2019 ANNUAL REPORT

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GOVERNOR

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ACTING MEDICAID INSPECTOR GENERAL

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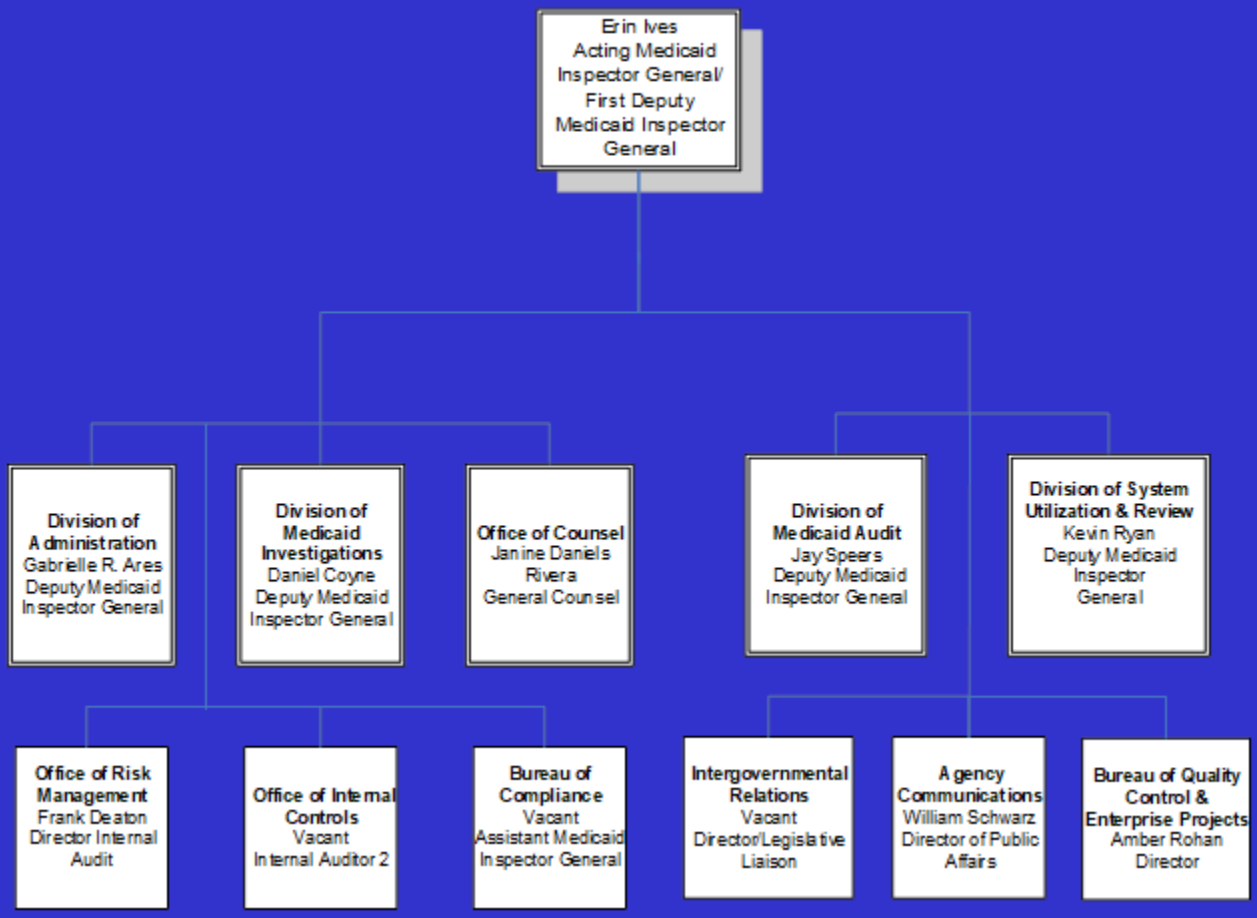
OMIG Organizational Chart



Message from the Acting Medicaid Inspector General

I am pleased to present the 2019 Annual Report detailing the initiatives of the Office of the Medicaid Inspector General (OMIG) to detect and prevent fraud, waste, and abuse in the State's Medicaid program. OMIG investigative and auditing activities resulted in more than $2.9 billion in Medicaid recoveries and cost savings in 2019.

As the following Annual Report will detail, 2019 highlights include:

- Cost-avoidance measures that generated savings of more than $2.3 billion.
- Medicaid recoveries - which are generated through provider audits and investigations –accounted for more than $552 million.
- New authorization to conduct annual program integrity reviews of Managed Care Organizations (MCO) and Managed Long-Term Care Plans (MLTCP).
- More than 1,800 audits finalized with identified overpayments exceeding $234 million.
- Over 3,000 investigations opened and more than 2,700 completed.

Working closely with other State agencies and our law enforcement partners at all levels, OMIG will continue to protect the integrity of the Medicaid program, which saves taxpayer dollars and helps ensure high-quality care throughout the State's health care delivery system.

Sincerely,

Erin E. Ives
Acting Medicaid Inspector General

General Overview

History and Authority

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

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

Mission Statement

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

Annual Reporting

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

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

2019 Program Integrity Activities

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

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

Executive Initiative: Managed Care Program Integrity Reviews

Chapter 57 of the Laws of 2019, which took effect April 1, 2019, added subdivision 36 to Social Services Law (SOS) §364-j, authorizing OMIG to conduct annual reviews of MCOs and MLTCPs to assess compliance with contractual standards that prevent fraud, waste, or abuse. Current reviews utilize contractual obligations in effect on or after January 1, 2015, with the review period beginning no earlier than January 1, 2018. MCOs/MLTCPs are entitled to receive draft and final audit reports, as well as hearing rights pursuant to 18 NYCRR Part 517 and Part 519 respectively.

OMIG, in consultation with the DOH, published on its website a matrix of the contractual provisions subject to review related to program integrity for the review period, providing:

- the contractual obligation;
- the performance standard;
- a measurement assessment; and,
- a benchmark.

The initial review period for the Managed Care Program Integrity Reviews (MCPIR) is January – December 2018 and pertains to the Managed Care/Family Health Plus/HIV Special Needs/Health and Recovery Plan Model Contract (Model Contract) dated March 1, 2014 and as amended October 1, 2015.

Fifteen program integrity obligations were selected for the initial review period, which are divided into two broad categories:

- Fraud and Abuse Prevention
- Reporting Requirements

Pursuant to SOS §364-j(36)(c), where OMIG determines that an MCO is not meeting its program integrity obligations under the Model Contract, OMIG may recover up to two percent (2%) of the administrative component of the Medicaid premium paid to the MCO for the period under review. OMIG will evaluate MCO performance according to the standards outlined in each line of the Matrix and assess a score for that line (between 0% and 100%), and then take the total average score for all Matrix lines. The recovery percentage will be calculated based on the following average scores:

Average Score	Recovery Percentage
≤60%	2%
>60% and <90%	Between 1.93 and 0.067%*
≥90%	0%
* The range of percentages listed here are close approximations of the recovery percentage for the average scores listed.	

OMIG initiated 15 mainstream managed care MCPIRs and received documentation from the MCOs for evaluation. OMIG is currently reviewing the documentation submitted by the MCOs in preparation for producing audit reports to the MCOs identifying specific finding areas and recovery amounts.

Managed Care

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

Managed Care Audit Activities

OMIG's audit efforts include performing various match-based reviews utilizing data mining and analysis to identify potential audit areas/targets. These audits led to the recovery of inappropriate premium payments and identification of actions to address systemic and programmatic concerns.

These efforts resulted in 483 finalized audits with more than $179 million in identified overpayments. Highlights of managed care audit activities are described below.

Managed Care Annual Deceased Enrollee Audit

OMIG continues to audit managed care enrollment issues in several project areas, including monthly premium payments made on behalf of deceased enrollees. Local Departments of Social Services (LDSS) conduct first-level reviews and submit retroactive disenrollment notifications to the MCOs to recover premium payments paid after an individual's date of death. OMIG performs second-level reviews by comparing monthly premium payments paid to MCOs against data provided by NYS's Bureau of Vital Statistics, the New York City (NYC) Bureau of Vital Statistics, and individuals who are indicated as deceased on eMedNY. OMIG identifies monthly premium payments paid to the MCOs for months subsequent to the enrollee's month of death that were not voided by the MCOs as part of the first-level reviews. OMIG finalized 98 audits and identified more than $40 million in inappropriate premium payments paid on behalf of deceased enrollees after their date of death.

MC - Family Planning Chargeback/MCO

Federal regulation 42 CFR 431.51 permits access to family planning and reproductive services for Medicaid recipients. As a result, Medicaid managed care enrollees may receive these services from any fee-for-service (FFS) Medicaid provider, without referral or prior approval from the MCO. If the enrollee's MCO incorporates family planning and reproductive services as part of its benefit package, the Model Contract includes a chargeback provision. Under this provision, if a managed care enrollee seeks treatment from a provider outside the MCO network, the provider is compensated by Medicaid, and the

MCO agrees to reimburse Medicaid for the payments made to the non-network provider. OMIG collaborated with DOH to finalize the criteria to identify these family planning services and reconcile the claims subject to the chargeback with the MCO. OMIG conducted a reconciliation where MCOs reviewed the claims identified by OMIG to ensure they met the criteria and were not billed by one of their network providers. OMIG finalized 13 chargeback audits identifying more than $14 million in overpayments.

Any claim billed by a network provider that was removed from the MCO's chargeback liability was reviewed as part of the Family Plan Chargeback/FFS project. This project resulted in 47 finalized audits with identified overpayments of more than $1.5 million.

Foster Care

When a child is placed in agency-based foster care a per diem rate is paid to the foster care agency responsible for the child's care, and that child is no longer eligible for Medicaid managed care. Currently, there are separate upstate and downstate Welfare Management Systems (WMS), which are used for enrolling recipients in the Medicaid program. As a result of these separate systems, a child may be issued a duplicate client identification number, which creates the possibility that duplicate Medicaid payments may be made.

After the child is placed in foster care, the New York State of Health (NYSoH), LDSS, and New York City Human Resources Administration (NYC HRA) are responsible for retroactively adjusting the enrollee eligibility file, notifying OMIG of the retroactive disenrollment, and notifying the MCO to void any premium payments received when the child was in agency-based foster care for the entire payment month. OMIG then conducts a second-level review to identify instances where a child was placed in agency-based foster care for the entire payment month and the MCO did not void the premium payment. OMIG finalized 14 projects and identified overpayments of more than $17 million.

Incarceration Match

On an annual basis, OMIG conducts an incarceration match project. OMIG uses Medicaid enrollee data from the Medicaid Data Warehouse (MDW) and compares it to files provided by the NYS Department of Corrections and Community Supervision and the NYS Division of Criminal Justice Services to identify individuals who were incarcerated while also being listed on monthly Managed Care enrollee rosters. Model Contract language allows for the recovery of monthly premium payments from MCOs for enrollees listed on the monthly roster, who are determined to be incarcerated for an entire payment month. Following up on the first-level review conducted by the LDSS, OMIG has routinely conducted a second-level review to recover inappropriately paid premium payments for incarcerated Medicaid managed care enrollees. OMIG

finalized 47 incarceration match audits, identifying more than $31 million in overpayments.

Building upon an earlier project conducted by MFCU, OMIG began requesting incarceration data directly from the county jails across NYS. This data provides more detailed information, including periods of incarceration prior to sentencing, to discover additional Medicaid enrollees who may not have been previously identifiable in the NYS data alone. This additional information has the potential to positively impact the results of future reviews.

Managed Care Project Teams

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

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

Following are select highlights from the project teams:

Managed Care Network Provider Review

The Managed Care Network Provider Team finalized six OASAS provider reviews; additional audits are in various stages of the audit process. While conducting these reviews, OMIG auditors enhanced their understanding of the following:

- complexities of reviewing network providers both at the provider and plan levels;
- ensuring the validity of encounter data; and,
- the intricacies of auditing when there is a subcontractor involved with the reporting of encounters.

Managed Care Plan Review

Team members initiated on-site visits with MLTCPs to discuss program integrity-related processes and procedures. Similar to the mainstream managed care on-site visits that were completed previously, these visits are part of a coordinated

effort to gain a greater understanding of MLTCP business practices. While MLTCPs receive significantly higher capitation rates than mainstream MCOs, MLTCPs with fewer than 10,000 enrollees lack a SIU dedicated to handling issues of fraud, waste, and abuse. OMIG conducted five MLTCP on-site visits and found that the program integrity functions of the MLTCPs could be improved, and there was a low volume of referrals for fraud, waste and abuse. OMIG will use information gained from these on-sites to continue its collaboration with DOH to strengthen program integrity requirements for the MLTCPs.

Value Based Payments

OMIG's Value Based Payment (VBP) Team's mission is to determine how value-based payment systems are being implemented, identify potential areas for improvement and make recommendations to DOH to help strengthen program integrity in value-based payment systems. Since its inception, VBP Team members have participated on the VBP Workgroup, which brings MCOs and other state agencies together to discuss changes in the VBP Roadmap and effects on VBP in the future. Several divisions within DOH gave presentations on the Roadmap and changes that MCOs could expect in the coming year. OMIG's VBP Project Team will continue to monitor the progress of VBP implementation and will collaborate with DOH to develop criteria for program integrity oversight as the program grows.

Audits

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

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

Fee-For-Service Audit Activities

OMIG finalized 408 FFS audits that resulted in identified overpayments of more than $23 million. The most common audit findings were associated with documentation; specifically, missing, late or not properly authorized plans of care. These findings reinforced to providers the importance of maintaining proper documentation. These plans of care may have different titles across the various categories of service in the Medicaid program, but they form the fundamental basis for authorized Medicaid services. Below are some examples of FFS audits.

Licensed Home Care Services Agency (LHCSA)

Under the NYS Medicaid program, medically necessary nursing services may be provided to eligible individuals in their homes by Registered Nurses (RNs) or Licensed Practical Nurses (LPNs). A physician provides written orders or a letter of medical justification, then a certified home health agency or a LDSS provides a written assessment of the need for private duty nursing and authorizes a specific number of hours of care.

Nursing services are reimbursed at hourly fees not to exceed those negotiated by the LDSS, and approved by DOH, Office of Health Systems Management, and the State Budget Director. Issues identified during these audits include:

- missing service documentation;
- billing for nursing services in excess of hours authorized;
- deficiencies in the nurse's health assessment records, including lack of tuberculosis tests; and
- absence of evaluation by the agency of the nurse's performance.

OMIG finalized four audits with identified overpayments of more than $3 million.

OASAS Opioid Treatment Program

An Opioid Treatment Program (OTP) is an OASAS-certified program where methadone or other approved medications are administered to treat opioid dependency. These programs encompass medical and support services including counseling, educational, and vocational rehabilitation, and are designed to support and help treat individuals with opioid-dependency issues, in many cases by providing daily dispensing of necessary medication. If providers are not following the applicable regulations and program requirements, there is the potential for significant consequences for the very individuals relying on them for life-saving services.

OMIG's audits provide critical oversight of these very important programs. OTP services are provided in either hospital-based or free-standing settings. OMIG reviews clinical documentation to ensure OTPs are in compliance with applicable regulations. Issues identified during these audits include:

- missing or late individual treatment or recovery plan review;
- missing or late signature on an individual treatment or recovery plan review; and,
- failure to meet individual counseling requirements.

OMIG finalized one audit and identified overpayments of more than $4 million.

Electronic Health Records (EHR) Incentive Payment Program

In 2009, the United States Congress included provisions in the American Recovery and Reinvestment Act allocating approximately $19 billion in federal incentives to eligible Medicaid providers and hospitals for the adoption and meaningful use of certified electronic health record technology (CEHRT). With CMS approval, each state administers the program ensuring that the federal incentives are issued to the eligible providers enrolled in the state's Medicaid program. In NYS, this program is referred to as the NY Medicaid EHR Incentive Program, however on the federal level the official name was changed in 2018 to the Promoting Interoperability Program. The program is designed to encourage providers to replace paper-based systems with EHRs that will increase the interoperability and patients´ access to health information while reducing costs and increasing the overall efficiency of the country's healthcare system.

To receive an incentive payment in NYS, providers must attest to their eligibility through the DOH's online portal known as the Medicaid EHR Incentive Program Administrative Support Service. For providers' first year of the program they must attest to the adoption, implementation, or upgrade (AIU) of an EHR system certified by the Office of the National Coordinator for Health Information Technology. For subsequent years in the program, providers must attest to

meaningful use of a certified EHR system by meeting federal objectives and requirements.

The NY Medicaid EHR Incentive Program began paying incentives in 2011 and will end in 2021. In accordance with a CMS-approved audit strategy, OMIG's post-payment audits of providers receiving the incentive payments in NYS, will continue through the end of the federal fiscal year 2023. Where paid providers are determined ineligible for the incentive, OMIG recoups the funds and repays the federal government at 100% federal share.

To meet its audit objectives, OMIG continues to work closely with program stakeholders, such as DOH, the Regional Extension Centers – NYC Regional Electronic Adoption Center for Health (REACH), New York eHealth Collaborative (NYeC), as well as program staff from other states.

In 2019, OMIG finalized 208 audits with identified overpayments of over $3 million which was returned to the Federal Government.

Self-Disclosure

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

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

To meet these requirements, providers identify and investigate possible fraud, waste, abuse, or inappropriate payments they may have received through self-review, implementation of compliance programs, and internal controls. OMIG's self-disclosure unit finalized 307 reviews with identified overpayments of more than $12 million.

2019 Initiated Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	15	0	13	0	28
Managed Care	320	77	113	0	510
Medicaid in Education	2	1	3	0	6
Provider	340	92	103	6	541
Rate	136	15	107	0	258
Self-Disclosure	129	91	93	6	319
System Match and Recovery	157	70	75	67	369
Total	1,099	346	507	79	2,031

2019 Finalized Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	8	4	4	0	16
Managed Care	308	70	104	1	483
Medicaid in Education	0	0	1	0	1
Provider	276	62	65	5	408
Rate	57	40	37	0	134
Self-Disclosure	131	82	89	5	307
System Match and Recovery	206	117	95	75	493
Total	986	375	395	86	1,842

2019 Overpayments Identified by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	($370,454)	$389,266	($140,239)	$0	($121,427)
Managed Care	129,291,781	32,551,096	12,798,594	4,649,889	179,291,359
Medicaid in Education	0	0	23,451	0	23,451
Provider	17,942,591	2,688,968	2,748,539	59,500	23,439,598
Rate	12,011,024	2,621,642	1,058,923	0	15,691,589
Self-Disclosure	9,641,029	1,013,006	1,381,942	428	12,036,405
System Match and Recovery	2,026,937	216,548	1,174,856	638,347	4,056,688
Total	$170,542,908	$39,480,526	$19,046,066	$5,348,164	$234,417,663

2019 Overpayments Recovered by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	$3,527,642	$373,647	$232,432	$0	$4,133,721
Managed Care	132,419,956	33,882,979	14,324,055	4,649,889	185,276,879
Medicaid in Education	14,775	0	0	0	14,775
Provider	18,672,047	2,761,796	1,349,130	72,812	22,855,784
Rate	7,813,593	3,097,357	3,195,322	0	14,106,272
Self-Disclosure	10,812,916	1,194,989	2,923,690	428	14,932,023
System Match and Recovery	3,821,237	563,057	229,699	822,135	5,436,128
Total	$177,082,166	$41,873,825	$22,254,328	$5,545,264	$246,755,582

Data Mining and Technological Support

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

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

BBI processed the following requests:

- 1,625 data requests, which consisted of Medicaid FFS and managed care data extraction and analysis in support of:
  - OMIG Division of Medicaid Audit (DMA), Bureau of Compliance (BOC), and Division of Medicaid Investigations (DMI) activities;
  - System Match and Recovery audits;
  - CMS Payment Error Rate Measurement (PERM) audit;
  - CMS Healthcare Fraud Prevention Partnership (HFPP) Data Analysis and Review Committee (DARC);
  - Office of the State Comptroller audits;
  - U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) audits;
  - Unified Program Integrity Contractor (UPIC) Audits;
  - United States Department of Justice (U.S. DOJ);
  - District Attorney's Offices;
  - Department of Homeland Security;
  - Medicaid EHR Incentive Program;
  - OPWDD;
  - OMH;
  - Federal Bureau of Investigations (FBI); and
  - Self-disclosure reviews.
- 165 statistical samples created for DMA audits and DMI investigations, including:
  - County Demonstration audits;
  - UPIC audits;
  - Self-disclosure reviews;
  - Medicaid EHR Incentive Program audits; and
  - Dental reviews.

Positive Provider Reports

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

Audit Summations	
Audit Department	**2019**
County Demonstration Program	11
Medicaid in Education	8
Provider	284
Rate	214
Total	517

Third-Party Liability

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

Medicaid Recovery Audit Contractor

Pursuant to the federal requirement under ACA, OMIG engaged a Recovery Audit Contractor (RAC) to supplement the agency's Medicaid program integrity efforts. The RAC's mission is to: reduce improper payments through the efficient detection and collection of overpayments; to report suspected fraudulent and/or criminal activities; and implement actions that will prevent future improper payments. Utilizing data mining to identify improper payments and working with providers to recover any overpayments helps to dissuade providers from submitting future improper claims. OMIG recovered more than $67 million in overpayments as a result of these efforts, which was $14.9 million more than in 2018. In addition to the increase in recoveries, the efforts of the RAC prevented additional improper payments.

Casualty and Estate Project

SOS §369 gives the State the authority to make recoveries from estates and personal injury actions. Recovery of Medicaid funds from casualty and estate settlements are performed by OMIG's contractor, Health Management Systems' (HMS), as part of third-party retroactive recovery projects.

Casualty recoveries are made when a Medicaid recipient is injured, receives a settlement as a result of that sustained injury, and Medicaid paid for the treatment of injuries. Any amounts paid by Medicaid are then subject to recovery by the State from those settlement funds. When a Medicaid recipient passes away, the estate and any assets owned by the recipient are subject to recovery for Medicaid expenses for services provided prior to the recipient's death.

HMS uses a variety of sources to identify casualty and estate cases including contacts with the LDSS, County Surrogate's court filings, as well as numerous files and referrals from other state and public entities.

The recoveries for the Casualty and Estate project increased by $13 million from $105 million in 2018 to $118 million in 2019. The increase can be attributed to multiple areas of program and process improvements identified by OMIG and HMS collaboratively. HMS focused on streamlining their casework and review process, enhancing quality assurance, and increasing database reporting functionality. These additions and

improvements reduced turnaround times resulting in more timely and increased recoveries.

OMIG and HMS increased education and outreach to LDSS regarding the Casualty & Estate program. Webinars were held with LDSS on county specific issues, as well as general information regarding the database system utilized by HMS to track casework. OMIG implemented a new process utilizing caseworkers designated to counties in order to facilitate regular dissemination of information between the counties and HMS. Additionally, HMS utilized their experience and large network of contacts to increase outreach to attorneys, the bar association, and the court systems statewide. Bringing more awareness of the program and processes has led to an increase in referrals and efficiency in the flow of information utilized by HMS to recoup Medicaid funds for both casualty and estate cases.

2019 Third-Party Liability and RAC Recoveries	
Activity Area	**Amount**
Casualty & Estate	**$118,626,318**
Third-Party Liability	**97,057,023**
Recovery Audit Contractor	**67,518,058**
Home Health Care Medicare Maximization Project	**21,074,286**
Self-Disclosed TP Health Insurance	**1,313,799**
Total	**$305,589,484**

Investigations

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

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

Pharmacy Investigation

In March 2019, in Manhattan Supreme Court, the NYS Attorney General MFCU announced an owner of three NYC-based pharmacies pled guilty to Grand Larceny and was sentenced to two to six years in state prison, as well as being required to forfeit more than $3.6 million in restitution to Medicaid. The owner paid kickbacks to have HIV prescriptions filled at her pharmacies and billed for medication that was never actually provided. During the investigation, MFCU requested the services and expertise of OMIG's pharmacy consultants who examined and assisted in the seizure of various drugs. MFCU investigators sought and obtained an additional search warrant for a second location. OMIG assisted with cataloging the drugs that had been seized at the additional site. OMIG excluded the owner and the three pharmacies from the Medicaid program in 2017.

Recipient Fraud Investigations

The Recipient Investigations Unit (RIU) is OMIG's single point of contact for all Statewide Medicaid eligibility and prescription drug diversion investigations. The RIU conducts investigations generated from complaints and referrals from the general public, as well as other state, federal and local governmental and law enforcement agencies. The RIU also conducts investigations as a result of internal data mining and data analysis. The RIU coordinates with LDSS, NYSoH, and local, county, state, and federal law enforcement and regulatory agencies to advance the integrity of the Medicaid program. Outcomes of these investigations include prosecution, fiscal recovery, or other administrative actions.

Recipient Fraud Investigation with Erie County

OMIG received an anonymous complaint alleging that a Medicaid recipient was concealing her actual residential address. During the investigation, it was found

that the recipient failed to report the correct number of people living in the household and income of the household members, which would have made the recipient ineligible for benefits. OMIG's made a referral to the Erie County District Attorney's (DA) office and this investigation concluded with a prosecution of the recipient. In February 2019, the recipient was charged with Grand Larceny in the Third Degree, Welfare Fraud in the Third Degree and two counts of Offering a False Instrument for Filing in the First Degree, all felonies. As a result of the misrepresentation, the recipient received $17,687 in Medicaid benefits and $14,966 in Supplemental Nutrition Assistance from July 2013 through October 2017, to which they were not entitled. In August 2019, the recipient pleaded guilty to Welfare Fraud in the Fourth Degree, a Class E misdemeanor, signed a Confession of Judgment, and entered into a repayment agreement with LDSS for full restitution with ordered probation supervision.

Investigations with Suffolk County

OMIG participated in a joint investigation with Suffolk County LDSS Special Investigations Unit. The investigation substantiated concealment of income allegations against a NYS Medicaid recipient, proving that the recipient concealed their true earnings from July 1, 2018 through July 25, 2019. If reported, it would have made them ineligible to receive Medicaid benefits. In November 2019, the recipient requested and entered into a voluntary repayment agreement to repay Medicaid for any expenditures made on their behalf, totaling $7,735.

In a second investigation, OMIG was contacted by the Suffolk County LDSS and notified that the Suffolk County DA's office was interested in pursuing charges against a recipient for Medicaid Recipient Fraud. OMIG assisted in the investigation by confirming the recipient was an owner of a transportation company and provided additional income documentation proving the recipient received income from the NYS Medicaid program through the transportation company. On June 26, 2019, the recipient was sentenced to three to six years of incarceration for Welfare Fraud in the Second Degree, a class C felony, for misrepresenting his income on Medicaid recipient applications to the Suffolk County LDSS. Additionally, a restitution judgment order was filed for $200,000.

Consumer Directed Personal Assistance Program and Recipient Investigation

OMIG received an anonymous complaint alleging that a Medicaid recipient was not reporting income and was also receiving services in the Consumer Directed Personal Assistance Program (CDPAP) while being cared for by his wife, a violation of CDPAP rules because a spouse is not permitted to provide services. A joint investigation by OMIG and Suffolk County LDSS revealed that the recipient was working and failed to report all income sources. The case was referred to the Suffolk County DA's office. In November 2019, the recipient pled

guilty to Welfare Fraud in the Fifth Degree, a Class A misdemeanor, in violation of New York State Penal Law § 158.05. The recipient was sentenced to a conditional discharge and a restitution judgment order, totaling $290,037.

Explanation of Medicaid Benefits

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

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

High-Cost Prescriptions

The EOMB Unit targeted high-cost drugs, including doxepin 5% cream. Doxepin is an expensive cream indicated for short-term use only, typically up to eight days. One pharmacy had a high number of refills for this drug, which is unusual due to the potential psychotropic side effects of the cream. Some reasons that EOMBs were returned included:

- a prescription was refilled for a recipient who passed away three months prior;
- recipients picked up the first prescription and did not pick up the refills that were billed; and,
- recipients who never received or were prescribed the medication.

Based on 29 EOMBs received with allegations, this provider was referred to HHS-OIG.

Optician Investigation

OMIG began an investigation of an optician after receiving a complaint from a Medicaid recipient alleging the provider charged the recipient for services not received. OMIG sent out 301 EOMBs to recipients of the provider and received 79 EOMBs containing additional allegations. Examples of allegations received include the following:

- not knowing who the doctor was;
- not having used this optician;
- not having or wearing bifocals;
- not having received any of the services listed; and
- not having new glasses in years.

OMIG investigators confirmed a sample of these allegations by conducting face-to-face interviews with a selection of the recipients. Due to these findings, OMIG referred the provider to the NYS Office of Professional Discipline (OPD). OPD charged the provider with fraudulently practicing the profession of Ophthalmic Dispensing due to the fact that the provider submitted numerous claims to Medicaid for reimbursement for services that were never performed. The optician surrendered his license and was excluded from the NYS Medicaid program in January 2019.

Summary of Investigations by Source of Allegation and Region

Initial Source	Downstate		Upstate		Out of State		Totals	
	Opened	Completed	Opened	Completed	Opened	Completed	Opened	Completed
Anonymous	213	197	114	138	0	1	327	336
District Attorneys	5	40	1	0	0	0	6	40
EOMB	48	15	41	16	0	0	89	31
Enrolled Recipients	84	73	22	30	3	4	109	107
Federal Agencies	61	47	11	14	2	1	74	62
General Public	183	178	118	118	6	6	307	302
LDSS	7	15	29	56	0	0	36	71
Managed Care Plans	171	118	85	143	20	18	276	279
Managed Long-Term Care Plans	170	139	14	28	0	0	184	167
Non-Enrolled Providers	0	1	0	0	0	0	0	1
Non-Enrolled Recipients	12	12	4	5	0	0	16	17
Providers	65	107	51	56	2	2	118	165
State Agencies (including OMIG)	573	524	665	540	254	76	1,492	1,140
UPIC	9	0	0	0	0	0	9	0
Total	1,601	1,466	1,155	1,144	287	108	3,043	2,718

Program Integrity Referrals to MFCU and Other Agencies

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

Referrals to MFCU	
Provider Type	**2019**
Capitation Provider	2
Child Care Institution	1
Clinical Psychologist	1
Clinical Social Worker (CSW)	2
Consumer Directed Aide	22
Dentist	5
Diagnostic and Treatment Center	2
Home Health Agency	12
Home Health Aide	3
Laboratory	4
Long Term Care Facility	2
Medical Appliance Dealer	4
Multi-Type	4
Multi-Type Group	1
Non-Enrolled Provider	33
Nurse	7
Owner	1
Pharmacy	27
Physician	28
Physicians Group	7
Podiatrist	1
Social Adult Day Care	3
Therapist	1
Transportation	33
Total	**206**

Referrals to Other Agencies	
Agency	**2019**
AG - Not MFCU	7
Internal Revenue Service	1
Law Enforcement Agency	55
LDSS	44
Local District Attorney	15
Local Municipality	3
MAS-Medical Answering Service	4
NYC Department for the Aging	1
NYC Department of Health	3
NYC HRA Bureau of Client Fraud Investigations	71
NYC Office of the Special Narcotics Prosecutor	5
NYS Bureau of Narcotic Enforcement	3
NYS Department of Environmental Conservation	1
NYS Department of Health	159
NYS Department of Justice	21
NYS DOH Office of Professional Medical Conduct	20
NYSED – Not Professional Discipline	10
NYSED – Office of Professional Discipline	112
NYS Justice Center	2
Out of State	1
UPIC	4
US Attorney	13
US Health and Human Services (HHS-OIG)	7
Total	**562**

2019 Recoveries

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

2019 Recoveries	
Activity Area	**Amount**
Managed Care	$185,276,879
Casualty & Estate	118,626,318
Third-Party Liability	97,057,023
Recovery Audit Contractor	67,518,058
Provider	22,855,784
Home Health Care Medicare Maximization Project	21,074,286
Self-Disclosure	14,932,023
Rate	14,106,272
System Match and Recovery	5,436,128
County Demonstration Program	4,133,721
Self-Disclosed TP Health Insurance	1,313,799
Medicaid in Education	14,775
Investigation Financial Activities	(89,072)
Total	$552,255,994

Cost Savings

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

OMIG utilizes an internal workgroup of cross-divisional staff to develop, review, and approve its cost savings methodologies. This team reviews all cost savings initiatives on an ongoing basis to identify and assess variations in the savings amounts reported. Variations can occur naturally over time for any of OMIG's initiatives, and the workgroup ensures that methodologies are being reviewed on a timely basis and updated as needed. As a result of these proactive efforts, OMIG saved NYS taxpayers more than $2.3 billion. Some examples of these activities are outlined below.

Pre-Payment Insurance Verification

OMIG's third-party liability contractor, HMS, performs pre-payment insurance verification (PPIV) services and third-party retroactive recovery projects. For this project, HMS identifies and loads new third-party health insurance segments to the MMIS, establishing Medicaid as the payor of last resort to make sure the appropriate insurer will be billed first. PPIV cost avoidance for 2019 was more than $2.2 billion, an increase of over $224 million from calendar year 2018. The increase can be attributed in part to:

- Expanding the scope period from 6 months to 12 months to look for overlapping insurance coverage.
- Streamlining verification methods enabled HMS to clear up a large backlog of PBM manual verifications by switching to an automated process.
- Making general process improvements to HMS' system logic allowed them to select and process more records. This enhancement links Medicaid members to corresponding TPHI, allowing for more matches to be made, leading to additional cost savings.

At the end of 2019, OMIG agreed to increase the number of weekly records from 20,000 to 25,000 allowing HMS to deliver additional segments. The results of this change will be reflected in the cost avoidance reported in 2020.

Exclusion Cost Savings

OMIG issued 706 notices excluding individuals and entities from the NYS Medicaid program resulting in the removal of undesirable providers and significant cost savings. OMIG calculates cost savings for those excluded providers that had previously been enrolled and billing as FFS providers in the program.

In addition to the actions taken by OMIG based on unacceptable practices discovered during investigations or audits of providers, there are derivative actions that originate from other agencies including OPD, OPMC, HHS-OIG and MFCU. OMIG also searches the internet for press releases and articles that identify providers that have been arrested or convicted of health care related crimes. OMIG then contacts the appropriate court to obtain the pertinent documents to take administrative action against the provider. Cost savings are counted as Exclusion/Terminations - External, if the administrative action is a result of an outside agency/source. However, if the administrative action is a result of an OMIG investigation and/or referral to one of its partners, it's counted as Exclusion/Terminations - Internal.

Recipient Medicaid MC Benefits

OMIG staff collaborated with the newly established Consumer Investigations Unit (CIU) within DOH. The meeting was set up to establish and reinforce OMIG's referral processes and methods of working collaboratively to close Medicaid benefits when an investigation revealed fraudulent activity. Additionally, the discussion covered DOH's responsibilities in closing a Medicaid benefit, and what actions OMIG could take to streamline the process. OMIG and DOH established direct contacts to refer cases and will continue to refer investigative findings to this new unit. The CIU will also send referrals to OMIG when they suspect fraudulent activity. Our collaboration with CIU ensures that benefits are closed when our investigation is completed which are then counted on our cost savings initiative. Cost Savings associated with these closed benefits were more than $650,000.

2019 Cost Savings Activities	
Activity Area	**Amount**
Dental Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	$748,689
Enrollment and Reinstatement Denials	35,560,417
Exclusions/Terminations – Internal	5,344,344
Exclusions/Terminations – External	4,896,806
Medical Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	3,604,825
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	11,912,408
Pre-Payment Insurance Verification Commercial	1,806,109,807
Pre-Payment Insurance Verification Medicare	402,418,357
Recipient Medicaid MC Benefits - Case Closures for False Information	650,607
Recipient Restriction	93,926,493
Total	$2,365,172,753

OMIG Collaborations and Outreach

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

HFPP Executive Board and Leadership Forum

OMIG attended the Health Care Fraud Prevention Partnership (HFPP) Executive Board and Leadership Forum held in Washington, DC in September 2019. HFPP was established in 2012 to conduct nationwide studies of providers to identify trends and patterns of abusive billing practices. OMIG has been an active participant in HFPP since 2015. HFPP was created based on a Government Accountability Office recommendation to CMS to develop a vulnerability analysis process throughout the industry to get ahead of the "pay-and-chase" approach. Currently, there are 170 partners in HFPP. The September 2019 Executive Board and Leadership Forum was held to update executive staff on the successes and future initiatives of HFPP. The Executive Board Meetings are facilitated by CMS and are generally attended by MCO's, CMS, DOJ, Department of Labor, Coalition Against Insurance Fraud, and other federal agencies. As a result of its ongoing involvement with HFPP, OMIG received a personal invitation to attend the September 2019 meeting.

Medicaid Integrity Institute

In September 2019, OMIG staff attended the "Program Integrity in Medicaid Managed Care" seminar at the Medicaid Integrity Institute (MII) in Columbia, South Carolina. MII was developed by the CMS in collaboration with the U.S. DOJ, Office of Legal Education to meet the training and education needs of state Medicaid program integrity employees. OMIG presented to the participants on managed care program integrity efforts and the many different initiatives put into place to enhance working relationships with the MCOs. Some of the initiatives discussed were:

- Function of the designated SIU liaisons as the single point of contact;
- Enhance communication in regard to fraud referrals; and
- Quarterly meetings held with the MCO SIUs.

Wage Parity Reviews

The NYS wage parity law, PHL § 3614–c, requires employers within Suffolk, Westchester, and Nassau counties and New York City to comply with established levels of total compensation for home care workers. Wage parity increases are funded through the Medicaid rates, and the law prohibits Medicaid payment for any episode of care furnished by a home care aide who is compensated at a rate less than the minimums established within the law. OMIG continues to work in collaboration with the NYS Department of Labor (DOL) to conduct wage parity reviews of LHCSA.

The purpose of the OMIG review has been to analyze a sample of employees and determine if those employees received total compensation as defined under wage parity law. Completed reviews are referred to DOL for further investigation and to enforce the statutory wage requirements when providers are not paying home care workers in compliance with wage parity parameters. OMIG concluded nine reviews which were referred to DOL. Each referral included a detailed summary of OMIG's initial findings to assist DOL when conducting their audit. DOL completed an audit resulting from an OMIG referral with more than $210,000 identified by DOL in audit findings.

Administrative Actions

Sanctions – Exclusions

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

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

OMIG issued 706 exclusions and 133 censures. The NYS Medicaid Exclusion List contains 7,313 Medicaid and non-Medicaid provider exclusions. This list is updated daily (except holidays and weekends) and is available to the public on OMIG's website, www.omig.ny.gov.

Exclusions	
Reasons for Exclusions	Number of Actions
Affiliations – 18 NYCRR 504.1(d)(1)	81
Unacceptable Practice – 18 NYCRR 515.2	5
Indictments – 18 NYCRR 515.7(b)	92
Convictions – 18 NYCRR 515.7(c)	176
Imminent Danger – 18 NYCRR 515.7(d)	3
Professional Misconduct – 18 NYCRR 515.7(e)	157
Mandatory Exclusion – 18 NYCRR 515.8	192
Grand Total	706

Conclusion

OMIG appreciates the opportunity to share the results of its Medicaid program integrity activities for 2019. OMIG's provider education and outreach programs, coupled with its comprehensive audit and investigative efforts, and success in identifying and recovering inappropriate Medicaid payments, play a vital role in preventing and detecting Medicaid fraud and abuse, while promoting the delivery of high-quality care to millions of New Yorkers. OMIG's commitment to preventing, detecting, and rooting out fraud and abuse in the Medicaid program remains unwavering.

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