation payments made to an MCO on behalf of managed care enrollees for dates of service prior to the enrollee's month of birth.

Supplemental Capitation Payments Made Without Corresponding Encounter Data

MCOs are entitled to a supplemental newborn capitation payment (paid under the newborn's recipient ID) and a supplemental maternity capitation payment (paid under the mother's recipient ID) in instances where the MCO paid a hospital for the newborn/maternity hospital stay and/or birthing center delivery. In accordance with the Medicaid managed care and Family Health Plus contract, Section 3.8 (Payments for Newborns) and Section 3.9 (Supplemental Maternity Capitation Payments), if the MCO cannot provide documentation to support the newborn/maternity billing, the OMIG will request repayment of the supplemental capitation payment. The DMA opened 38 new audits in this area in 2008, closing two as a no finding based on documentation submitted by the MCO to support their payments.

Audit of Quarterly Medicaid Managed Care Operating Reports

In 2008 DMA opened one audit related to a review of the reported costs used by the DOH in finalizing the MCO's rate. The OMIG is determining the accuracy of the information reported and is conducting electronic analysis of the MCO's reported paid claims to confirm that reported medical costs were incurred and paid in compliance with provider contracts. DMA is also conducting an analysis of the reporting and propriety of third-party recoveries; a review of the appropriateness and allocation of direct and indirect administrative costs; an analysis of related party transactions and contracted expenses; and a review of the accuracy of incurred but not reported (IBNR) accruals by product line.

Preliminary analysis of MCO's indicate that many plans are not reporting third party recoveries or investment income, and that actuaries are not being utilized by the DOH in their rate negotiation process.

Recovery of Capitation Payments for Retroactive Disenrollment Transactions

The Medicaid managed care and Family Health Plus model contract, Section 8.2, requires MCOs to void premium claims for any months where a managed care enrollee is retroactively disenrolled from managed care, and the MCO was not at risk to provide medical services to the enrollee during the month. The OMIG will continue to identify and review retroactive disenrollment of beneficiaries on an annual basis to ensure that the MCO repays, or voids, capitation payments when the MCO was not at risk for the provision of benefit package services during any month. In 2008 19 MCO's retroactively repaid $1.8 million related to disenrolled beneficiaries.

Child Health Care Institute Review

In 2008, the OMIG issued a final report to a provider who was not enrolled in New York State's Medicaid Program and improperly billed Medicaid for students attending their out of state child health care institutions. Total recovery was $1.4 million.

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 2008, the counties of Albany, Broome, Dutchess, Monroe, Nassau, Rensselaer, Westchester and the city of New York were conducting audits and/or investigations of Medicaid providers. The counties of Erie, Orange, and Rockland were pursuing Medicaid fraud using the expanded authority afforded under part 145-b of the social services law. Chautauqua, Niagara, Onondaga, Schenectady, and Suffolk counties were developing the infrastructure with which to support the initiative, for example, local approvals to proceed, initiate competitive processes to select vendors, and/or employee recruitment for new positions.

Under this demonstration project, 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 Attorney General's Office for possible criminal prosecution.

During 2008, the counties initiated seven audits. However none of these are finalized, as all were referred to the NYS Attorney General's Office. County investigations resulted in 16 referrals to the NYS Attorney General's Office.

Summary of Audit Activities

2007 Audits				
Audit Dept.	**Audits Initiated**	**Audits Finalized**	**Audit Findings**	**Audit Recoveries**
Provider Audit Total	380	167	$ 38,657,484	$23,444,518
Rates Audit Mgmt. & Dev. Unit/Managed Care	952	704	101,755,999	66,507,483
School Medicaid Program	11	33	2,893,812	2,879,362
Total	**1,343**	**904**	**$143,307,295**	**$92,831,363**

Division of Administration

Bureau of Budget and Fiscal Management

The 2008-09 Enacted State Budget provides $90 million to support the continued operations of the OMIG. This budget strengthens OMIG's anti-fraud capabilities through increased staffing, additional technology and enhanced anti-fraud measures, including, the following new activities and initiatives:

- The addition of 75 staff members to enhance the OMIG's investigative, audit and systems technology capabilities;
- Conduct and expand audits of rate-based providers and other service categories which have had no or diminished comprehensive audit activity in past years;
- Expand front-end editing and prepayment review functions; and upgrade the OMIG's data mining technology and software. The OMIG is improving its focus on data mining and intends to implement more sophisticated methods to discover data relationships.
- Expand the Cardswipe and Post & Clear Programs. The Cardswipe Program was developed to reduce the incidence of recipient card loaning and theft by unauthorized or Medicaid ineligible individuals. The Post & Clear Program reduces the incidents of stolen prescriptions by requiring prescribers to post the prescriptions they write on the eMedNY Medicaid Eligibility Verification System, and requiring pharmacies to clear the prescriptions before they are dispensed.
- Perform certain recovery, legal and internal controls activities.

Through these efforts, the OMIG achieved its State savings goal of $695 million in State Fiscal Year 2008-09 through a combination of cash recoveries and cost avoidance activities. This reflects an increase of $190 million over the 2007-08 Audit Plan Target.

Bureau of Collections Management

The Bureau of Collections Management continues to make progress toward proactive management of accounts, and has improved the speed and efficiency of the collection processes, as well as improving the clarity of the financial data being collected and reported.

Bureau accomplishments and initiatives for 2008 are as follows:

- **Staffing**: A staffing plan was completed and classification action was taken to fill 12 positions. The bureau commenced recruitment, hiring and training of new staff.

- **Open Receivables**: The bureau completed a review to identify all OMIG open receivable files as noted on FACTS.

- **Civil Recovery Receivables**: A comprehensive review of outstanding civil recovery files was completed in 2008. Of the 130 files identified and reviewed, 27 files remain open.

- **FACTS Financial**: The Bureau of Collections Management has participated in ongoing meetings with information technology staff to accomplish necessary changes to align the FACTS data system's financial capabilities with changing organizational needs and F-SHRP reporting requirements.

- **MFCU**: The Bureau of Collections Management is 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 made significant progress toward meeting F-SHRP goals with regard to reporting of settlements and court decisions resulting from MFCU investigations. All MFCU settlements and court decisions are now incorporated into FACTS for F-SHRP reporting.

Bureau of Human Resources Management

Recruitment and Staffing

The authorized fill level for the OMIG, as defined by the state fiscal year 2008-09 budget, is 753 positions. The OMIG has been striving to fill jobs consistent with a target to provide a workforce that is needed in order to meet revenue goals consistent with the State's fiscal plan and the State's Federal State Health Reform Partnership (F-SHRP) goals.

For the first eight months of the 2008 calendar year the OMIG engaged in an aggressive effort to recruit, hire and retain qualified staff for its various program areas. The recruitment effort was specifically targeted to fill several positions that are difficult to fill, including: Senior Auditors, various nursing titles and pharmacists.

During the period of January 1, 2008 through December 31, 2008, the OMIG hired 209 staff. During the same period, the agency lost 68 staff. The combination of hired and separated staff represented a net gain of 141 staff. Hiring was limited during the last four months of the year due to the State's difficult fiscal situation.

Staffing Data

Staffing in January 2008 = 441 staff
Staffing in January 2009 = 582 staff

Total number of new hires from January 2008 to January 2009 = 209

In an attempt to address its auditor recruitment needs the OMIG joined together with several other State agencies to propose a change in the present examination mechanism (i.e., written examination) used to test for accounting and auditing titles because the examination is viewed as an ineffective selection device. The various agencies drafted a joint letter and forwarded it to the Department of Civil Service (DCS) requesting that the DCS explore more innovative ways to examine for the titles in question. The OMIG and the other impacted agencies continue to work with the DCS on this initiative. The DCS formally approved the proposal in February 2009, and will be introducing a new examination (i.e. Training and Experience Examination) in the fall of 2009.

The Creation of the OMIG as a Separate Appointing Authority

In 2008 management of both the OMIG and Department of Health (DOH) developed and finalized an agreement (i.e., memorandum of understanding) and other necessary documents to establish the OMIG as a separate appointing authority. A copy of this document was also forwarded to the DCS for their review and approval. The DCS gave its approval to the documents and has allowed the OMIG and the DOH to proceed with a Transfer of Function in accordance with Section 70.2 of the New York State Civil Service Law.

In conjunction with the above, the OMIG and DOH have held joint meetings with representatives of the Public Employees Federation (PEF) and the Civil Service Employees Association (CSEA) to discuss the proposed Transfer of Function and to answer any questions that the two organizations may have.

The two agencies have been working aggressively to implement the procedural requirements necessary for the Transfer of Function to occur. An effective date of October 15, 2009, has been established for the Transfer of Function to occur. All employees to be transferred will be formally notified by DOH of their proposed transfer to the OMIG and their rights.

Workforce and Succession Planning

The OMIG presently has a workforce consisting of 582 filled positions. Of that number approximately 50 percent are filled by individuals who, within the next two to three years, will be eligible to retire from state service either with or without penalty. On the basis of these numbers, the agency must embark on an aggressive path to ensure that it will retain the knowledge, experience and institutional memory that will walk out the door with these retirees. This becomes especially important if the agency is to continue to fulfill its core mission of improving 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.

The OMIG is in the process of developing and implementing strategies to address the loss of its experienced staff, and to minimize the impact that these losses will have on the agency's ability to fulfill its core mission. Many of the steps the OMIG will pursue are

detailed in the Department of Civil Service/Governor's Office of Employee Relations Workforce and Succession Planning Guide.

Division of Technology and Business Automation

Bureau of Third Party Liability

Identification of Third Party Insurance

Medicaid is the payor of last resort, but providers often do not bill the responsible third party insurer. A significant amount of the state's Medicaid recoveries are the result of the Bureau of Third Party Liability's (BTPL) efforts to obtain payments from third party insurers responsible for services inappropriately reimbursed by Medicaid funds.

New York uses two main methods to determine if a recipient has third party insurance coverage:

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

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

Application of Third Party Insurance

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

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

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 & UMASS). The contractors 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 initiated.

Pre-Payment Insurance Verification

Results of insurance matches are verified and loaded to the eMedNY Third Party subsystem prior to inclusion in the Bureau of Third Party Liability (BTPL) monthly retroactive recovery projects. This places the emphasis on the prospective cost avoidance of the insurance information while the BTPL continues its recovery efforts.

Actual eMedNY load results are recorded and tracked for a period of one year using an average savings per recipient. The average is determined through data warehouse analysis of paid and denied claim information.

For 2008, BTPL added 231,178 insurance segments to eMedNY. Estimated cost savings for those policies is $781.2 million**.**

Medicaid Match and Recovery Contract (HMS)

The primary objective of the Medicaid Match and Recovery Contract is to identify and maximize private health insurance and Medicare coverage. This enables the State and local governments to achieve cost avoidance savings and/or recover Medicaid funds. The contractor is expected to perform comprehensive third party identification and post payment recovery reviews. The contractor must have the ability to accommodate process enhancements, improvements, and/or expansion into new work areas to accomplish the mission of the OMIG.

During 2008, OMIG, through its vendor HMS, initiated 7,023 third party reviews, with recoveries totaling $107,666,145.

Home Health Care Demonstration Project (UMASS)

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

This demonstration project replaces previous Third Party Liability audit activities of individually gathering Medicare claims from home health agencies for every dual eligible Medicaid claim the State has possibly paid in error. This is an enormous administrative savings in resources for the home health agencies, as well as the regional home health intermediary and for the participating states. During the past year, this project recovered $117,689,460

Legislative Initiatives

Implementation of the Deficit Reduction Act 2005 - Changes Related to Third Party Liability

The Deficit Reduction Act (DRA) of 2005 amended the Social Security Act to clarify the definition of "third parties" and "health insurers," which may be liable for payment of Medicaid services provided. The DRA mandates that states enact legislation, requiring that health insurers provide coverage, eligibility and claims data necessary to identify potentially liable third party insurers. This provides the OMIG with new data matching opportunities with employers' self-funded health plans, third party administrators and pharmacy benefit managers.

Clarification of the Definition of an Overpayment

The current definition of an overpayment - located in 18 NYCRR §518.1 (c) - are not in compliance with the federal definition located at 42 CFR § 433.310.

The current regulations unnecessarily included improper Medicaid payments identified through review programs (i.e. third party liability) for which administrative review processes exist separate from those available under the above listed regulations. This results in a duplication of administrative review processes unnecessarily burdening the Medicaid program and the affected provider community.

Where third party payments or non-payment decisions have been made to providers, they are the result of prior administrative action by the paying agent, so further hearing as to the decision would be duplicative.

Leaving the regulation unchanged may jeopardize millions in gross Medicaid recoveries annually and potentially create an overwhelming administrative burden on the fair hearing system.

18 NYCRR §§518.5(b), 519.4(b) and 540.6(e) were also amended to include further clarification regarding third party liability and fair hearing rights.

New Initiatives

Managed Care Third Party Recovery

Managed care (MC) plans are currently responsible for the collection of third party revenues pursuant to respective MC contracts. These recoveries must be reported on MC cost reports, and BTPL's review of the last three years revealed nominal reported recoveries. Accordingly, the OMIG is proposing to conduct these third party recovery activities. This will generate additional cash recoveries and provide accurate revenue information for actuarial use to determine prospective premiums. Further discussions with the DOH Office of Managed Care are necessary. This proposal will require the

OMIG to obtain MC encounter and paid claims data, and may require changes to existing MC contracts.

Systems Match & Recovery Unit

In addition to the staff functions described for developing systems matches, the Bureau of Business Intelligence (BBI) includes the Systems Match and Recovery Unit (SMR) which is responsible for collecting the overpayments identified by each match. Since most matches are performed on a multi-year basis, the staff researches Medicaid policy and billing guidelines annually to ensure that each match is still accurate and optimal. Staff must review 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. During 2008, SMR initiated a total of 1,001 provider reviews with recovery activity totaling $6,914,000. Some of the specific highlights and areas of focus for 2008 are outlined below.

Inpatient Crossover with Home Health, Nursing and Personal Care - It has been determined that some home health, nursing and personal care agencies continue to bill Medicaid for services while a client is receiving inpatient services. This match identified billings from these types of providers during the inpatient stay of the Medicaid recipient. During 2008 OMIG recovered $1,256,982 from this project.

Inpatient Crossover with Ancillary Services - This match identifies hospital based laboratory services and hospital based ambulatory services, other than laboratory services, that were billed during the Medicaid recipient's inpatient stay. These services are paid within the inpatient rate and should not be reimbursed separately. During 2008 OMIG recovered $435,042 from this project.

Products of Ambulatory Care (PAC) - PAC clinic rates are all inclusive clinic reimbursement rates associated with procedures, diagnosis and recipient age. General clinic visits are not allowable when PAC codes are submitted for payment. Ancillary testing and physician services are also included in the all inclusive rates and should not be billed as fee for service. During 2008 OMIG recovered $1,044,416 from this project.

Prenatal Care Assistance Program (PCAP) - This match addresses multiple issues of erroneous billings for Medicaid clients who are receiving prenatal care services. Billing issues surrounding the PCAP program include clinic, physician, laboratory services, and ordered ambulatory services for participating in the PCAP program. 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 2008 OMIG recovered $905,718 through this project.

Office of Legislative and Intergovernmental Affairs

In 2008, OMIG created the Office of Legislative and Intergovernmental Affairs (OLIA). One goal of the new division was to initiate an outreach program and visit all of the 15 counties in the Medicaid Fraud, Waste and Abuse County Demonstration Program (County Demonstration Program). As part of the visit, the Deputy Medicaid Inspector General visited with local elected officials, and social services commissioners, as well, as the State members of the New York State Legislature from those areas.

Division staff also met with the executive director of the New York State Association of Counties to assess the progress of the County Demonstration Program and bring about needed modifications. As a result, the County Demonstration Program began to show renewed signs of activity at the end of 2008 and into the early part of 2009.

The audit program is fully operational in Albany, Broome, Dutchess, Monroe, New York City, Nassau, Rockland, Rensselear, Suffolk and Westchester Counties; with Chautauqua, Niagara, and Schenectady in the start up phase. Erie, Onondaga, and Orange counties will be starting their initiatives in the near future. One county is conducting investigations in addition to audits. A total of 16 fraud referrals were made to the MFCU as a result of county initiated investigations.

In addition to the County Demonstration Program, OLIA was involved in handling more than 14 individual Assembly member inquiries and 21 Senate inquiries on a variety of matters. These range from questions about excluded physicians and pharmacists, to pharmacies and labs which have been denied Provider status for various reasons.

Legislative outreach efforts continue. The Deputy Medicaid Inspector General of the OLIA met with nearly one third of the Assembly and Senate's elected membership. A new Assistant Medicaid Inspector General will be added to the OLIA in order to help develop and expand strategies to improve OMIG's ongoing efforts to fight fraud, waste and abuse in the Medicaid system.

In conjunction with the OMIG's Public Information Office, the OLIA has been involved in developing a comprehensive communication strategy. This strategy will enhance the OMIG's communication efforts in the provider community, the governmental /political community, and with the general public.

Outreach and Communications Initiatives

"[James] Sheehan is making New York far more sophisticated about spotting abuses in the home care industry, he told an audience of home health agency managers at a compliance seminar organized by the Home Care Association of New York State. 'We want to make sure you understand the audit process and what the rules are,' he said. The inspector general's goal is to emulate the credit card industry, where front-end controls keep the loss ratio at 0.07 percent. That means catching fraud before it happens."
--Crains Health Pulse
September 9, 2008

During 2008, the Office of the Medicaid Inspector General undertook a number of outreach initiatives tailored to reach both internal and external audiences. The hiring of a full-time public information officer in April enabled the OMIG to enhance its visibility and further publicize the agency's mission of identifying and preventing fraud, waste and abuse in, and preserving the integrity of, New York State's Medicaid program.

The goals for the office of public information in 2008 included:

- Increase the agency's visibility with the Legislature, health care providers and their related trade associations, local and federal government officials, and the public in general
- Create an internal newsletter/communications vehicle for in-house staff communications purposes
- Establish rapport with appropriate representatives of the electronic and print news media and ensure that they are familiar with OMIG's work and role in protecting the integrity of the Medicaid program
- Communicate regulatory priorities to providers

Website

One of the most important aspects of outreach and communication in today's environment is an organization's Web site. The OMIG's website (www.omig.state.ny.us) is particularly critical because it contains information on how to report potential incidents of fraud, waste or abuse to the OMIG's office.

During 2008, the OMIG made major changes to the external website, including adding:

- final audit reports
- listing of disqualified providers
- diagnostic-related groups (DRG) code pairings
- links to external staff presentations
- a "listserv" capability through which members of the health care community and the general public have the ability to subscribe to the OMIG's listserv so that they might receive important updates from the office

- OMIG's governing regulations and statutes

The posting of final audit reports is unique to New York State and offers providers within the same level of care (e.g., hospitals, nursing homes, home health care, etc.) the opportunity to examine the approach that the OMIG staff uses during the audit process, and use that information to improve the operations at their own facility or agency.

OMIG Intranet (MIG-Net)

One of the OMIG's major goals in 2008 was to develop an internal user-friendly intranet site for employees. With a July 1, 2008 goal of going live with the intranet, the OMIG convened an internal committee comprised of information technology staff, the public information officer, and representatives from all divisions within the agency.

Thanks to persistence and input from across the OMIG, the July 1, 2008 goal was achieved.

The MIG-Net is a fluid document, constantly growing and evolving. It contains departmental profiles, employment opportunities, a discussion board, daily news clips, a list of frequently used acronyms, a staff directory, and both the latest and archived editions of the employee newsletter, *The OMIG Examiner*.

External Speaking Engagements

Outreach through public speaking and appearances is critical to an agency such as the OMIG. Members of the public hear press reports about Medicaid fraud, waste and abuse, but are just as often uninformed about New York State's efforts to identify and prevent such activities, as well as to recover improper payments, and return those monies to the state's coffers.

Similarly, members of the Legislature and provider groups have specific questions about particular issues. Public appearances offer unique opportunities for OMIG representatives to interact with auditees and answer questions that may arise regarding OMIG regulations and audit processes.

In 2008, OMIG representatives spoke to a variety of groups, including:

- The New York State Society of Certified Public Accountants (CPAs)
- The New York State Bar Association
- The Healthcare Financial Managers Association
- The Department of Health and Human Services' 90th anniversary dinner
- The Greater New York Hospital Association
- The New York State Alliance for Children with Special Needs
- The American Healthcare Lawyers/Healthcare Compliance Association's annual fraud conference

The Medicaid Inspector General also began a grassroots speaking tour by meeting with members of Rotary clubs within a 40-mile radius of Albany. These speaking engagements will continue during the first part of 2009. Such direct interaction with members of the public who are also local business leaders in their respective communities have led to productive discussions about the way in which New York State guards the integrity of the Medicaid program through the detection and prevention of Medicaid fraud, waste and abuse.

Office of Counsel

The Office of Counsel (OC) in the OMIG promotes the agency's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel. The OC is responsible for providing general legal services to the OMIG. These services include providing advice and support regarding the OMIG's programs and operations, representation at administrative hearings and assisting the Office of the Attorney General in its representation of the OMIG in judicial proceedings relating to matters of Medicaid fraud, waste and abuse. The OC is also responsible for revising current regulations and promulgating new regulations to effectuate the OMIG's statutory mission.

Administrative Actions

Sanctions – Terminations & Exclusions

The OMIG has broad discretionary power to impose several different sanctions against "persons" as defined in its regulations[1] (including but not limited to Medicaid providers) based on its audit and/or investigative activities. Sanctions include: censure, exclusion, or conditional or limited participation in the Medicaid program (18 NYCRR § 515.3). A sanction may be imposed upon a finding that a person has committed an "unacceptable practice" pursuant to 18 NYCRR § 515.2. The Notice of Agency Action sent as a result informs the person of the right to appeal the determination through an administrative hearing, as well as the requirements and procedures for doing so.

OMIG may impose an "Immediate Sanction" and/or a "Mandatory Exclusion" when certain other conditions have been met in violation of the rules and regulations of the Medicaid program (18 NYCRR § 515.7 and § 515.8). Immediate sanctions and Mandatory exclusions are imposed based upon a finding that a person has:

- been indicted with committing a felony relating to or resulting from the furnishing or billing for medical care, services or supplies;
- been convicted of a crime resulting from the furnishing or billing for medical care, services or supplies;
- demonstrated 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 or regulation, 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.

A person sanctioned under these provisions is not entitled to an administrative hearing, but is permitted to submit an appeal, comprised of written arguments and documentation within thirty (30) days of the date of the notice. A person appealing a Mandatory exclusion may

[1] Pursuant to 18 NYCRR § 504.1(17), "person" includes natural persons, corporations, partnerships, associations, clinics, groups and other entities.

submit written arguments and documentation regarding whether the determination was based upon mistake of fact. A person appealing an immediate sanction may submit written arguments and documentation on the following issues:

- whether the determination was based upon mistake of fact
- whether any crime charged in an indictment, or any conviction of a crime, resulted from furnishing or billing for medical care, services or supplies; and
- whether the sanction imposed was unreasonable

OMIG conducted investigations and imposed discretionary exclusions during this time period based upon:

- New York State Education Department actions 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 data which provided relative ownership information to determine affiliations of excluded providers

Thirty-nine terminations and 660 exclusions were issued during 2008. Most of those terminations and exclusions were dependent on actions taken by entities outside of the OMIG. OMIG's own work resulted in three of these terminations and 61 the exclusions for 2008. During 2008, 80 appeals were filed. Of the 73 decided appeals, three exclusions were reversed, five appeals were not filed in a timely manner and were dismissed, and 65 appeals affirmed the OMIG's initial determination to exclude the provider. Additionally, one appeal was withdrawn.

OMIG's current list of persons who are not eligible to participate in the Medicaid program is maintained on its Web site (www.omig.state.ny.us) and contains 1,367 non-Medicaid provider exclusions, and 4,629 Medicaid provider exclusions.

Pre-Consent Orders – Beginning in August 2008, pursuant to an agreement with the Office of Professional Medical Conduct (OPMC) and the State Education Department (SED), the OMIG started reviewing pre-consent orders on licensure actions to advise whether the OMIG would exclude the provider from the Medicaid program. Agreed upon and signed pre-consent orders will usually result in agreement not to exclude the practitioner from the Medicaid program. This is an assurance that the practitioner's name will not appear on the published list of disqualified providers. Any practitioner excluded following pre-consent documentation review is notified directly by the Medicaid Exclusions Unit of that decision. This process has eliminated previous situations where providers assumed the SED and OPMC consent order satisfied all concerns, only to then receive an exclusion determination from the OMIG.

Signed Consent Orders– Signed Consent Orders which reflect the agreements reached with the provider on licensure actions received from OPMC and SED are regularly reviewed by Medicaid Exclusions Staff from administrative, medical and legal standpoints to determine whether to exclude the provider from the Medicaid program. If not enough information is contained in the consent order to make a decision then additional investigative reports are requested from the appropriate agency.

Monetary Penalties

In addition to a sanction, the OMIG may impose a monetary penalty under 18 NYCRR § 516 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 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.

During 2008, the OMIG submitted an amendment to 18 NYCRR § 516 (Monetary Penalties) to conform to recent changes to the governing statute; Social Services Law 145-b. The planned regulatory change authorizes the OMIG 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 an improper claim, even when the claim was considered to be an overpayment.

For 2008, 67 providers were issued monetary penalties totaling $133,385. It is to be noted that the number of providers and the total monetary penalties were significantly higher in 2007 due to a major OMIG initiative undertaken during that year. The 2008 numbers signal a return to more traditional practices.

Attorney General Civil Collection Efforts

The Bureau of Collections Management 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.

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. The OMIG often refers these proceedings to the Office of the Attorney General, Civil Recoveries Bureau.

In 2008, one proceeding was referred to the Civil Recoveries Bureau, within the Office of the Attorney General.

Administrative Hearings and Article 78 Proceedings

The OMIG's final determinations involving sanctions, penalties, and/or overpayments, are issued by way of a Notice of Final Agency Action or Final Audit Report. Both notices, regardless of format, are subject to administrative review and, if necessary, judicial review.

Administrative review of certain OMIG final determinations is performed by an administrative law judge in the context of an administrative hearing. Representing the interest of the OMIG, as reflected in the final determination, is the role of OMIG's Office of Counsel. This includes preparing witnesses to testify in the proceeding, making opening statements before the administrative law judge to summarize what the case will show and what evidence will be presented, cross-examining appellants and their witnesses, making timely objections during the administrative hearing, gathering, reviewing and submitting into evidence all necessary and supporting documentation that supports the final determination, preparing a closing brief, and creating a record for the administrative law judge that both explains and supports the action taken.

Judicial review of OMIG final determinations are commenced in Supreme Court pursuant to Article 78 of the Civil Practice Law and Rules (CPLR). The OMIG provides legal support to the Office of the Attorney General in its representation of the OMIG in judicial proceedings.

In 2008, 52 administrative hearings were requested to challenge the final determination of the OMIG. In 2008, four cases were resolved by stipulation of settlement, 12 hearing requests were withdrawn, and nine hearing decisions were issued; all of which were favorable.

During 2008, 20 Article 78 proceedings were filed. At the conclusion of the reporting period, six proceedings were closed. Of the six closed proceedings, three cases were dismissed and three cases were affirmed.

False Claims Act/*Qui Tam* Recoveries

In 2007, the State of New York passed the New York False Claims Act (FCA). The FCA mirrors the provision of the Federal FCA with respect to whistleblower protections and the ability of whistleblowers to share in the proceeds of recoveries made as a result of disclosing information as a FCA filing to the New York State Attorney General.

FCA whistleblower actions are an important part of the OMIG's efforts to encourage effective compliance programs and disclosure of overpayments by providers. Whistleblower actions receive timely and appropriate investigation.

The OMIG works closely with the New York State Attorney General's Office and federal authorities to review and analyze allegations, decide whether to intervene in the case, investigate the allegations, and participate in litigation and/or settlement. A total of 55 *Qui Tams* were opened in 2008.

Regulatory Agenda

The OMIG continues to work closely with the Governor's Office of Regulatory Reform to revise current regulations and promulgate new regulations to effectuate the OMIG's statutory mission. A comprehensive regulatory agenda was proposed and published in the State Register in January 2008. Some of the noted regulatory amendments for 2008 include Title 18 NYCRR Parts 516, 518, 519, and 521.

The OMIG is proposing to amend 18 NYCRR Part 516-Monetary Penalties to increase the monetary penalties for violations of the Medicaid program rules and policies, conforming the regulation to the recent changes to the governing statute; Social Services Law 145-b. The OMIG is also currently in the process of amending Title 18 NYCRR Parts 518-Recovery and Withholding of Payments and Overpayments, and 519-Provider Hearings. In addition, consistent with the obligations of New York Social Services Law 363-d, the OMIG devoted substantial efforts to creating Part 521 to Title 18 NYCRR-Provider Compliance Programs, mandating provider compliance programs. The OMIG continues to work with staff and with other state agency partners to discuss and develop initiatives, implement and amend

regulations relating to such areas as Medicaid program integrity, quality of care and other policy-related issues.

Accomplishments

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 than it is to recover improper payments after they have been made. 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
- restricted recipient initiatives designed to control abusive and excessive utilization of services through the assignment of a recipient to a single primary care provider, and
- exclusions and terminations.

Cost Savings Methodologies Review

The OMIG uses a variety of methods to determine the cost savings within the Medicaid program. It is imperative that there is a clear understanding of the methodologies used to calculate the savings to the Medicaid program. The methodologies used must be reasonable, consistent from one period to another and supported. The methods used by various OMIG bureaus are dependent on the program to which the cost is attributed. For example, one method is used to calculate the savings for the Card Swipe and Post and Clear programs, and a different method is used for the Exclusion/Termination program area.

The Medicaid Inspector General held a series of meetings with representatives of the bureaus that report cost savings to discuss the various methods used. These meetings resulted in each bureau justifying the reason for the various calculations used to determine the cost savings. The uniqueness of each program supports the various methods used; but, the OMIG was interested in determining if commonalities exist that can be utilized by all the bureaus when calculating cost savings.

Each program area's methodologies, calculations and data are being reviewed by an OMIG staff member outside of the respective bureaus. Findings determined in the course of the review are reported and recommended actions to be taken by the impacted bureaus are suggested for implementation. The report is shared with the bureau to allow for comments and submission of a corrective action plan by the bureau.

The purpose of this review is to:

- Evaluate the appropriateness of the methodologies used
- Determine if common ground exists across all program areas
- Decide whether the same scope (period) can be used for all program methodologies, and
- Verify that the methodologies and calculations used yield accurate data results.

System Edits

Edits are one of the most effective tools, and the first line of defense, the OMIG uses to prevent fraud, waste and abuse. These are automated controls built into the Medicaid claims processing system, eMedNY, to help ensure the proper payment of all claims. Developed collaboratively by staff of OMIG, the Office of Health Insurance programs (OHIP), and the DOH fiscal agent, Computer Sciences Corporation (CSC); edits aid in controlling fraud, waste and abuse as identified by audits and investigations.

For 2008, the OMIG modified or created 12 eMedNY System Edits. Of the 12 eMedNY System Edits, 10 system edits accounted for approximately $30.8 million in denied claims. In addition, total cost avoidance from OMIG sponsored edits, or edit modifications, amounted to approximately $153 million.

OMIG staff has begun a continuous effort to review and assess edits. Where appropriate, action may include removal of obsolete edits or edit combinations, adjustment of edit settings (e.g., a change from “pay and monitor” to “deny”) or identification of new edits or combinations that should be introduced.

Prepayment Claims Review

The Prepayment Review Unit uses capabilities within the Medicaid claims processing system to review some or all of the claims for providers of interest. Using this capability, unit staff is able to monitor and review the claiming of providers who demonstrate aberrant, unacceptable or inappropriate billing practices. Through the use of data mining tools, data warehouse queries and post payment reviews, as well as referrals from other OMIG units and outside agencies, OMIG staff selects providers and build edit criteria to review targeted claims submissions.

The Prepayment Review staff is comprised of a diverse group of professionals, including nurses and dental hygienists. In the nearly three years since implementation, staff have reviewed more than 1,900 providers, including dentists, pharmacies, outpatient clinics, diagnostic and treatment centers, durable medical equipment providers, physical therapists, and out of state hospitals.

For 2008, cost savings totaled $17.2 million. In addition 86 providers were referred to OMIG’s Divisions of Medicaid Investigations and Audit for further investigation of potential fraud or recoupment of previously paid claims.

Specific areas of focus during 2008 include:

- Pharmacy providers that use a facility identification number, or out of state codes, instead of a valid prescriber's identification number to circumvent the license verification edit.
- Psychiatrists submitting claims for psychiatric codes that duplicate services
- Pharmacies filling prescriptions from providers who are no longer allowed to participate in the Medicaid program
- Durable Medical Equipment dealers dispensing adult diapers
- Pharmacies incorrectly entering prescription serial numbers
- Dentists submitting claims for duplicate and unnecessary testing
- Pharmacies filling prescriptions for Subutex and Suboxone without a DEA wavier

Examples of prepayment success stories from 2008 are listed below.

Chemotherapy Clinic Service **-** The New York State Medicaid Program has several enhanced fee programs designed to assist providers in caring for a specific population of recipients. For recipients receiving cancer treatment, clinics can bill Medicaid using rate code 3092 (Chemotherapy Clinic Service); however, the recipient must have been diagnosed with cancer. Recipients undergoing testing for cancer, or receiving treatments for blood disorders such as anemia, hemophilia, sickle cell anemia or other chronic blood disorders, are generally not eligible for this rate code unless exempted by OHIP.

The Prepayment Review Unit determined that clinics were billing the 3092 Chemotherapy Clinic Service rate code for recipients who had not been diagnosed with cancer. In 2008, staff identified 27 hospital outpatient clinics that had been submitting claims using rate code 3092 for recipients with no corresponding diagnosis of cancer. Staff suspended those claims from payment and reviewed each individual claim, as well as the recipient's previous two year claim history. If the recipient had no diagnosis of cancer for the two year period, the claim was denied, and the clinic was instructed to resubmit the claim under rate code 2870 (Outpatient Department). If the recipient had a diagnosis of cancer, the claim was paid.

This review has resulted in savings of $1,278, 621 to the Medicaid program, as well as educating providers regarding the use of this enhanced rate code. Since the inception of our edit criteria in January 2008, New York State has seen a 24 percent decrease in claims billing rate code 3092.

Inappropriate Identification of Orderer **-** In February 2008, a new system edit was implemented to deny pharmacy claims with the identification number of a facility in the provider's license number field. According to Medicaid policy, it is inappropriate for a pharmacy to use a facility's Medicaid identification number in the ordering/referring/prescribing provider license number field on a Medicaid claim. After implementing this edit, OMIG staff determined that some pharmacies were

circumventing the edit by using a physician profession code with the facility number i.e., the claim matched to a physician's license number and was subsequently paid. Based on an analysis of paid claims, the Prepayment Review Unit identified 180 pharmacy providers that appeared to have circumvented the edit. Staff developed criteria to suspend payment for claims that reported a physician profession code with the facility number in the prescribing provider's license number field. Copies of the original prescriptions were obtained and where the prescriber was misidentified the claims were denied. Providers were educated regarding accurate submission of prescribing providers information and were afforded the opportunity to resubmit claims using the correct prescribing provider information.

Inappropriate Dental Billing Practices **-** Prepayment reviews have been conducted on 54 dentists and dental groups. When a provider is under prepayment review, staff manually adjudicates every claim submitted by the provider. The beneficiaries' dental services history is analyzed during the 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 claimed services.

Dental prepayment reviews have identified numerous improper and fraudulent billing practices which include:

- 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

As a result of our dental reviews, one dentist was excluded from the Medicaid program and an additional seven have been recommended for exclusion. These providers were paid more than $3.6 million by Medicaid in the years prior to having been placed on prepayment review.

Card Swipe Program

The OMIG designates providers, based on various criteria, to become a mandatory "swiper" as part of the Card Swipe program. The swipe is accomplished using a terminal which is similar to those used commercially to process credit cards. For designated providers, the terminal is supplied to the provider at no cost and the provider is required to swipe the recipient's Medicaid card in a substantial number of instances at the point of service.

At the end of calendar year 2008, 847 providers were designated as swipers. As part of the Point of Service (POS) Unit's on-going provider reviews, 53 providers were removed from the program and 134 dental providers were added.

Also during 2008, the OMIG spent a great deal of effort planning a major expansion of the program. Highlights of this expansion and the associated activities include:

- Adoption of a new, portable cardswipe device for deployment to private duty nurses providing home healthcare services, and non-emergency transportation providers
- Staff worked on the $3.25 million procurement to acquire the 2,000 devices and customization and deployment services from the Medicaid fiscal intermediary
- Enabling the receipt and transmittal of point of service information from the mobile devices using cellular technology
- Enhancing functionality to be able to swipe a recipient's Medicaid card at the beginning of the service and at the completion and integrate the resulting control information with claims data
- Encrypting recipient-specific information for HIPAA security compliance
- Developing reports to show transactions and provider swiping percentages
- Linking point of service transactions to claim data
- Customizing screen menus for each peer group to streamline the process and expedite the transaction for the user
- Development of support documentation and training to ensure that the fiscal intermediary's call center can provide day-to-day support

This program expansion is expected to be implemented in early 2010. As the unit progresses and nears the rollout phase, staff will be reaching out to the providers to ensure adequate training and understanding of the program's goals and requirements.

Post and Clear Program

The Post and Clear Program consists of a set of enhanced controls designed to ensure that Medicaid claims for ordered services are actually ordered by the provider indicated in each claim. Provider's selected for the program must electronically 'post' their orders to the Medicaid claims processing system. This 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. When claims are received identifying a 'posting provider' as the orderer, there must be matching posts in order to "clear" the claim.

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

- Providers who have had security breaches such as stolen or misused script pads.
- Referrals from other agencies and OMIG Bureaus, such as the DOH Bureau of Narcotic Enforcement and the OMIG Division of Medicaid Investigations.

- Providers who generate large numbers of orders (in excess of $500,000) or bill for a high volume of patients.
- Providers who prescribe a high volume of drugs that are abused and/or marketable on the street for resale.
- Providers whose prescribing patterns fall outside their specialty (e.g. a psychiatrist prescribing antihistamines).
- Providers treating patients who fall outside the expected age group of their specialty (e.g. pediatricians treating adults).
- Enrollees who patronize several pharmacies for prescriptions ("pharmacy hopping") in an attempt to fill duplicate prescriptions or obtain early refills.

Being selected for the Posting Program does not imply that the provider is engaged in illegal or inappropriate behavior. The program serves to protect both the provider and the Medicaid program, ensuring that only claims representing authorized services and supplies receive payment. The program helps curtail fraudulent practices such as forged prescriptions, duplication of services, and, in fact, some providers voluntarily participate in the program, recognizing the benefits of protecting the integrity of their medical practice.

At the end of calendar year 2008, 389 providers were designated as posters. As part of the POS Unit's on-going provider reviews, 39 providers were added to the program and 15 removed.

For 2008, the Cardswipe and Post and Clear programs created cost savings totaling approximately $93.4 million.

DMI Cost Savings Initiatives

Exclusions and Terminations, External

Each year, the OMIG issues notices of administrative actions, excluding or terminating providers from the Medicaid program. This results in removing undesirable providers and significant cost avoidance. Many of these cases originate in other agencies including the New York State Education Department's Office of Professional Discipline (OPD), the Office of Professional Medical Conduct (OPMC), the Bureau of Narcotic Enforcement (BNE), the New York State Attorney General's Medicaid Fraud Control Unit (MFCU), and the U.S. Department of Health and Human Services (HHS). The cases are referred to OMIG to consider termination or exclusion of the provider. The subsequent cost avoidance is counted as "Exclusions/Terminations, External" if the OMIG was not involved in the case.

Cost Avoidance for Exclusions and Terminations, External totaled $15,321,431 in 2008.

Exclusions and Terminations, Internal

The OMIG issued 23 notices of administrative action excluding or terminating providers from the Medicaid program based on investigations and audits conducted by the OMIG's Division of Medicaid Investigations and the Division of Medicaid Audit. When potentially fraudulent/abusive practices performed by Medicaid providers are detected, OMIG can decide to take an immediate action or refer the case to another agency such as the MFCU, OPD, OPMC, or BNE for additional review. Upon confirmation of inappropriate or fraudulent practices, providers are subject to administrative action including exclusion or termination resulting in the "Exclusions/Terminations, Internal" cost savings.

Cost Avoidance for Exclusions and Terminations, Internal totaled $22,649,846 in 2008.

Recipient Restrictions Program

The New York State Recipient Restriction Program (RRP) is an administrative mechanism whereby selected recipients with a demonstrated pattern of abusive utilization of Medicaid services are restricted to specific primary providers. These primary providers may include:

- one primary medical provider (physician or clinic), and/or
- one primary pharmacy, and/or
- one designated inpatient hospital, and/or
- one durable medical equipment dealer, and/or
- one dentist, and/or
- one podiatrist.

The following two objectives are critical components of the RRP:

- To provide restricted recipients with coordinated medical services thereby improving the quality of their care
- To reduce the cost of health care through the elimination of abusive utilization behavior by Medicaid recipients.

When a recipient is "restricted", his or her primary provider must refer or provide their services and ordered services within the restricted categories of service.

At the end of 2008, there were 7,948 restricted recipients, while at the same time in 2007, 7,706 recipients were restricted. Cost avoidance for RRP totaled $133,977,595 in 2008.

Program Initiatives

Mandatory Compliance Programs under Social Services Law §363-d

The New York State Legislature passed Social Services Law §363-d, effective January 1, 2007, requiring certain categories of medical assistance program providers to develop and implement compliance programs. New York is the first state to make provider compliance programs mandatory. This initiative is based on the belief that an effective compliance program will assist Medicaid providers to self-identify and address the receipt of overpayments or inappropriate conduct.

Consistent with the obligations of the statute, the OMIG drafted regulations and compliance guidelines. OMIG held meetings with providers and their representatives to discuss the goals of the initiative and solicit feedback on the proposed regulations. The regulation expands upon the providers currently mandated by statute to adopt and implement effective compliance programs i.e., those subject to Articles 28 or 36 of the Public Health Law or Articles 16 or 31 of the Mental Hygiene Law. As adopted, the regulation also includes providers ordering services or supplies or receiving reimbursement, directly or indirectly, or submitting claims for at least $500,000 annually. As part of the regulation, providers will be required to certify annually, that they have satisfactorily met the requirements of the statute and regulation. Providers have 90 days to comply after the July 1, 2009 effective date.

The OMIG also continues to engage providers in developing specific compliance program guidance that will promote the creation and implementation of effective compliance programs. Through this collaboration, compliance initiatives will be a significant tool for reducing fraud, waste and abuse of New York's Medicaid program.

The OMIG collaborated with the New York Council of Nonprofits, Inc. to develop and present a program for Board members of non-profit healthcare organizations. The program, "Non-profit Board Member Responsibilities for Governance of Medicaid Supported Programs" was added to the State Training Consortium's Achieving Excellence in Governance series and was delivered throughout the state to providers. A large portion of the program was focused on the new mandatory compliance program requirements.

The text of the regulation, and the compliance program guidance, when issued, will be available on the OMIG's internet website - www.omig.state.ny.us

Review of Off-Line Medicaid Expenditures

The Department of Health, which administers New York State's Medicaid program, and its fiscal agent, Computer Sciences Corporation, use eMedNY, a computerized payment and information reporting system, to process and pay claims submitted by providers who render services to Medicaid-eligible recipients.

Certain types of claims require special processing or fall under eMedNY limitations. Claims that are run through eMedNY but are not paid through the system are referred to as "adjudicated" payments. Claims that are not run through eMedNY and not paid through the system are referred to as "offline" payments. Adjudicated claims include federal reimbursement amounts for state operating costs for the Office of Mental Health (OMH) and Office of Mental Retardation and Developmental Disabilities (OMRDD).
Off-line Medicaid claims include, but are not limited to, payments to providers from public good pools established to reimburse providers for services rendered to indigent persons, payments of Medicare insurance premiums on behalf of Medicaid recipients, and reimbursements to local governments and state agencies for submitted off-line claims.

For calendar year 2008, OMIG reviewed the adjudicated payments and off-line Medicaid expenditures submitted to the federal government for reimbursement. OMIG developed a list of adjudicated payments and off-line program and administrative expenses, and identified the sources of these expenditures, and past and current internal and external audit activity.

OMIG's preliminary review raised questions about the varied processing systems for claims submitted for reimbursement by local governments and state agencies, as well as questions regarding the documentation to support these claims. In 2010, the OMIG will conduct a targeted review of these local government and state agency off-line claims. As part of this review, the OMIG will determine the potential risk for each expenditure type by assessing the size of the expenditure and the extent to which the expenditures have been subject to prior internal and external audit activity. Those expenditure areas demonstrating high rates of risk will be incorporated into the OMIG audit work plan.

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 receiving $5 million or more in Medicaid funds 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.
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*.

Payment Error Rate Measurement (PERM) Program

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

One-third of states in the Medicaid program were sampled in Federal Fiscal Year (FFY) 2006, one-third in FFY 2007, and the remaining third were sampled in FFY 2008. New York State is part of the FFY 2008 states.

The OMIG was responsible for two of the five areas to be reviewed under PERM: Medicaid fee-for-service (FFS) payments and Medicaid managed care capitation payments. OMIG also provided the universe of claims for both. The Office of Health Insurance programs (OHIP) was responsible for the other three areas: Medicaid eligibility, SCHIP eligibility and SCHIP capitation payments.

The Centers for Medicare and Medicaid Services (CMS) reduced the sample sizes for the Medicaid FFS reviews from 250 claims per quarter to 130 claims per quarter. This matches the number of claims CMS reviewed in other states during FFY 2006 and 2007. CMS also dropped the review of SCHIP Managed Care capitation payments and SCHIP FFS claims. CMS completed the review of all 520 Medicaid FFS claims, and identified only two payment errors. One claim, worth under $200, was insufficiently documented. Another claim was improperly coded but with no payment amount error because the correct payment was made.

The OMIG's PERM staff tracked the CMS review of the same claims to ensure that CMS received complete documentation and to dispute any error determination. The one payment error found by CMS was billed in error, according to the provider, so additional documentation for this claim was not pursued. Two error determinations were disputed and overturned due to the work of the OMIG's PERM staff.

PERM Plus

The OMIG uses PERM staff and additional audit staff to expand the CMS review of Medicaid FFS claims to determine a benchmark percentage of Medicaid claims paid in error, and also the percentage paid as a result of potential fraudulent activity. PERM Plus activities go beyond the

scope of the traditional PERM reviews by asking for additional documentation not requested in the PERM review. This additional documentation helps the OMIG to identify overpayments and billing errors.

Claims reviewed in the PERM Plus project include the claims originally drawn by CMS from OMIG's universe of claims for the PERM project but later dropped by CMS when they reduced the sample sizes from 250 claims to 130 claims per quarter. Additional universes and samples will be established for the quarters in the years that follow New York's PERM cycle year.

PERM Plus is 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 Plus measures the effectiveness of prepayment controls, post payment audits and investigation efforts.

Problems and Concerns

At the time the OMIG was created, one of the primary issues in controlling Medicaid fraud waste and abuse had been 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 responded to this with the creation of the OMIG in November 2006, resulting in a fundamental change in the structure and operation of its program integrity efforts. CMS's Medicaid Integrity Group (MIG) conducted a follow-up program integrity review of the New York State Medicaid Program with a focus on compliance with the findings and vulnerabilities discovered during its 2005 comprehensive review of the New York State Medicaid Program. The MIG conducted its onsite portion of the review at the OMIG's Albany office in August 2008. As stated in CMS's letter to the Office of Health Insurance Programs, "the follow-up review showed that New York has addressed the two areas of non-compliance related to 42 CFR §§ 455.105(a) and 455.106(b)…The four areas of vulnerability noted in 2005 have also received attention from the State." "OMIG's authorized staffing has increased and, despite several vacancies, OMIG has a solid staff foundation, including core clinical staff, to support investigations."

However, significant impediments to OMIG's success remain:

1. ***Peace Officer Status for Investigators***: 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. OMIG DMI investigators are frequently, in the course of their duties, present in any number of provider locations where there is the possibility of a crime being committed. Examples of these include being in pharmacies to investigate prescription fraud, out on the street with the general public and with Medicaid providers being offered to unlawfully purchase narcotics and other prescription drugs, and witnessing other crimes related to the Medicaid program such as Health Care Fraud. OMIG investigators are frequently put into high-risk situations in their day-to-day assignments. OMIG Medicaid fraud investigators are utilized similarly to other specialized law enforcement units, including 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. These specialized law enforcement units all have Peace Officer status.

   Pursuant to the New York State Criminal Procedure Law §2.20, peace officers have the power to make warrantless arrests, use physical force and deadly physical force

when making an arrest or preventing an escape, and carry out warrantless searches-when the search is constitutionally permissible.

Without peace officer status, OMIG investigators are stymied in their investigations. Other law enforcement agencies do not include OMIG investigators in sensitive operations, despite the Medicaid impact and the expertise of the investigators, because OMIG investigators are viewed the same as internal Special Investigation Units for insurance companies licensed in New York and not as part of the law enforcement community. The expertise of the Medicaid investigators is underutilized to the detriment of what should be an overarching multi-agency investigation. This negatively affects the Medicaid program.

Prior to joining the OMIG several investigators were certified police or peace officer instructors. According to the New York State Division of Criminal Justice Services (DCJS), those individuals immediately lose their status as certified instructors upon joining the OMIG because OMIG investigators lack peace officer status. If OMIG investigators obtain peace officer status their status as certified instructors will automatically return, assuming the individual instructor's effective expiration date has not lapsed. Enrollment in a DCJS qualified course to retain instructor certification is open only to those individuals currently employed with a peace officer status. If OMIG investigators rapidly receive status as peace officers then the financial impact will be negligible to the State since OMIG's currently employed certified instructors will immediately regain their status and the OMIG can conduct its own training program in coordination with DCJS.

Section 2.30 of the Criminal Procedure Law, every peace officer in the state who works full-time for his/her employer must successfully complete a training program, a portion of which is prescribed by the municipal police training council and his/her employer (i.e., the state or local agency/commission, a unit of local government, public authority or private organization).

Under some circumstances, OMIG investigators are unable to complete an assigned mission without peace officer status thereby limiting the effectiveness of the OMIG and its ability to ensure cost savings and recoup wrongful payments to providers. In many instances DMI investigators are, in the course of their duties, present during the commission of crimes which directly impact the Medicaid program. These crimes can include larceny, criminal impersonation, forgery and criminal possession of a controlled substance. In their present status they are powerless to make arrests for the crimes committed in their presence.

With no additional funds spent, already certified peace officer training instructors within OMIG can train and certify investigators so they can be fully engaged in combating fraud, waste and abuse and returning dollars to the people of the State of New York. This is a no cost, revenue increasing initiative for New York and should be executed immediately.

2. *Third Party Liability Challenges*

Home Health Demonstration Project

In August 2003, New York State, the Commonwealth of Massachusetts and the State of Connecticut entered into a waiver-only project with the Centers for Medicare and Medicaid Services (CMS) entitled "Demonstration of Home Health Agencies Settlement for Dual Eligible's". The purpose of the project was to allow New York Medicaid to recover home health expenditures which should have been paid by Medicare for the more than 500,000 New Yorkers who have both Medicare and Medicaid coverage. This project replaced the traditional administratively burdensome case by case review, requiring home health providers to bill and document, and Medicare to process, over 30,000 individual home health claims each year to both Medicare and Medicaid.

The demonstration project used a sampling methodology used to determine appropriate liability and payment for dual eligible beneficiaries. This demonstration project was scheduled to run for five years, covering claims through Federal Fiscal Year (FFY) 2005. Because of the project's effectiveness in reducing costs and administrative burdens on both providers and government agencies, CMS and the states (including New York) agreed to extend the demonstration project to include claims through FFY 2007. New York anticipates that the project will ultimately result in the recovery of over $900 million from Medicare for the New York Medicaid program. The OMIG's request for another extension to cover claims for FFY 2008 was rejected in September 2008.

The elimination of the demonstration project will force the State to return to the traditional case by case review process and place an enormous and expensive administrative burden on home health care providers to prepare, submit, support and appeal Medicare claims and the CMS Regional Home Health Intermediaries responsible for claims processing. The federal government will bear a significant additional financial burden to process, consider appeals on, and pay thousands of individual claims, without any change in the ultimate outcome except greater expense.

The OMIG believes that extending the demonstration project to include FFY 2008; and adopting the project approach as a permanent part of the Medicare program with respect to determining Medicare's financial liability for dual eligible Home Health Care expenditures will reduce federal, state and home health agency costs, and allow home health agencies to focus on their primary mission of patient care.

Medicare Part B Billing

Due to the establishment of the National Provider Identifier (NPI), New York State lost its ability to bill Medicare directly for Medicare Part B claims. Medicare will not accept Part B claims without this unique identifier. The volume of claims makes it

impracticable for the State to ask providers to re-bill Medicare for these Medicare eligible services related to retroactive enrollment. At the time services were rendered, no Medicare coverage was available for the services rendered.

This has resulted in diminished recoveries for the State. The State has requested that CMS establish a separate NPI, or an alternative workaround, for direct billing. The State was issued an NPI (for State operated medical facilities) in January 2008, but current CMS policy precludes use of the State NPI for services performed by non-state providers.

CMS has rejected the State's requests to use this NPI and has not offered a meeting to discuss the issue.

The OMIG is seeking federal legislation, with appropriate State and Congressional support, that would require CMS to allow the State to use their NPI; or direct CMS to develop an alternative direct billing protocol.

3. ***Evaluating and Determining Accurate and Appropriate Costs Attributable to Medicaid Managed Care Enrollees:*** New York State Department of Health reports show specific costs attributable to managed care enrollees. For calendar year 2007 (the most recent report available on the DOH website, www.nysdoh/medstat/ex2007/prepaid/reports) total New York Medicaid managed care expenditures were $8.5 billion for approximately 2.5 million enrollees. However, New York makes additional payments on behalf of Medicaid enrollees.

   First, certain services are "carved out" from the managed care benefit, and are paid for on a fee-for-service basis. The most significant carved out benefit is pharmacy services. The Medicaid program derives an advantage from the pharmacy carve out since the State receives rebates from drug manufacturers which it would not receive if drugs were purchased directly by managed care plans.

   The disadvantage of the carved out benefit lies in the difficulty of coordinating care management, benefit review and program and fraud controls where both the managed care organization (MCO) and the Medicaid program have responsibility. Neither the treating physicians nor the MCOs have access to carve out data on a real time basis, and the managed care encounter data available to the OMIG is only available with significant time delays.

   Second, the New York State legislature in enacting laws establishing Medicaid managed care, decided to provide certain protections for existing provider groups. These providers were expected to negotiate their best deal with the over 120 managed care plans within New York Medicaid. In addition, each time these providers saw a managed care patient, New York Medicaid pays them twice – first through the price negotiated by the Medicaid managed care plan, and a second time through a supplemental payment directly by New York Medicaid fee-for-service. There is no coordination at the time of payment between Medicaid fee-for-service and the MCO.

Determining when the fee-for-service payments are due, whether and when the fee-for-service is paid, and whether the amount claimed by and paid to the provider has been a challenge both for the Medicaid program and for the OMIG.

a) ***Review of Graduate Medical Education Payments:*** Managed care contracts with teaching hospitals generally do not include an additional payment for Graduate Medical Education (GME) services in their DRG fee schedule. The Department of Health permits teaching hospitals to bill Medicaid for GME services performed when the patient is enrolled in Medicaid managed care organizations (MCO).

The OMIG identified $191 million dollars in GME expenditures for the three years ended December 31, 2005. For these expenditures there was no corresponding managed care encounter data showing that an adjudicated/paid health care claim was paid for the managed care enrollees for these dates of service. The OMIG opened 28 audits in August 2008 identifying $46 million in GME payments that were made to hospitals where there was no corresponding encounter data submitted by the MCO to support an approved service provided by the hospital, or paid by the MCO.

In undertaking these audits, OMIG attempted to determine whether the hospitals had performed the services claimed, whether the hospitals submitted claims for the services to MCOs, whether the MCO determined that a reimbursable service had occurred, and whether the MCO had properly reported the patient encounter to the State, as it was required to do by contract.

b. ***Federally Qualified Health Care Centers ("FQHC") - Supplemental Transitional Payment Program ("STPP") Shortfall Payment:*** The Medicaid managed care and Family Health Plus model contract requires Managed Care Organizations (MCOs) to report all encounter data on a monthly basis to the New York State Department of Health (DOH).

In 2008 the OMIG opened 15 audits for the three years ended December 31, 2005 identifying $26 million in STPP shortfall payments made to FQHCs with no corresponding managed care encounter data showing an adjudicated/paid health care claim was made for the managed care enrollees for those dates of service.

4. ***Payments to Out-of-State Hospitals:*** The OMIG has reviewed how Out-of-State hospitals are reimbursed by the New York State Medicaid program, with current emphasis on ambulatory surgery and inpatient stays.

In January 1984, the New York State Department of Social Services established regulations governing payments to Out-of-State hospitals. Medicaid payments to out-of-state hospitals are outlined in Social Services regulations Title 18 Section 527.1, which when paraphrased states:

"(a) Maximum reimbursable rates for payments made to out-of-state providers of medical care and services shall be as follows: …"

For Inpatient

(1) [Paraphrased] the lower of:
Payments established for the hospital under Medicaid in that state.
Payments established by Medicare for that hospital.
The hospitals customary charge for public beneficiaries.
Maximum New York State Medicaid payment for similar inpatient care.

Most inpatient services are paid as DRG exempt rates and in at least one instance, a provider is being paid 75% of submitted charges.

The payment for health care services for eligible recipients at "75% of submitted charges" is substantially in excess of what Medicaid would have paid a New York State provider for the same services. We could not locate any documentation to explain the reason for this arrangement.

The following section from Title 18 Section 527.1 governs payments for out of state ambulatory surgery services:

(3) For all other medical care and services:

(i) rates applicable to New York State providers for similar services when the care was rendered by an out-of-state provider of services who is located within the usual medical marketing area of the community where the patient resides; or

(ii) charges as billed by the out-of-state provider of services when such provider of service is located outside the usual medical marketing area of the community where the patient resides.

The OMIG has identified out of state providers that meet criteria (3) (i) above but are paid at significantly higher rates.

The payment policy, as currently drafted, requires Medicaid to make a determination as to whether "the provider of service is located outside the usual medical marketing area of the community where the patient resides". This determination is difficult to do through an automated claims system. Most of the information needed to make the determination is in the possession of the provider, and can only be captured through a post-payment audit and document review. The policy also provides a potential windfall for out-of-state hospitals; virtually no private payor pays the full "charge as billed" a hospital elects to impose.

5. Residential Health Care Facilities:

Temporary Staffing Costs

Through December 31, 2006, the Medicaid program permitted residential health care facilities' (RHCF) rates to be "rebased" if the facility was sold to another party. "Rebasing" allows a nursing home to recalculate its payments from the Medicaid program based upon actual costs in the "rebase" year.

OMIG identified a number of facilities purchased prior to January 1, 2007 that experienced significant increases in their operating cost component, arising out of "rebasing". The increases in operating cost component appeared to be attributable to the new owners transferring most salaried employees to temporary staffing agencies and entering into contracts with temporary staffing agencies for the same staff at a higher hourly rate.

The OMIG has reviewed the facilities' contracts with the temporary staffing agencies, invoices for staffing and the previous owner's payroll records. OMIG is seeking to determine if the transactions between the nursing home owners and temporary staffing agencies are related party transactions. OMIG undertook this review to ascertain if it was a prudent business decision by the new owners to transfer salaried employees to temporary staffing agencies which were billed back at higher hourly rates.

Because of the limitations of the cost reporting process, the information necessary to evaluate the cost reports submitted by these providers required multiple information requests to multiple parties, and, in some cases, subpoenas.

Medicare Part B Reimbursement Information

Since 1999, the Centers for Medicare and Medicaid Services (CMS) altered its Medicare Part B reimbursement methodology and its reporting of Part B payment information to the provider. Instead of issuing the final settlement to the provider, the payment for Part B ancillary services is reflected in the Medicare Provider Statistical and Reimbursement (PS&R) reports to the RHCFs. The Part B physician payments are not reflected in the PS&R reports. Instead, IRS Form 1099 is issued to the individual provider.

RHCFs rates have a Part B carve-out based on estimated Part B revenue. The OMIG needs the actual Part B reimbursement information from CMS in order to compute the correct carve-out.

The OMIG is working with CMS to obtain the Part B reimbursement information for the physical, occupational and speech therapy ancillary services. The OMIG is also trying to obtain the Part B physician reimbursement information from CMS. OMIG staff provided the proposed Part B methodology to the DOH Office of Health

Insurance Programs, Bureau of Long Term Care Reimbursement (OHIP BLTCR), in mid-2008 for their approval. The methodology is being reviewed by the BLTCR.

6. ***Deceased Providers and Recipients:*** The OMIG has been working collaboratively with staff from the New York State Department of Health's (DOH) Office of Health Insurance Programs, and DOH Systems to develop a process for identifying deceased recipients and providers on a timely basis. This process was the result of external audits that identified cases where Medicaid claims were being paid for services provided either to deceased recipients or by deceased providers. The recently implemented process uses recipient eligibility and provider enrollment data to identify these incidents. Each month, a file of eligible recipients and providers with active enrollment is sent to DOH Systems for matching with DOH Vital Statistics and New York City's Vital Records data. Recipients and providers are matched using pre-determined criteria. The match results of deceased providers and recipients are transferred to the Medicaid Data Warehouse. DOH staff access these results and contact DOH Local Districts to verify that the recipients are deceased. If it is confirmed that the recipient is deceased, Local District staff will end-date the recipient's Medicaid eligibility, ensuring that no further Medicaid claims are paid for that recipient. In addition, DOH Provider Enrollment staff take the match data for Medicaid providers and, in cases where there is an exact match, terminate the provider's Medicaid enrollment. This ensures that no further Medicaid claims are paid for this provider where the provider appears as the billing, ordering, servicing, prescribing, or referring provider on a Medicaid claim. Finally, OMIG Systems Match and Recovery staff will use the match results to identify Medicaid claims that may have been paid subsequent to the recipient/provider's date of death and recover any overpayments.

   There may be cases where death information is not reported to DOH Vital Statistics or NYC Vital Records on a timely basis. This presents a problem since it may allow Medicaid providers to continue to bill Medicaid after the recipient or provider has died. OMIG recognized the risks that this presented to the Medicaid Program and developed an additional process, in collaboration with DOH's fiscal agent, Computer Sciences Corporation, to identify deceased recipients on a more timely basis. OMIG staff created a process using Medicaid claims data to identify recipients who are being reported as deceased. In reviewing historical data, this information was found to be very reliable. OMIG staff created a database of these recipients and, on a weekly basis, matches the recipient database to Medicaid claims paid during that week. In cases where Medicaid claims are being paid for deceased recipients, OMIG staff will identify the providers involved and will suspend or deny any future claims being billed by these providers for the deceased recipient. A similar process could not be created for deceased providers since this information is not routinely available outside of the DOH Vital Statistics and NYC Vital Records data. Medicaid payments for deceased providers, although an ongoing problem, pales in comparison to the amount that Medicaid has historically paid for deceased recipients. The processes that have been implemented ensure that Medicaid payments for deceased recipients and providers are mitigated.

The OMIG will collaborate with the State Education Department's (SED) Office of the Professions and share data that identifies deceased providers. SED can use this information to identify medical professionals who are deceased but have active medical licenses. SED can then end-date the license status. This will prevent the license number of a medical professional who may be deceased from being used.

7. ***Medicaid Data Warehouse and Claims Processing System Replacement:*** The Department of Health's Office of Health Insurance Programs (OHIP) has two significant initiatives underway in which OMIG's involvement will be crucial. The Department's contract with its fiscal agent, Computer Sciences Corporation (CSC), will expire in July 2012. As the fiscal agent, CSC's two main responsibilities include operating the Medicaid data warehouse and the Medicaid claims processing system, eMedNY. In preparing for the expiration of CSC's contract, OHIP decided to separate these responsibilities and conduct two procurements: one for the data warehouse and one for the claims processing function.

   During 2008, OHIP began the re-procurement process for replacing the Medicaid data warehouse. The estimated date of implementation of the new warehouse is July 2010. The re-procurement process was started in 2008. Requests for proposals/bids were sent to potential vendors; in response, vendors submitted bids, and the bid evaluation process was underway at the end of 2008. During 2009, the bid evaluation process continued.

   OHIP, with the assistance of a vendor, FOX Systems, began the process for replacing the Medicaid claims processing system in 2008. FOX Systems and OHIP conducted assessment sessions using the Centers for Medicare and Medicaid Services (CMS) advocated Medicaid Information Technology Architecture - State Self-Assessment process. CMS advised state Medicaid programs to use this process when preparing advance planning documents for this type of re-procurement. CMS uses the advance planning document review process and criteria when reviewing and approving a state's draft request for proposal before the state requests bids from potential vendors. During 2009, OHIP continued the process of preparing the request for proposal.

   During 2008 and continuing in 2009, OMIG participated in these planning sessions to ensure the replacement systems address OMIG's needs and concerns relating to system integrity and preventing Medicaid fraud, waste and abuse. In addition, OMIG will participate in application design sessions once the contracts are awarded.

8. ***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.

   When the Office of Health Insurance Programs (OHIP) was established in 2007 one of its 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 2008, a Project Management Office was established. The project management office is staffed jointly by OHIP and Computer Sciences Corporation (CSC) staff. Weekly evolution meetings are held to provide detailed schedules of all evolution projects. New technology was implemented to accelerate the creation of new edits and system functionality permitting simple edits to move through the evolution process quickly. Enhanced capabilities were also developed for more complex edits.

In 2008, an Evolution Control Board was established to ensure appropriate prioritization of projects. The Board convened a workgroup of OHIP and OMIG staff members whose mission was to develop structured and formalized procedures to control all edit activity within eMedNY, and develop written guidelines for these procedures to ensure that responsibilities are clearly understood by all process participants. In conjunction with these activities, the workgroup identified and deactivated obsolete edits, simplified communication, and augmented edit development capacity.

Over the course of several months, the workgroup closely reviewed current edit control processes and procedures, as well as forms and methods used for communication. In nearly all areas, insufficient controls, inefficiencies or obsolescences were noted, and recommendations for improvements were discussed and developed. Three new edit control forms were created to enable process improvements and detailed instructions for all three were developed and memorialized. Process narrative descriptions were written to communicate the new control procedures, and procedures were also developed and written for the new communication methodologies.

As part of the workgroup activity, OMIG is engaged in an ongoing effort to update obsolete edit combinations, determine proper edit settings, identify any edits that should be removed, as well as any new combinations that should be included.

The Evolution Control Board continues to meet quarterly. 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.

9. ***Accounts Receivable Management and Collection:*** The Bureau of Collections Management (BCM) was created in 2007 to manage receivables and collections for OMIG related activities. Initial problems and obstacles that needed to be overcome included:

    - Inadequate staff resources to handle the volume of work generated by increased audit activities.

    - Maintenance of receivables, which required identification of all open and past due accounts

- BCM inherited a large number of aged accounts

- There was a need to establish a process to reconcile OMIG accounts to the Department of Health's Fiscal Management Group's (FMG) data which is the system of record for Medicaid accounts.

- Posting of receipts and adjustments into the OMIG Fraud Activity Case Tracking System (FACTS) was done using a manual process – i.e. staff would physically input all data to FACTS.

- No referrals were made to Attorney General's Office for Civil Recovery for a long period of time, and there was a lack of progress on accounts referred in the past.

- The State's Federal-State Health Reform Partnership (F-SHRP) agreement with CMS increased scrutiny on the reporting of receivables

- OMIG, as a new state agency, started with minimal administrative and legal staff to offer expertise in support of collections activities.

Accomplishments to date:

BCM initiated ongoing discussions with all relevant State Agencies to account for all Medicaid recoveries identified due to the discovery of fraud and abuse that contribute to the State meeting its F-SHRP milestones.

A comprehensive review was conducted on all accounts to determine current aging status and ensure accurate account information was posted in FACTS.

  - 787 accounts identified and reviewed

  - 406 additional/new accounts were identified and/or created while conducting the review

  - 1,193 accounts completed

A revised Interest Protocol was drafted to be consistent with the FMG methods. Additionally, a Revised Repayment Options were drafted and took effect in January 2009. The options increased the standard withhold percentage from 10% to 15%. BCM initiated a new Hardship Request policy and procedure for those providers requiring repayment agreements that exceed two years in duration Internal Controls surrounding BCM activities were reviewed and strengthened.

To ensure timely entry of data and reduce the risk of human error when entering collection information, the BCM implemented the electronic integration of receipts from FMG into FACTS. BCM revised FACTS statuses to better align with the OMIG collection business process. A Collection Request Tracking

System (CRTS) was developed. The CRTS is an electronic tickler system to track the progress of collections and provide a management tool for BCM staff accountability.

The BCM's efforts to review and process accounts receivable has increased awareness in the provider community and positively impacted the resolution of debts.

Additional BCM Initiatives:

- Continue the evolution of systems support through the redesign of FACTS Financial. The goal of the redesign is to improve data capabilities to support collections related activities and define aging of accounts.

- BCM is exploring options to enhance collection capability. Some of these options include:

    - Administrative Offsets

    - Withholding Medicaid funds from affiliated providers

    - Referral to Private Collection Agencies

    - Referral to the Attorney General's Office for Civil Recovery

    - OMIG's ability to handle filing of judgments pursuant to New York Social Services Law §145-a

    - Certification of debts to the New York State Department of Taxation and Finance

    - Medicare payment offsets

- Through training, BCM continues the development of staff resources to handle increased work loads resulting from continued increases in the OMIG's activities associated with revenue goals for F-SHRP and the State Fiscal Plan.

Conclusion

The 600 members of the OMIG staff appreciate the opportunity to address New York's Medicaid fraud, waste and abuse problems. As we end our second year we have strengthened our partnerships with other state agencies, allowing us to increase our abilities to effectively investigate and audit providers whose practices may be questionable, or who need to better control their Medicaid system.

Through our increased outreach efforts, we have had the opportunity to get out the message that the State of New York and OMIG 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, or adult day care providers – we demand the highest quality that your profession commands.

We look forward to increasing our efforts to control Medicaid fraud, waste and abuse in the upcoming year and to make program integrity a priority for everyone involved in New York State's Medicaid program. Through these efforts we will continue to strive to be a model for the rest of the nation to emulate.

Appendix

Operational Statistics

Appendix – Operational Statistics

2008 Investigations by Source and Region

Source	Downstate		Upstate		Totals	
	Initiated	Completed	Initiated	Completed	Initiated	Completed
DMI - Self Generated	207	168	477	434	684	602
CMS	5	3	2	2	7	5
CSC Fraud Unit	1	0	0	0	1	0
Correspondence	84	21	125	111	209	132
County Demo Project	32	2	0	13	32	15
DOH - Other Than DMI	13	5	7	10	20	15
DUR	0	0	2	0	2	0
Edit 1141	8	1	3	0	11	1
Enrollment	98	73	66	58	164	131
EOMB	35	16	15	17	50	33
Executive, Legislature, Administrative	2	0	1	3	3	3
Fidelis	1	0	0	0	1	0
H.I.P. Referral	1	0	0	0	1	0
Hotline	191	83	730	560	921	643
Internet	18	9	89	73	107	82
Law Enforcement	31	3	4	2	35	5
Local District	1	0	34	8	35	8
Managed Care	2	0	10	2	12	2
Medicaid Fraud Control Unit	2	1	1	1	3	2
Medi-Medi	6	0	3	0	9	0
Office of Professional Discipline	5	0	0	2	5	2
Office of Professional Medical Conduct	5	2	1	2	6	4
OHIP (OMM)	29	5	23	17	52	22
OMIG Division of Medicaid Audit	23	6	11	4	34	10
OMRDD	5	4	2	1	7	5
Other	0	0	0	3	0	3
Qui Tam	58	2	1	0	59	2
RRP	5	0	0	0	5	0
Shop/CVR/Comp Target	25	3	39	9	64	12
SURS	32	10	679	599	711	609
Telephone Call	19	7	12	11	31	18
Total	**944**	**424**	**2,337**	**1,942**	**3,281**	**2,366**

2008 Fraud Financial Investigations by Region and Project Type

2008 Downstate Fraud Financial Investigations				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Annual Ambulette Survey	20	20	$ 0	$ 11,935
Billing Issue	8	0	0	330,636
Court Decision	1	1	475	475
CVR – Transportation – Base	4	0	0	0
CVR – Transportation – Vehicle	1	0	0	0
Diagnostic And Treatment Center	0	0	0	68,260
Fraud and Abuse	14	2	3,084,882	447,096
No Supervising Pharmacist	0	5	0	43,748
Nursing Home	0	0	0	136,500
Other	1	1	0	127,948
Personal Care	1	2	9,500	309,297
Pharmacy	0	8	0	(7,844)
Pharmacy Inspection Onsite	2	0	0	0
Provider Prescription Fraud	2	0	0	0
Transportation	2	0	0	0
Unlicensed Provider	0	0	1,266,832	0
Total	**56**	**39**	**4,361,689**	**1,468,051**

2008 Upstate Fraud Financial Investigations				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Annual Ambulette Survey	6	6	$ 0	$ 3,379
Billing Issue	2	1	741	741
CVR – Transportation – Base	1	0	(4,966)	104,604
CVR – Transportation – Vehicle	0	1	172,895	7,904
Fraud and Abuse	1	0	0	0
No Supervising Pharmacist	0	6	0	2,574
Personal Care	0	1	(519,809)	450,361
Pharmacy	0	4	(74,285)	590
Service Not Rendered	0	0	0	37,432
Transportation	1	0	0	51
Total	**11**	**19**	**$ (425,424)**	**$ 607,636**

2008 Total Fraud Financial Investigations				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Annual Ambulette Survey	26	26	$ 0	$ 15,314
Billing Issue	10	1	741	331,377
Court Decision	1	1	475	475
CVR – Transportation – Base	5	0	(4,966)	104,604
CVR – Transportation – Vehicle	1	1	172,895	7,904
Diagnostic & Treatment Center	0	0	0	68,260
Fraud and Abuse	15	2	3,084,882	447,096
No Supervising Pharmacist	0	11	0	46,322
Nursing Home	0	0	0	136,500
Other	1	1	0	127,948
Personal Care	1	3	(510,309)	759,658
Pharmacy	0	12	(74,285)	(7,254)
Pharmacy Inspection Onsite	2	0	0	0
Provider Prescription Fraud	2	0	0	0
Service Not Rendered	0	0	0	37,432
Transportation	3	0	0	51
Unlicensed Provider	0	0	1,266,832	0
Total	**67**	**58**	**$ 3,936,265**	**$ 2,075,687**

2008 Summary of Civil Recoveries

Project Type	Identified	Recoveries
Credentials	$ 72,290	$ 1,092
Dentist	121,217	88,434
DME and Orthopedic Shoe Vendor	527,222	220,353
DME Mailouts	127,980	79,235
High Ordering Providers	3,062,607	146,206
Nursing Reviews	34,944	1,491
Pharmacies	132,516	0
Physician Reviews	1,110,531	290,290
Podiatrists	3,425	468
Radiology	2,099,662	348,708
SNF - Dropped Services	757,379	0
Total	**$8,049,773**	**$ 1,176,278**

2008 Provider Audits by Type and Region

2008 Downstate Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ambulatory Surgery	1	0	$ 0	$ 0
Certified Home Health Agency (CHHA)	1	0	0	0
Death Match	0	3	55,211	10,618
Dental Clinic Services	0	1	195,279	195,279
Dentist	1	2	192,591	118,351
Diagnostic and Treatment Center	14	11	8,123,608	1,915,507
DME and Orthopedic Shoe Vendor	8	2	(3,418)	121,647
Exception Codes	26	0	0	0
HHC – Long Term	2	0	0	0
High Ordering Providers	16	0	25,754	390
Hospice	2	0	0	0
Hospital Outpatient Department	1	13	5,004,755	3,406,786
Laboratories	2	3	117,303	56,248
NAMI – Net Amt of Monthly Income	1	0	0	0
OASAS	14	4	950,167	899,409
Ob/Gyn Services	0	0	0	54,873
OMH	17	4	966,636	1,094,630
OMH – Outpatient	0	0	0	61,833
OMRDD	45	7	434,003	553,741
Optical Provider	1	1	2,122	2,122
PCAP	0	0	0	57,346
Pharmacies	8	1	1,140,486	88,883
Physician Reviews	0	0	0	14,313
Self Disclosure	18	12	8,226,352	7,870,204
Traumatic Brain Injury	3	0	0	0
Total	**181**	**64**	**$ 25,430,848**	**$ 16,522,179**

2008 Upstate Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Certified Home Health Agency	1	0	$ 0	$ 0
Dentist	0	0	1,319,893	27,506
Diagnostic and Treatment Center	3	4	226,510	460,222
DME and Orthopedic Shoe Vendor	3	2	(3,552)	0
Exception Codes	4	0	0	0
HHC – Long Term	3	0	0	0
High Ordering Providers	1	0	0	0
Hospice	1	0	0	0
Hospital Outpatient Department	7	5	769,676	1,005,202
OASAS	5	6	1,865,856	358,156
Ob/Gyn Services	0	0	0	38,202
OMH	10	7	1,006,374	674,912
OMH Rehabilitation	1	0	0	0
OMRDD	23	2	9,541	2,386
Pharmacies	8	4	23,655	161,739
PCAP	0	0	0	9,523
Physician Reviews	1	0	0	10,690
PRI	1	0	0	0
Self Disclosure	13	7	299,365	467,010
TBI	2	2	684,846	172,186
Transportation	0	2	491,599	5,596
Total	**87**	**41**	**$ 6,693,763**	**$ 3,393,328**

2008 Western Region Provider Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Certified Home Health Agency	3	0	$ 0	$ 0
Dentist	2	0	0	0
Diagnostic and Treatment Center	0	2	122,114	122,114
DME and Orthopedic Shoe Vendor	4	2	80,431	99,413
Exception Codes	1	0	0	0
High Ordering Providers	1	0	0	0
Hospice	2	0	0	0
Hospital Outpatient Department	0	1	47,370	47,370
Laboratories	1	0	0	0
OASAS	5	8	589,385	494,252
Ob/Gyn Services	0	0	0	4,223
OMH	15	5	366,862	406,908
OMH Rehabilitation	1	0	0	0
OMRDD	18	2	627	1,820
PCAP	0	1	0	0
Personal Care	3	0	0	0
Pharmacies	22	17	1,920,479	615,943
PRI	1	0	0	0
Radiology	0	0	0	7,900
Self Disclosure	26	21	2,574,915	1,152,096
TBI	2	2	323,455	66,613
Transportation	0	0	0	2,495
Total	**107**	**61**	**$ 6,025,638**	**$ 3,021,148**

2008 Out-of-State Provider Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ambulatory Surgery	1	0	$ 0	$ 0
DME and Orthopedic Shoe Vendor	1	0	0	101
Laboratories	1	0	0	0
Ob/Gyn Services	0	0	0	480
Physician Reviews	0	0	0	49
Self Disclosure	2	1	507,234	507,234
Total	**5**	**1**	**$ 507,234**	**$ 507,863**

2008 Statewide Provider Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ambulatory Surgery	2	0	$ 0	$ 0
Certified Home Health Agency (CHHA)	5	0	0	0
Death Match	0	3	55,211	10,618
Dental Clinic Services	0	1	195,279	195,279
Dentist	3	2	1,512,484	145,857
Diagnostic and Treatment Center	17	17	8,472,232	2,487,843
DME and Orthopedic Shoe Vendor	16	6	73,461	221,161
Exception Codes	31	0	0	0
HHC – Long Term	5	0	0	0
High Ordering Providers	18	0	25,754	390
Hospice	5	0	0	0
Hospital Outpatient Department	8	19	5,821,801	4,459,358
Laboratories	4	3	117,303	56,248
NAMI – Net Amt of Monthly Income	1	0	0	0
OASAS	24	18	3,405,408	1,751,817
Ob/Gyn Services	0	0	0	97,779
OMH	42	16	2,339,872	2,176,451
OMH Outpatient	0	0	0	61,833
OMH Rehabilitation	2	0	0	0
OMRDD	86	11	444,171	557,947
Optical Provider	1	1	2,122	2,122
PCAP	0	1	0	66,869
Personal Care	3	0	0	0
Pharmacies	38	22	3,084,620	866,565
Physician Reviews	1	0	0	25,052
PRI	2	0	0	0
Radiology	0	0	0	7,900
Self Disclosure	59	41	11,607,866	9,996,544
TBI	7	4	1,008,301	238,799
Transportation	0	2	491,599	8,091
Total	**380**	**167**	**$ 38,657,484**	**$ 23,444,518**

2008 Rate Audits by Type and Region

2008 Downstate Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
ALP/Inpatient Crossover	0	0	$ 0	$ 0
Bed Reserve	3	7	3,773,821	2,026,566
Child Health Care Institute	0	1	1,180,332	0
Clinic – FQHC	17	0	0	0
GME – No encounter	83	0	0	0
Home Health Care	0	0	(19,174)	5,565
Hosp Inpatient	2	0	0	0
Managed Care	133	144	16,094,466	15,446,470
Medicare Crossover	0	6	369,076	15,733
Medicare Max	0	0	0	16,007
OASAS	1	1	1,441,338	0
OMH COPS	13	0	0	0
Skilled Nursing Facility Audits	219	198	36,671,298	25,172,765
Transportation	0	8	78,201	102,710
Total	**471**	**365**	**$ 59,589,359**	**$ 42,785,816**

2008 Upstate Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Bed Reserve	0	0	$ 0	$ 176,522
Clinic – FQHC	1	0	0	0
GME – No encounter	39	0	0	0
Managed Care	38	40	1,872,688	1,644,783
Medicare Crossover	0	1	44,377	44,377
OMH COPS	3	0	0	0
Skilled Nursing Facility Audits	109	84	18,362,652	7,458,390
Transportation	0	4	18,401	18,773
Total	**190**	**129**	**$ 20,298,118**	**$ 9,342,844**

2008 Western Region Rate Audit				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
ALP/Inpatient Crossover	0	1	$ 1,635	$ 0
Clinic – FQHC	1	0	0	0
GME – No encounter	49	0	0	0
Managed Care	46	25	1,632,865	2,018,463
Medicare Crossover	0	2	2,688	2,688
OMH COPS	3	0	0	0
Skilled Nursing Facility Audits	192	181	20,231,334	12,357,491
Transportation	0	1	0	181
Total	**291**	**210**	**$ 21,868,522**	**$ 14,378,823**

2008 Statewide Rate Audit Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
ALP/Inpatient Crossover	0	1	$ 1,635	$ 0
Bed Reserve	3	7	3,773,821	2,203,087
Child Health Care Institute	0	1	1,180,332	0
Clinic – FQHC	19	0	0	0
GME – No encounter	171	0	0	0
Home Health Care	0	0	(19,174)	5,565
Hosp Inpatient	2	0	0	0
Managed Care	217	209	19,600,021	19,109,717
Medicare Crossover	0	9	416,142	62,799
Medicare Max	0	0	0	16,007
OASAS	1	1	1,441,338	0
OMH COPS	19	0	0	0
Skilled Nursing Facility Audits	520	463	75,265,284	44,988,646
Transportation	0	13	96,602	121,664
Total	**952**	**704**	**$ 101,755,999**	**$66,507,483**

2008 Medicaid in Education Reviews by Region and Type

2008 Medicaid in Education Downstate Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
SSHSP*	0	3	$ 51,400	$ 51,400
Systemic Review	0	0	308,817	308,817
SSHSP – ICF***	0	0	36,942	36,942
Total	**0**	**3**	**$ 397,159**	**$ 397,159**

2008 Medicaid in Education Upstate Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
SSHSP	4	2	$ 144,815	$ 144,815
PSHSP**	2	3	187,745	177,978
Systemic Review	0	0	275,767	275,767
SSHSP – ICF	1	0	41,614	41,614
Total	**7**	**5**	**$ 649,941**	**$ 640,174**

2008 Medicaid in Education Western Region Reviews				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
SSHSP	4	23	$ 1,364,968	$ 1,364,968
PSHSP	0	2	46,363	46,363
Systemic Review	0	0	273,968	269,285
SSHSP - ICF	0	0	161,412	161,412
Total	**4**	**25**	**$ 1,846,711**	**$ 1,842,028**

2008 Medicaid in Education Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
SSHSP	8	28	$ 1,561,183	$ 1,561,183
PSHSP	2	5	234,108	224,341
Systemic Review	0	0	858,553	853,870
SSHSP – ICF	1	0	239,968	239,968
Total	**11**	**33**	**$ 2,893,812**	**$ 2,879,362**

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

2008 Systems Match Recoveries by Region and Type

2008 Downstate Systems Match and Recovery Audits				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	3	$ 52,678	$ 52,678
Deceased Recipients	0	26	180,016	223,054
Dental	0	49	510,403	416,151
General Clinic	83	14	302,724	266,898
Hemodialysis	63	40	685,845	525,114
Home Health	161	109	1,028,727	1,049,889
Home Health - Nursing Home	30	2	18,306	18,306
Hospice – Skilled Nursing Facility	4	3	30,069	30,069
Inpatient/Ancillary/Lab	82	57	302,258	276,562
Medicare Part B	0	0	10	10
Net Available Monthly Income (NAMI)	0	4	254,716	254,716
PAC and PAS	15	10	735,302	735,302
PCAP – Prenatal Care Assist Program	0	19	461,337	461,337
Radiology	0	54	392,764	393,467
Total	**438**	**390**	**$ 4,955,156**	**$ 4,703,554**

2008 Upstate Region Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Dental	0	5	$ 32,766	$ 28,305
General Clinic	55	12	513,701	418,236
Hemodialysis	19	8	15,143	15,143
Home Health	89	59	131,173	133,557
Home Health - Nursing Home	7	2	2,169	2,169
Hospice – Skilled Nursing Facility	2	1	1,068	1,068
Inpatient/Ancillary/Lab	55	35	79,369	79,768
PAC and PAS	5	4	220,544	220,544
PCAP – Prenatal Care Assist Program	0	8	276,905	176,646
Radiology	0	17	152,237	149,826
Total	**232**	**151**	**$ 1,425,075**	**$ 1,225,260**

2008 Western Region Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	3	$ 21,813	$ 21,813
Deceased Recipients	0	1	3,726	3,726
Dental	0	4	33,753	32,240
General Clinic	72	12	448,286	353,612
Hemodialysis	19	9	12,968	12,968
Home Health	93	65	73,836	73,537
Home Health - Nursing Home	8	1	818	818
Hospice – Skilled Nursing Facility	1	1	3,547	3,547
Inpatient Crossover/Clinic/ER	0	1	1,592	1,592
Inpatient/Ancillary/Lab	78	50	72,400	78,712
PAC and PAS	8	6	224,539	88,571
PCAP – Prenatal Care Assist Program	0	17	167,477	179,142
Radiology	0	8	67,791	36,701
Total	**279**	**178**	**$ 1,132,545**	**$ 886,978**

2008 Out-of-State Systems Match Recoveries				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	1	$ 37	$ 37
Deceased Recipients	0	1	14,811	14,811
General Clinic	39	29	55,570	55,091
Hemodialysis	4	3	1,620	1,620
Home Health	1	1	541	541
Inpatient/Ancillary/Lab	8	3	2,572	2,186
Radiology	0	8	23,921	23,921
Total	**52**	**46**	**$ 99,072**	**$ 98,207**

2008 System Match and Recovery Statewide Totals				
Project Type	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Ancillary/Same Day Clinic Visit	0	7	$ 74,528	$ 74,528
Deceased Recipients	0	28	198,553	241,591
Dental	0	58	576,922	476,696
General Clinic	249	67	1,320,281	1,093,837
Hemodialysis	105	60	715,576	554,845
Home Health	344	234	1,234,277	1,257,523
Home Health - Nursing Home	45	5	21,292	21,292
Hospice – Skilled Nursing Facility	7	5	34,684	34,684
Inpatient Crossover/Clinic/ER	0	1	1,592	1,592
Inpatient/Ancillary/Lab	223	145	456,600	437,229
Medicare Part B	0	0	10	10
Net Available Monthly Income (NAMI)	0	4	254,716	254,716
PAC and PAS	28	20	1,180,384	1,044,417
PCAP – Prenatal Care Assist Program	0	44	905,719	817,125
Radiology	0	87	636,713	603,915
Total	**1001**	**765**	**$ 7,611,848**	**$ 6,914,000**

Cost Savings Activities

Activity Area	2008
Pre-Payment Insurance Verification Commercial	$ 588,863,329
Pre-Payment Insurance Verification Medicare	192,359,190
Pharmacies License Verification	38,730,016
Edit 1236/1238 - Order/Servicing/Referring Provider #	46,244,639
Clinic License Verification	49,082,156
Card Swipe Program/ Post & Clear Program	93,385,105
Edit 939 - Ordering Provider Excluded Prior to Order Date	23,560,515
Part-Time Clinic Verification	215,547,148
Pharmacy Prior Authorization (Serostim)	52,015,450
Serialized Rx Program Edits	43,338,567
Edit 1141 Activities	17,185,282
Edit 903 – Ordering/Referring Provider Number Missing	20,688,067
Recipient Restriction	133,977,595
Exclusions/Terminations – Internal	22,649,846
Exclusions/Terminations – External	15,321,431
Enrollment and Reinstatement	44,324,262
Transportation Crossover Edit	359,451
Duplicate Clinic/Nursing Home Claim Editing	224,442
Edit 760 – Suspected Duplicate, Covered by Inpatient	3,334,711
Total	**$ 1,601,191,202**