NEW YORK STATE | Office of the Medicaid Inspector General

2020 ANNUAL REPORT

KATHY HOCHUL
GOVERNOR

FRANK T. WALSH, JR.
ACTING MEDICAID INSPECTOR GENERAL

Message from the Acting Medicaid Inspector General

I am pleased to share the New York State Office of the Medicaid Inspector General's (OMIG) 2020 Annual Report. OMIG plays a vital role in New York's comprehensive health care delivery system by rooting out Medicaid fraud, waste, and abuse, promoting efficient high-quality patient care, and preserving precious health care resources to maintain access to high-quality services for Medicaid recipients throughout the State.

In 2020, COVID-19 presented unprecedented challenges to the State and the provider community. Every facet of the healthcare delivery system, business and economic sectors, and the daily lives of each and every New Yorker was impacted.

As the following report details, OMIG rose to the challenge to both meet its mission and obligation to protect the integrity of the Medicaid program generating over $3 billion in Medicaid recoveries and cost savings, while reinventing procedures for a remote working environment and working collaboratively to avoid unnecessary burdens for health care providers and recipients to ensure that essential health services continued to address the critical needs of New Yorkers.

I am also honored to recognize the significant contributions of many OMIG staff who volunteered their time and talents to support and improve various critical initiatives associated with New York's response to the COVID-19 pandemic.

On behalf of all the staff at OMIG, the agency looks forward to continuing to work collaboratively with all partners and stakeholders and build upon the lessons learned over 2020 to continue to protect the integrity of the Medicaid program.

Sincerely,

Frank T. Walsh, Jr.
Acting Medicaid Inspector General

History and Authority

On July 26, 2006, Chapter 442 of the Laws of 2006 was enacted, establishing OMIG as an independent office. The legislation amended the New York State (NYS) 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, investigations, 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

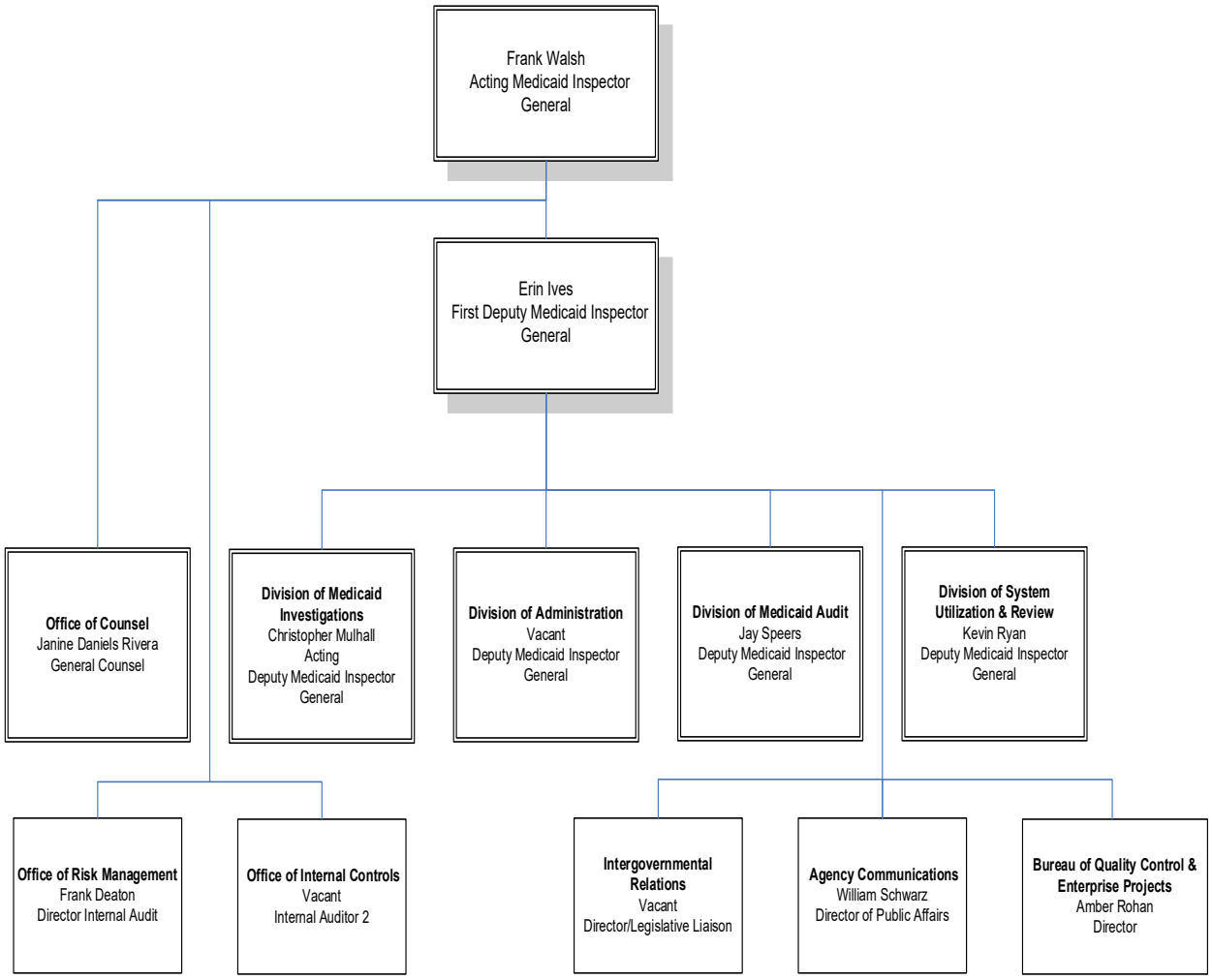
The mission of OMIG is to enhance the integrity of the NYS Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds, while promoting high quality patient care.

Annual Reporting

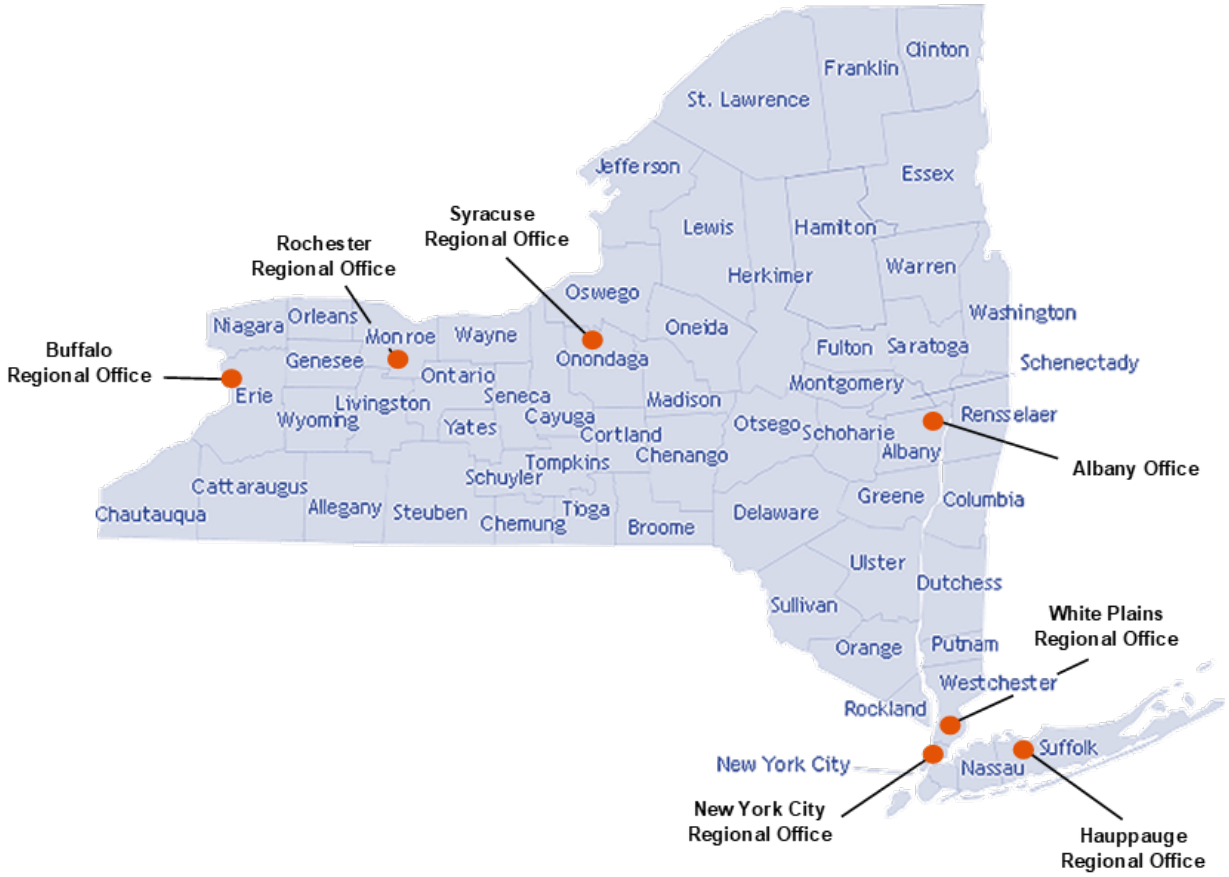
As required by NYS Public Health Law (PBH) §35(1), OMIG must annually submit a report summarizing the activities of the agency for the prior calendar year. This Annual Report includes information about audits, investigations, and administrative actions, initiated and completed by OMIG, as well as other 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 not complied with program requirements or 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 and may be larger than the amounts identified during the reporting period. Identified overpayments and recovery amounts reflect total dollars owed to the Medicaid program, as well as adjustments related to hearing decisions, and stipulations of settlement.

Executive Organization Chart



Regional Office Locations and Staffing



OMIG has 398 full-time equivalent staff working on Medicaid program integrity functions throughout the agency. These positions include auditors, investigators, nurses, data analysts, pharmacists, other clinical / medical professionals, program administrators/managers, and persons providing legal, technological, and clerical support. OMIG has offices across the state located and staffed as follows:

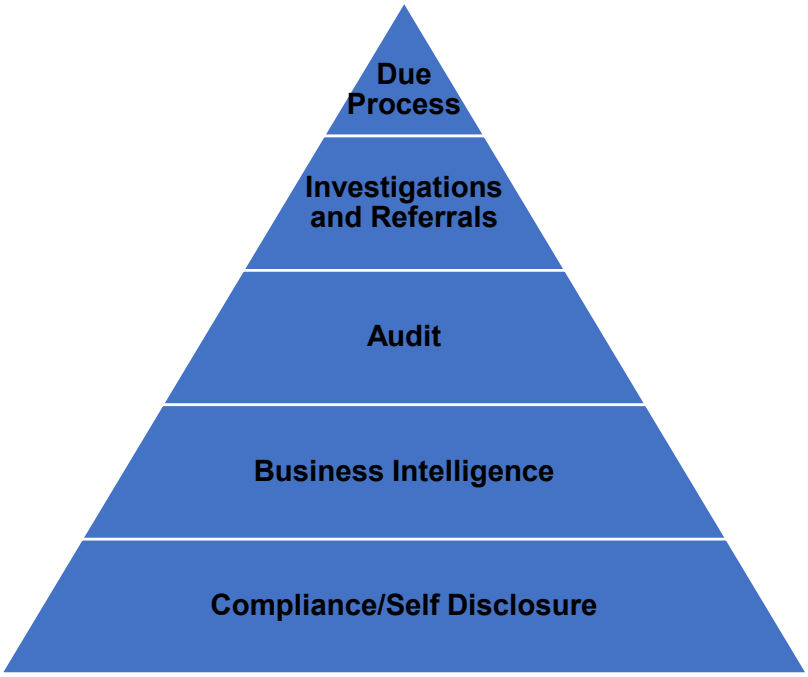
- Albany 239
- New York City 73
- White Plains 24
- Buffalo 20
- Hauppauge 17
- Rochester 13
- Syracuse 12

Agency Highlights

OMIG is an independent agency responsible for the enhancement and protection of Medicaid program integrity statewide, the promotion of efficient and high-quality health care service delivery, and the preservation of resources and support for the continued provision of critical health care services to over 7 million Medicaid recipients.

In realizing these objectives, OMIG actively seeks to:

- Understand, promote, and advise upon Medicaid policies and procedures that advance or detract from program integrity objectives.
- Closely coordinate with New York State Department of Health (DOH) and other state agencies involved in the Medicaid program to identify their priorities and objectives and develop enforcement strategies that align with these priorities and objectives.



- Educate and collaborate with Medicaid providers and payers, including Managed Care Organizations (MCO), to improve their understanding and compliance with current Medicaid requirements and to tailor OMIG activities to minimize disruption.
- Monitor, identify and evaluate aberrant fiscal or programmatic trends and prioritize those that merit investigation or audit.
- Partner with and support other Federal, State, and local law enforcement and governmental agencies to identify inappropriate practices and enforce Medicaid rules and requirements.
- Cooperate, comment, and conduct appropriate follow-up actions, including the recovery of identified Medicaid overpayments, resulting from external audits of the NYS Medicaid program.
- Conduct audits in identified areas to assess provider compliance with Medicaid program and reimbursement practices to ensure that Medicaid recipients have access to quality medical services and that services are delivered efficiently. Where appropriate, OMIG publishes audit protocols in advance that are created in conjunction with the relevant state agencies and the provider community.

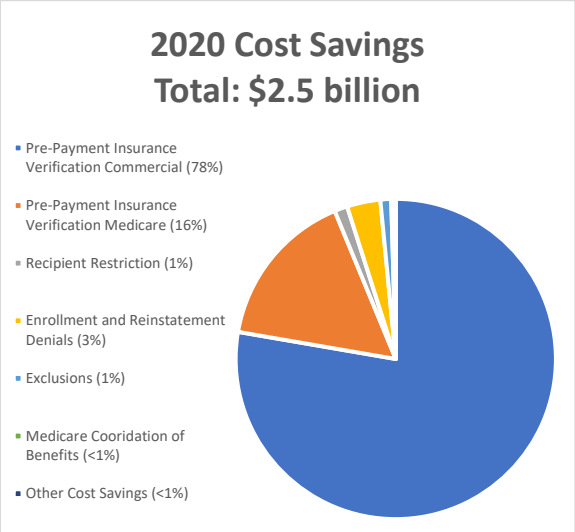
- Respond to allegations of fraud, waste, and abuse within the Medicaid program, initiate investigations of providers or recipients and take appropriate enforcement actions, including censure, exclusion, recipient restriction, or pre-payment review. OMIG also coordinates activities with the Special Investigation Units (SIU) of Medicaid managed care providers which strengthens program integrity and increases the numbers of referrals to OMIG.
- Referral of credible allegations or identified instances of fraud to the NYS Attorney General's Medicaid Fraud and Control Unit (MFCU) for review, recovery, and potential prosecution. OMIG works closely with MFCU to identify and analyze trends while safeguarding that activities undertaken do not conflict with MFCU activities.
- Promote and provide opportunities for due process in the course of OMIG audits, investigations and reviews, and associated final agency actions. Defend final agency actions at administrative hearing or Article 78 judicial proceeding.

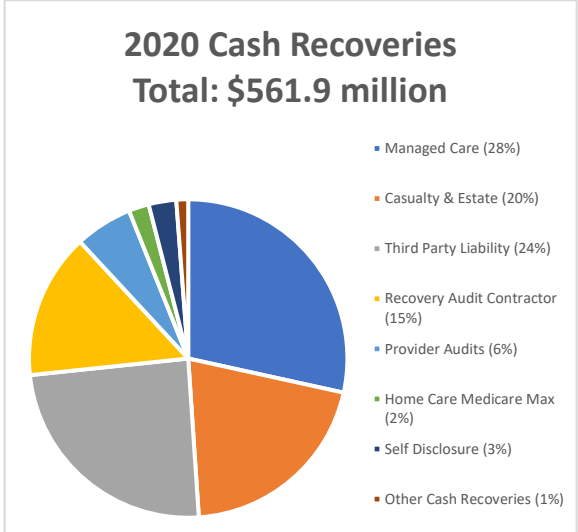
2020 Performance by the Numbers

OMIG uses a variety of techniques to ensure the appropriateness of Medicaid payments and promote program integrity. These techniques allow for the denial or limitation of inappropriate provider claims or recipient activities, the recovery of Medicaid overpayments through investigations, audits, casualty or estate settlements, and the identification of third-party health insurance and payors. OMIG also oversees and enforces providers' obligations to timely self-disclose Medicaid overpayments, as required by Federal and State laws and regulations.

New York consistently ranks among the national leaders in the advancement of Medicaid program integrity initiatives.

In 2020, OMIG activities resulted in Medicaid cost savings and recoveries totaling more than $3 billion ($2.5 billion and $562 million, respectively). Despite the impact of the COVID-19 pandemic, OMIG was able to keep pace and improve its cost savings and recoveries by nearly $100 million, or three percent (3%) over the prior year without unnecessarily impacting providers or the availability of critical health care services and supports.





In 2020, OMIG staff also:

- Conducted hundreds of meetings with DOH and other State agency staff
- Participated in 15 presentations and meetings with provider associations and individual Medicaid providers to provide guidance or respond to questions
- Responded to nearly 2,300 data requests that involved over 31,000 queries of Medicaid data systems
- Initiated 1,457 audits (1 under the County Demonstration Program)
- Finalized 1,240 audits (5 under the County Demonstration Program)
- Received over 2,800 allegations of Medicaid fraud
- Opened 2,477 investigations
- Completed 2,001 investigations
- Referred 87 cases to MFCU
- Effectuated 74 stipulations
- Participated in 38 administrative hearings, of which 29 were remote via WebEx
- Received final decisions in 22 administrative hearings

Impact of the COVID-19 Pandemic

The COVID-19 pandemic has impacted every sector of New York's healthcare delivery system. As the initial epicenter of the crisis, the State's health providers faced unprecedented challenges in 2020. These challenges profoundly affected our daily lives and business operations.

As part of New York's collective response, OMIG recognized the urgency to adapt its processes and operations to ensure continuation of the agency's critical work. At the same time, understood the unparalleled complications - fiscal, health and safety, and others - COVID imposed upon the provider community. Throughout 2020, OMIG worked closely with individual providers, associations, and other stakeholders to share information, establish mutually agreed upon timeframes and practices related to audits, and proactively address emerging issues and concerns.

To this end, to protect the health and safety of OMIG staff, the provider community and recipients, the agency conducted audits remotely, utilizing the latest technology to share information and documentation electronically. Additionally, OMIG equipped staff with the necessary resources to perform agency functions remotely. OMIG also deferred lower priority activities to avoid placing unnecessary burden on providers that were dealing with emergent needs, that could impact access to critical health care services and supports, or adversely impacting recipients or their families.

The implications of these business decisions for OMIG were mixed. Despite the temporary interruption of certain activities and the associated recoveries of Medicaid overpayments, OMIG total cost savings and recoveries exceeded $3 billion, which was in-line with the prior year. In addition, these efforts strengthened the relationship with Medicaid providers and inspired process improvements that are expected to improve operations over the long-term.

It is also important to note the impressive efforts of the many OMIG staff who volunteered their time and expertise to support and improve the wide range of critical initiatives the State implemented to battle the pandemic and help New York build back better. These volunteer efforts were in support of initiatives coordinated by the DOH, and the Department of Labor. Over 160 OMIG employees -- nearly half of the agency personnel -- participated in volunteer efforts including an unemployment insurance project, a COVID-19 data entry project, and the vaccination Point of Distribution project.

Throughout 2020, OMIG's efforts resulted in achieving two key objectives – first, protect the integrity of the Medicaid program, and second, maintain open communications and flexibility with program stakeholders to avoid imposing unnecessary burdens on a health care delivery system under siege by the COVID-19 virus.

More detailed information regarding the OMIG's efforts in response to the COVID-19 pandemic follows:

- OMIG held meetings with the provider community throughout the pandemic to communicate any changes to its processes and responded to any concerns that were raised.

- OMIG pivoted its audit activities to a remote setting and were flexible in giving providers additional time to respond to document requests, and temporarily paused non-urgent audit activities in regions when there were increases in positivity rates so that providers could address these emergent issues.

- OMIG directed its Recovery Audit Contractor (RAC) to suspend audits of nursing homes and other long term care facilities. These providers were working under extreme conditions and OMIG took steps to alleviate the additional burden of Medicaid audits during this time.

- OMIG directed its Casualty and Estate (C&E) contractor to pause efforts to collect from the estates of deceased nursing home patients.

- OMIG monitored COVID-19 related expenditures in real time to assist in identifying potentially fraudulent activity.

- OMIG received and processed 33 requests from providers concerning financial hardship. In response, in 2021, OMIG developed and implemented a new financial hardship process that affords providers the opportunity to apply for relief in the event an OMIG audit may pose a financial hardship to the organization. Financial hardship information is posted on OMIG's website at: https://omig.ny.gov/information-resources/financial-hardship-application-information.

- OMIG fully automated its Restricted Recipient Program (RRP) for a remote environment. Process improvements were instituted throughout the entirety of the review and restriction implementation process. This enabled monitoring to ensure key health care services continued during the pandemic.

- OMIG adjusted its process and began conducting Credential Verification Reviews (CVRs) remotely and through electronic exchange of information (e.g., photographs and scanned documentation).

MRT II 2020 HIGHLIGHTS

- Several Projects are being worked in collaboration with DOH
- MMCOR Penalty project fully implemented in 2020

In response to Medicaid program fiscal trends, former Governor Andrew Cuomo reconstituted a committee of stakeholders to find solutions that would maintain cost control within the NYS Medicaid program known as the Medicaid Redesign Team II (MRT II). Eleven of these projects address program integrity within the Medicaid system, which OMIG is responsible for implementing. Examples of these projects include expanding fraud, waste, and abuse (FWA) prevention/requirements for MCO and Managed Long-Term Care (MLTC) organizations, enhancing compliance and self-disclosure requirements, including progressive penalties to encourage performance; requiring attachment of an Explanation of Medical Benefits (EOMB) to a Medicaid claim connected with third-party health insurance (TPHI), introducing provider penalties for misstatement of facts on MCO cost reports submitted to the State, and the introduction of a home care worker unique identifier (ID) to standardize and improve oversight of home health programs. Further details are provided below.

Managed Care Fraud and Abuse Prevention

This initiative requires mainstream and MLTCs participating in Medicaid to adopt and implement policies and procedures to detect and prevent FWA. In addition, plans with more than 1,000 enrolled recipients will be required to establish a SIU. Furthermore, MCOs will be required to coordinate fraud, waste, and abuse prevention activities with OMIG and DOH.

Claim Attachments – EOB/52-8 Medicare Part C Crossover

This initiative requires providers to bill liable TPHI prior to billing Medicaid. It accomplishes this by requiring providers to attach an EOMB from third-party payors when submitting claims to the Medicaid program. The implementation team met with representatives from other state Medicaid programs who instituted similar requirements to discuss approaches and lessons learned. Working with the DOH systems group and stakeholders, the implementation team provided Global Dynamics Information Technology (GDIT) with the system needs for this project to facilitate full implementation.

Compliance Programs

Social Services Law (SOS) § 363-d requires providers, who meet certain criteria established by OMIG and DOH, to adopt and implement effective compliance programs. These requirements are further defined in 18 New York Codes, Rules, and Regulations (NYCRR) Part 521. Until the NYS statute was updated in 2020, the requirements

defined in SOS § 363-d differed from the federal requirements for the establishment of compliance programs. This MRT II initiative will result in corresponding changes needing to be made in regulations, policy, and guidance. The amendment also includes a monetary penalty for any required provider that fails to adopt and implement an effective compliance program that satisfactorily meets the requirements of SOS § 363-d. In 2020, the implementation team:

- successfully completed the transition of the annual compliance program certification from the OMIG website to the DOH Employer Tax Identification Number (ETIN) form and annual provider billing certification, and

- identified Article 16 and 31 of the NYS Mental Hygiene Law, and Article 28 and Article 36 of the NYS Public Health Law providers who are required to have a compliance program under SOS § 363-d. This was a collaborative effort with partners at DOH, Office of Mental Health (OMH), NYS Office for People with Developmental Disabilities (OPWDD), and NYS Office of Addiction Services and Supports (OASAS).

Monetary Penalties

SOS § 145-b(4) permits the imposition of monetary penalties for specific conduct related to fraud and abuse under the Medicaid program. For example, submitting claims for medically improper services or for services which were not rendered. The procedures for imposing penalties are established in 18 NYCRR Part 516. This MRT II initiative updates the statute and makes conforming changes to the regulation. In 2020, OMIG revised 18 NYCRR Part 516 to reflect changes made to SOS § 145-b(4). The revised regulation was published in the State Register on October 21, 2020.

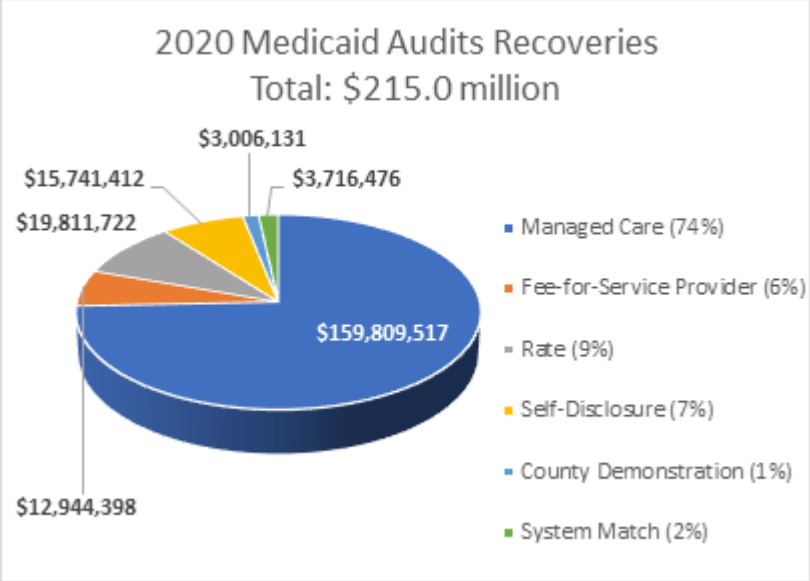
Medicaid Managed Care Operating Report Penalties

This initiative created a penalty for MCOs that submit cost reports containing misstatements of fact, which may result in inflated capitation rates paid to the MCOs. In 2020, OMIG revised 18 NYCRR Part 516 to reflect changes made to SOS § 364-j (38). The revised regulation was published in the State Register on October 21, 2020 and this initiative was considered fully implemented in November 2020.

Home Care Worker Unique Identifier

This initiative requires aides (including home health, personal care, and consumer directed personal assistance program) to register in NYS and to obtain a unique State identifier to be included on claims and encounters submitted to the NYS Medicaid program. Working with DOH systems group and stakeholders, OMIG provided GDIT with the system needs for the implementation of the project.

OMIG conducts audits of Medicaid expenditures across all provider and payer types, including MCOs, hospitals, clinics, nursing homes, home health, assisted living, and medical practitioners. The purpose of these audits is to assess provider compliance with Medicaid program integrity statutes, DOH, or other relevant State agency regulations and guidance. Where appropriate, OMIG publishes protocols created in conjunction with the relevant State agencies and the provider community. Audits are performed to ensure that Medicaid recipients have appropriate access to quality medical services, that services are delivered efficiently, and that those receiving program funds adhere to the program requirements which ensures that Medicaid recipients receive services at least equal to those who have private health insurance. In 2020, OMIG audits resulted in the collection of $215 million in Medicaid overpayments.



2020 AUDIT HIGHLIGHTS

Finalized over 1,200 audits and recovered $215 million in Medicaid funding

Duplicate CIN & Different Plan Project

- $45 Million in identified overpayments and recoveries

Retroactive Disenrollment

- $67 Million in identified overpayments and recoveries

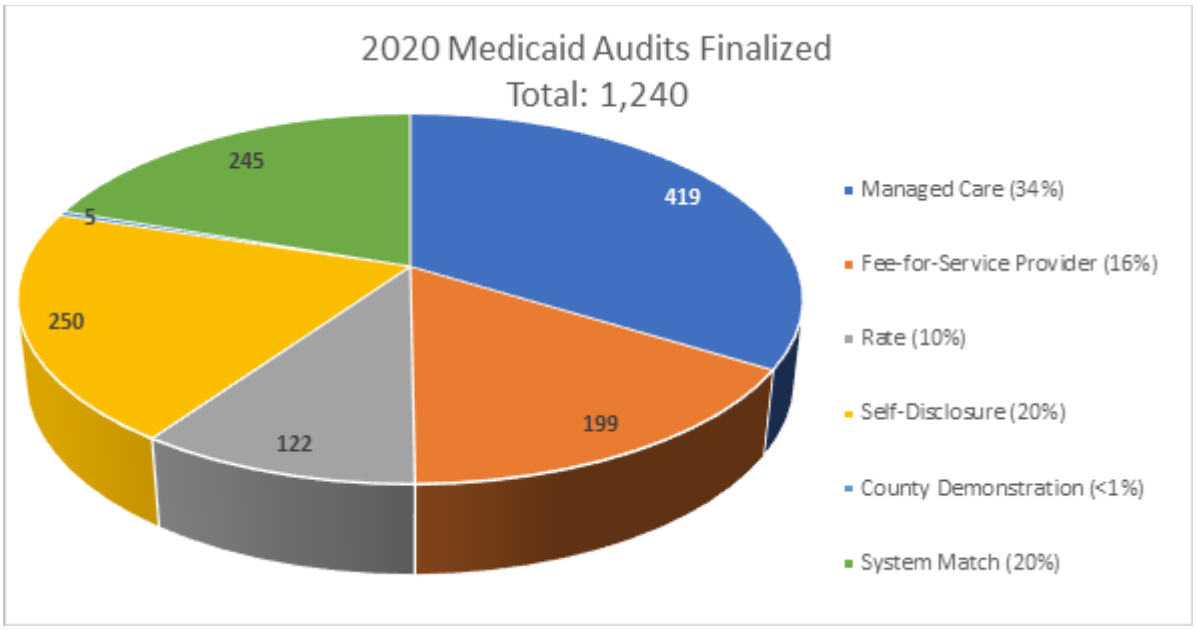
Incarceration Match Project

- $25 Million in identified overpayments and $22 Million in recoveries

Deceased Medicaid Enrollees

- $22 Million in identified overpayments and recoveries

In 2020, 1,240 audits were finalized, which includes audits that were initiated in prior years. These audits were primarily conducted by the Division of Medicaid Audit (DMA). Audits resulting from self-disclosures and system match projects are organized within OMIG's Division of System Utilization and Review (DSUR). DMA is comprised of 186 staff that are distributed among each of OMIG's seven regional office locations to address regional audit needs, with the most staff located in the Albany and New York City (NYC) offices. Consistent with Medicaid program financing trends, DMA is organized to conduct audits of MCOs and providers receiving reimbursement on a fee-for-service (FFS) basis.



DMA also responds to areas of vulnerability identified by outside agencies, such as the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG), to both validate their findings and recover identified overpayments that must be shared with the Federal government to avoid possible impact to NYS' Federal Financial Participation. OMIG performs audits of these claims to identify inaccuracies in their findings which would reduce the amount of the federal share funds that NYS would have to repay to the federal government. In 2020, this agency identified vulnerabilities in the areas of personal care services, opioid treatment programs, and assisted living programs. All these areas were subject to audit in 2020, and DMA's work will continue in these areas in 2021.

Managed Care Audits

In NYS, several types of MCOs participate in Medicaid managed care, including mainstream managed care plans, health maintenance organizations, prepaid health service plans, MLTCs, and Human Immunodeficiency Virus (HIV) Special Needs Plans. 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' SIUs to identify targets and discuss cases.

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

OMIG conducts audits and reviews to identify inappropriate payments resulting from Medicaid managed care enrollment or eligibility errors. During 2020, auditors quickly

adapted to the logistical and programmatic challenges presented by the COVID-19 pandemic, by enhancing existing projects and developing new ones.
These efforts include:

- The family planning contract provision allows members to obtain family planning services from any provider and are not limited to network providers of their Managed Care Plan. The family planning providers bill Medicaid directly on a FFS basis and OMIG reconciles with the MCO to repay the state for family planning services that are included in their benefit package. The family planning chargeback project has six criteria tables used to pull claims that pertain to family planning into a report so that the MCO can repay claims billed directly to Medicaid, by providers who do not have a contract with the MCO. The criteria tables used to pull the family planning reports had to undergo an extensive criteria revision to incorporate the transition of coding from International Classification of Diseases (ICD)-9 codes to a completely different code index of ICD-10 codes. In 2020, OMIG staff conducted extensive research to identify relevant ICD-10 codes and collaborated with DOH to ensure that the updated criteria was comprehensive and accurate. This project was implemented in 2021.

- Research and development of the Public Assistance Reporting Information System (PARIS) Interstate Match audit, which identifies individuals receiving public assistance in another state which makes them ineligible to qualify for NYS Medicaid benefits. Pursuant to Social Security Act (SSA) Section1903(r)(3), the Federal government requires states to have an eligibility determination system which provides for data matching through PARIS. OMIG is working to develop a statewide audit using PARIS data received from DOH. OMIG is also collaborating with the Office of Temporary and Disability Assistance (OTDA) to receive Electronic Benefit Transaction (EBT) data to assist in determining a member's geographic location at a specific point in time. Per discussions at the Medicaid Integrity Institute, other states have had success implementing EBT data, as it provides clarity on where a recipient is accessing their Medicaid benefits on a regular basis. This audit will be a point of emphasis in 2021.

Managed Care Enrollee Projects

OMIG also provides a significant ongoing and valuable role in validating that the list of managed care enrollees is accurate and ensuring that payments are appropriate. Given the expansion of managed care arrangements these efforts save millions of dollars for NYS and the Medicaid MCOs without disrupting the provision of services to their enrollees. Below are examples of audits that utilize these lists of enrollees.

Deceased Enrollees

OMIG routinely conducts a review to identify instances where capitation payments have been made to a Medicaid MCO for enrollees after their month of

death. The audit period is lagged approximately one year to allow local Departments of Social Services (LDSS), NYC Human Resources Administration (NYC HRA), and DOH to update deceased recipients' eligibility files. OMIG performs the final level of review of monthly capitation payments that are subsequent to a recipient's month of death. Staff detect these inappropriate capitation payments by matching Vital Statistics data to capitation payments on the Medicaid Data Warehouse (MDW), and supplement that data by identifying individuals who have a claim status indicating a death occurred or a date of death listed in their demographic data. Staff have consistently worked to improve this project to identify additional overpayments. In 2020, OMIG finalized 57 audits with identified overpayments and recoveries of more than $21.5 million.

Incarceration Match

In 2020, OMIG continued its work identifying overpayments to Medicaid MCOs for individuals who were incarcerated in state prisons and county jails. The Medicaid Managed Care Model Contract allows for the recovery of capitation payments for individuals who were incarcerated for an entire payment month because their healthcare is paid through other means. OMIG has traditionally conducted this audit and continues to incorporate incarceration data obtained directly from county jails, which was identified as an additional data source through collaboration with MFCU. This data includes pre-sentencing periods of incarceration and more accurate release dates for incarcerated individuals. In 2020, OMIG finalized 26 audits with identified overpayments of more than $25.3 million and $21.9 million in recoveries.

Multiple Client Identification Numbers (CINs) and Different Plan

OMIG continues to audit capitation and enrollment information in several managed care areas, including Medicaid recipients who have been enrolled in more than one MCOs under multiple CINs which results in the state paying multiple capitation payments for the same individual. Each recipient is assigned a CIN upon enrollment in the Medicaid program. In some cases, an individual may be assigned more than one CIN for various reasons, including human error (data entry mistakes) and enrollees moving from one of the three eligibility management systems in NYS to another. While an ongoing consolidation effort has transitioned most Medicaid managed care enrollees to the New York State of Health (NYSoH) system, the legacy eligibility systems of Welfare Management System Upstate and Welfare Management System Downstate are still in use by the LDSS to manage the eligibility of certain populations. A process exists to identify duplicate CINs across the multiple eligibility systems, but this process often only captures perfect matches (CINs where the demographic information is identical). The LDSS, NYSoH, and NYC HRA review this information and where appropriate, close the duplicate CIN. OMIG's reviews utilize a query that matches on a variety of demographic data elements to identify matches that may have been missed in the initial review due to slight variances in the detail of the two

CINs, such as the first and last name being transposed or the first name field including “Jr.” for one CIN and not the other. OMIG-identified matches are sent to the LDSS to confirm that they are indeed the same person. Once confirmed, capitation payments on the same date of service for the same person are pulled, and recovery is made on one of the duplicate payments. During 2020, OMIG’s Multiple CIN – Different Plan project finalized 37 audits with identified overpayments of more than $44.9 million and $44.6 million in recoveries.

Retroactive Disenrollment

During 2020, OMIG continued its work supporting the retroactive disenrollment process, a collaborative effort involving DOH, LDSS, NYSoH, and NYC HRA. For certain scenarios outlined in the Medicaid managed care contract, such as recipients with comprehensive third-party insurance, and per policy guidance provided by DOH, there are instances where an individual’s Medicaid managed care coverage should have ended at a point in the past. LDSS, NYSoH, and NYC HRA identify those instances and submit notification to the MCO of the individual’s retroactive disenrollment. The MCO is then required to void payments for those individuals. OMIG maintains a database of these retroactive disenrollment notifications submitted by the local districts and, in addition to tracking and reporting the voided claims submitted by the MCO in response to those notifications, conducts follow-up audits recovering capitation payments from MCOs who failed to void upon initial notification. In 2020, this project identified overpayments of more than $67.6 million and $66.6 million in recoveries.

Foster Care

Children in agency-based foster care have historically been ineligible for enrollment in Medicaid managed care. However, when a child enters agency-based foster care, their Medicaid managed care enrollment is not always updated in a timely fashion. As a result, capitation payments are often paid to an MCO for months during which a foster child’s medical care has been provided via a foster care agency. Local districts conduct a first-level review and submit retroactive disenrollment notifications for capitation payments paid for children in agency-based foster care for entire payment months. During 2020, OMIG conducted the final level of review and recovered capitation payments that were missed by the local districts. OMIG finalized nine audits with identified overpayments and recoveries of more than $4.9 million.

Managed Long-Term Care

The MLTC program allows for Medicaid enrollees with a high level of need to receive the required care in their home and community. OMIG audits this program to ensure that this most vulnerable population in fact receives the designated level of care. OMIG audits determine if the MLTC Plans are adhering

to the contractual obligations laid out by DOH and that the MLTC members are in receipt of the Community-Based Long-Term Care Services (CBLTCS) that the MLTC denotes as medically necessary within their individual plans of care. In order for an enrollee to qualify for the MLTC program, 120 days of CBLTCS must be received. The MLTC plan is responsible for the care management of their enrollees, to ensure the care has been determined to be medically necessary, and it has been received by their enrollees. For example, audits finalized in 2020 revealed that some providers were unable to document a plan of care for an 11-month period for enrollees who were to receive multiple hours of care per day.

During 2020, audit work continued during the COVID-19 pandemic by adapting processes to a remote working environment for both OMIG auditors and the MLTCs. During this time, OMIG MLTC audits identified $4.5 million in overpayments where the enrollees did not receive the appropriate care as delineated in the enrollee's plan of care.

OMIG also continues to collaborate with DOH in emerging areas within the managed care system, such as administrative costs, value-based payments, and implementation of MRT-II initiatives related to the Medicaid managed care operating reports.

Provider Audits

OMIG performs audits of FFS and managed care network providers in the Medicaid program. These audits apply the law, rules, and regulations of DOH and other relevant State oversight agencies. OMIG currently audits the following programs which fall under the oversight of DOH: assisted living, diagnostic and treatment center, health home, traumatic brain injury, nursing home transition and diversion, and personal care/home health. In addition, OMIG is also conducting audits within the behavioral health and disabilities field, under the oversight of Office of Mental Health (OMH), Office of Addiction Services and Supports (OASAS), and Office for People With Developmental Disabilities (OPWDD). Areas of provider audits are determined by a number of factors, including State agency referrals, external audits that identify vulnerabilities, and areas with high or aberrant claims patterns.

Incompatible Services

One identified area of focus is the delivery of incompatible services, which are services that cannot or should not be delivered in conjunction with another similar or contrary service. This was evidenced in 2020 in the following ways:

- OASAS renders addiction treatment services under a variety of programs. The rehabilitative and outpatient programs provide services that are not mutually exclusive as there is some overlap in the programs. OASAS provided guidance for OMIG to identify services that conflict with one that was previously reimbursed under another program. These audits eliminate duplicate payments

for services included under another treatment program, which eliminates waste without depriving patients of services.

- OMIG also identifies instances where a provider exceeds the number of medical procedures allowed by DOH. While a provider can provide multiple services in the same day, there are Ambulatory Patient Group (APG) category-specific Medicaid billing parameters that providers must abide by. These parameters set a limit of one service per day for certain types of APG service categories.

- OMIG identified services that were not allowed to be reimbursed on the same day of service. For example, a separate billing for counseling services conflicts with a same day billing for re-habilitation services, since re-habilitation is an all-inclusive billing. For all incompatible services, OMIG finalized 47 audits with identified overpayments of more than $390,000.

Health Home

The Health Home program is the care coordination and case management program that ensures recipients are receiving services at the proper level of care and that the quality of care is appropriate. This program is not a physical place, but a group of health care and service providers coordinating to ensure eligible beneficiaries receive the care and services needed to stay healthy. Health homes connect beneficiaries with heath care providers, necessary medications, medical transportation, housing assistance, social services, and other community programs. OMIG ensures that the health home function is performed in a manner that provides the services effectively and efficiently. For additional information on health homes please visit: https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/

In July 2019 the HHS-OIG issued a final audit report on New York State Health Home Providers (A-02-17-01004). HHS-OIG audit identified several deficiencies, including duplicate care management services, which is when a recipient receives Medicaid service coordination through an OPWDD provider and receives case management services under the Health Home program.

OMIG staff identified several health home providers that billed case management services in the same month the recipient received OPWDD Medicaid service coordination. Health home providers are required to verify no restrictions exist prior to billing services. OMIG utilized restriction and exception codes to identify recipients receiving duplicate case management and finalized 54 audits with identified overpayments of more than $642,000 and $499,000 in recoveries.

Assisted Living Program

The Assisted Living Program (ALP) allows for residents in an adult home residential environment to receive supportive medical care as an alternative to a nursing home

placement. The program provides a safe environment with therapeutic services and medical supervision being rendered on-site.

OMIG audits include the review of the medical documentation and plans of care to ensure the required care is documented. In addition, OMIG conducts a credential and health screening review of the employees rendering the services to make sure the environment is safe. In 2020, OMIG finalized two audits with identified overpayments of more than $413,000 and $525,000 in recoveries. These audits revealed deficiencies in staff training, lack of staff immunizations, and insufficient documentation of the provider rendering care to the recipients.

Diagnostic and Treatment Centers

Diagnostic and Treatment Centers provide primary health care services to recipients in need of immediate care. These providers are entrusted with the health and safety of their patients. OMIG performs audits of claim documentation to ensure appropriate services are being rendered by qualified individuals in a healthy and safe environment. As with all OMIG audits, if it is determined that there is a significant issue concerning quality of care, OMIG cooperates with relevant State oversight agencies, including DOH.

Diagnostic and Treatment Center audits examine claims for general medical services in active treatment of medical conditions and specialized condition-based therapies related to conditions in developmentally disabled patients. Both audits focus on care planning and patient safety via examination of service documentation in both environments. OMIG finalized three audits with identified overpayments of more than $400,000 and $392,000 in recoveries.

Nursing Home Projects

Capital Costs

With the migration to managed care and reimbursement methods that are fixed annually, the type and scope of Residential Health Care Facilities (RHCF) audits has become more limited and focused. Audits of RHCFs are conducted to ensure that costs that are reimbursed by Medicaid are documented, allowable, and related to patient care. Costs misstated by a provider may artificially inflate the rate paid to that provider.

RHCF costs are fixed and the related portion of the rate is calculated on a regional basis. OMIG conducts property component audits of individual providers by verifying reported capital costs (which are not fixed) are accurate, allowable, and substantiated. Property audits analyze and confirm or adjust the capital costs reimbursed in the property component of the rate.

In 2020, OMIG issued 19 final audit reports identifying overpayments of more than $9 million and $13 million in recoveries. Examples of disallowances include mortgage interest expenses and property insurance costs. A mortgage interest finding, for example, involved a change in ownership in which the mortgages were paid off. However, the provider continued to receive reimbursement for mortgage interest, mortgage amortization, and mortgage insurance. This finding was to prevent the State from paying costs that were not actually incurred.

Minimum Data Set Reviews

A nursing home's Minimum Data Set (MDS) is a representation of the level of care required by each Medicaid client residing in the home. MDS submissions are used to calculate each facility's case mix index, which is used to determine the direct cost portion of each nursing home's Medicaid rate.

Inaccuracies in MDS submissions can result in a higher Medicaid rate being calculated for a nursing home. OMIG reviews the accuracy of MDS submissions to verify that the data submitted by the nursing home was an accurate representation of each resident's medical condition. These reviews have identified up-coding errors in the activities of daily living (e.g., bed mobility, transferring, eating, toileting) and the number of physician orders and visits. In addition, these reviews have identified instances where skilled therapy, including speech, occupational and physical therapy, were documented as being provided when not medically necessary.

Due to COVID-19 restrictions, OMIG used this time to automate the MDS audit process to allow the transition from field audit activities to performing audit activities in a remote working environment which will improve the efficiency of MDS audits going forward. Such efficiencies include going paperless, streamlining the MDS data to send to DOH for recalculation, and automating documents reflecting audit findings to the provider. In 2020, OMIG finalized 97 reviews resulting in identified overpayments of more than $1 million.

System Match and Recovery Projects

The System Match and Recovery (SMR) Audits are conducted to identify uncommon and potentially inappropriate provider claiming patterns with the goal of advising the providers of the inappropriate claims to potentially prevent future errors and audit exposure. Data analysis is performed to match electronic claims against provider claiming rules or a predicted pattern of provider claims to identify inconsistent claiming patterns for further review. This gives OMIG the ability to conduct a comprehensive audit across many providers at once.

These types of audits are conducted in such a manner to foster two-way communication with the provider to resolve any disputes with the findings. The providers are encouraged to submit documentation for any identified claims they feel were properly billed and paid. OMIG reviews all documentation and determines if the claims are

appropriate based on the information provided. Ultimately, the provider retains due process protections if they are unsatisfied with OMIG's administrative determination.

In 2020, OMIG finalized 245 SMR audits of with more than $2.8 million in identified overpayments and recovered more than $3.7 million. Examples of the audits conducted include:

- **Inpatient Crossover/Clinic/Emergency Room**

  This audit reviewed the appropriateness of claims for clinic or emergency room services, laboratory and/or other ordered ambulatory services provided during an inpatient hospital stay. In 2020, OMIG finalized 133 audits with more than $1.5 million in identified overpayments and recoveries.

- **Managed Care - Excluded Provider**

  This audit reviewed managed care plans reported payments to providers excluded from the Medicaid program. In 2020, OMIG finalized 20 audits with more than $690,000 in identified overpayments and recoveries.

- **Transportation**

  This audit reviewed Medicaid fee-for-service transportation claims for recipients who were hospital inpatients on the date of service, and transportation claims for ambulette services to verify that the vehicle plate and driver's license number were present on the claim and authorized on the date of service. In 2020, OMIG had recoveries of more than $500,000 for this project.

- **Improper Episodic Payments**

  This audit reviewed claims paid to certified home health agencies for home care services billed under the episodic payment system, identifying improper use of discharge codes and instances of multiple episodic payments within 60 days. In 2020, OMIG had recoveries of more than $400,000 for this project.

- **Evaluation and Management Procedure Modifier**

  Surgical procedure codes billed to Medicaid may include a post-operative period in which evaluation and management services directly related to the surgery may not be billed separately by the same entity. If the entity provides evaluation and management services unrelated to the surgery, the claim must be coded properly to distinguish these services. This audit reviewed claims for evaluation and management services with missing or inappropriate procedure code modifiers either on the same day as or during the post-operative period of a surgical procedure. In 2020, OMIG finalized 63 audits identifying overpayments of more than $260,000 and recoveries of more than $360,000.

- **MLTC and Waiver Services**

  This audit reviewed the appropriateness of MLTC claims for recipients that were concurrently enrolled in a traumatic brain injury or nursing home transition and diversion waiver program. In 2020, OMIG finalized 12 audits with more than $250,000 in identified overpayments and recoveries of more than $126,000.

- **Ordering/Prescribing/Referring/Attending**

  This audit reviewed paid claims billed with a non-enrolled or excluded ordering, prescribing, referring, or attending (OPRA) provider. In 2020, OMIG finalized two audits with more than $57,000 in identified overpayments and recoveries of more than $54,000.

- **Vaccines for Children**

  This audit reviewed Medicaid fee-for-service claims for certain vaccines administered to children and the respective administration procedure code. In 2020, OMIG finalized nine audits with identified overpayments and recoveries of more than $17,000.

- **Home Health**

  This audit reviewed the appropriateness of claims for home health and/or personal care services billed during an inpatient or skilled nursing facility stay. In 2020, OMIG finalized three audits with identified overpayments of more than $3,800 and recoveries of more than $5,000.

Self-Disclosure

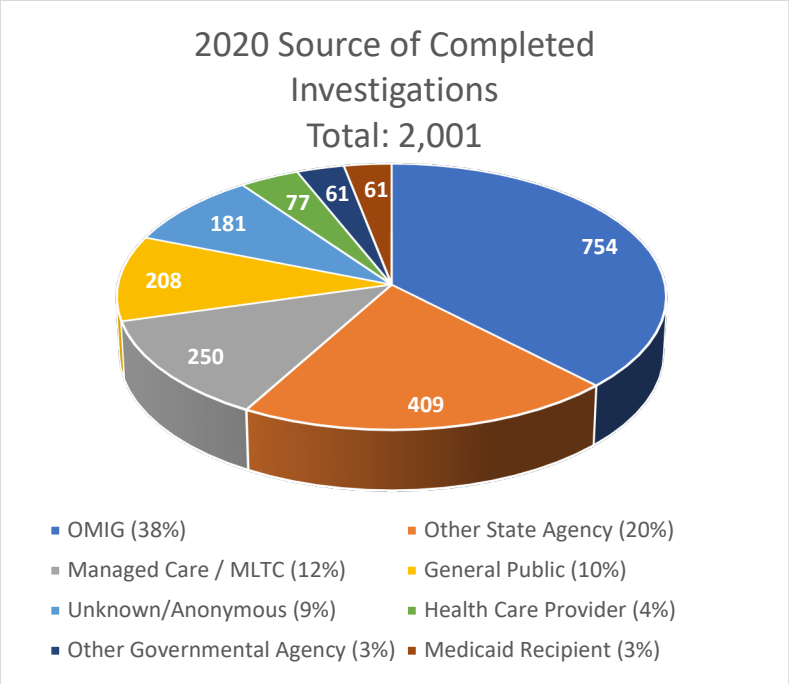
OMIG operates a long-standing mandatory self-disclosure program, in conjunction with its provider compliance efforts, which provides a mechanism for Medicaid providers to report, return, and explain self-identified Medicaid overpayments. Consistent with recently updated Federal requirements, this program requires providers in the Medicaid program to timely report, return, and explain Medicaid overpayments within 60 days of identification or face potential sanctions.

In 2020, OMIG processed 250 self-disclosure submissions and recovered nearly $16 million in Medicaid overpayments. In addition, State statute was enacted that updated OMIG's self-disclosure program to conform with Federal requirements, clarified provider expectations and processing guidelines, authorized OMIG flexibility to support compliant providers and the ability to sanction non-compliant providers to enforce program requirements.

County Demonstration Program

The Medicaid Fraud, Waste, and Abuse County Demonstration Program (County Demonstration Program) was implemented in 2006 and is a partnership between OMIG and participating counties including NYC HRA, to detect Medicaid provider fraud, waste, and abuse and recoup any identified overpayments. In 2020, the counties of Albany, Chautauqua, Erie, Niagara, and NYC HRA initiated or finalized audits. The areas audited in this program are pharmacy, transportation, DME, and ALP providers.

In 2020, OMIG worked with the counties to finalize five audits. Like most projects, in 2020, OMIG in working with the counties adjusted to a remote work environment and implemented electronic sharing of documents. Additionally, in 2020 OMIG started to create training programs for county staff on both remote techniques and on current best practices.



2020 INVESTIGATIVE HIGHLIGHTS

- Completed 2,001 investigations; the majority of which were initiated within OMIG
- Maintain productive partnerships with the health care community, law enforcement, and other governmental agencies
- Employ new tools to combat abuse within the Medicaid program
- 76 percent increase in allegations resulting from EOMB's

OMIG reviews all allegations of fraud, waste, and abuse within the Medicaid program. Nearly 40 percent of OMIG's investigations are generated by internal sources. OMIG subject matter experts conduct extensive reviews of paid claims, peer to peer comparisons, and other data to identify trends and patterns, as well as recipient demographic information in the interest of protecting the integrity of the Medicaid program.

Allegations are also received from a variety of sources, including other State agencies, health care plans and providers, federal and local governmental entities, law enforcement and the general public. Data analytics are conducted on the claims supporting an allegation, to determine the investigative course of action.

The Division of Medicaid Investigations (DMI) is comprised of over 100 staff that are distributed among OMIG's six regional office locations, with the most staff in the Albany and NYC offices. In addition, to investigative specialists and data analysts, staff includes former law enforcement, dentists, registered nurses, pharmacists, a physician, and a hygienist.

Reviews of allegations can vary in complexity which can have a direct impact on the time it may take to complete a case. Investigations of recipient allegations generally have a shorter investigation cycle as they are focused on a single recipient and generally require a routine check of their eligibility for Medicaid. Provider investigations

tend to be more complex and can be labor intensive. These investigations can involve analytics on provider claims, clinical reviews of numerous patient records, multiple interviews, on-site inspections, and coordination with external agencies. Substantiated allegations of provider fraud or unacceptable practices could lead to criminal referrals, administrative sanctions, and the recovery of Medicaid overpayments.

OMIG is not a prosecutorial agency and is required to refer any case of potential fraud to MFCU. In 2020 OMIG submitted 87 referrals to MFCU.

OMIG's expertise is also recognized and requested by law enforcement. OMIG collaborates with Federal, State, and local law enforcement officials in joint investigations aimed at prosecuting larger criminal enterprises, as detailed in examples provided later in this report. Investigations that lead to prosecution can take years, as the provider is afforded the ability to challenge the proceedings, which in turn delays OMIG from being able to close the case until there is a final resolution.

Provider Initiatives

Transportation

Transportation has been one of the fastest growing Medicaid service categories, both from a provider enrollment and cost perspective. Most providers are small, regionally specific operations with limited knowledge or connection to the NYS Medicaid program or the needs of its recipients. Consequently, both DOH and OMIG have identified it as an area for enhanced oversight.

In addition to the investigation of credible allegations, OMIG conducts this oversight in a variety of ways, including:

Pre-payment Reviews

When an investigation uncovers information indicating the provider may not be compliant with Medicaid rules or regulations, a pre-payment review may be requested to prevent improper payments being issued to the provider. In 2020, OMIG completed 127 pre-payment reviews of transportation providers' claims to confirm compliance with Medicaid program requirements, which resulted in nearly $956,000 in cost savings to the program. This was down from the prior year largely because of a hold placed on these activities to maintain necessary access to critical services and avoid financial hardships for providers during the COVID-19 pandemic.

Credential Verification Reviews

OMIG investigation staff routinely conduct on-site CVRs to gather information needed to assess compliance with program requirements and guidelines. The CVR process includes obtaining information on provider and staff credentials, the physical attributes

of the place of business, record keeping protocols, and procedures for Medicaid claiming. During the COVID-19 pandemic, conducting on-site CVRs was placed on hold. Therefore, OMIG adjusted its process and began conducting CVRs remotely and through electronic exchange of information (e.g., photographs and scanned documentation). In 2020, staff completed 365 CVRs of transportation providers, an increase from the 202 CVRs conducted in 2019.

Explanation of Medical Benefits (EOMBs)

- EOMBs allow improved communication with Medicaid recipients to validate service delivery patterns and identify quality of care concerns
- In New York, the data-driven use of EOMBs has become a valuable tool to both investigate and resolve inappropriate provider behavior. This has been recognized by federal Centers for Medicare and Medicaid Services (CMS) as a national best practice
- In 2020, OMIG generated 60,000 EOMBs across multiple provider categories. Of the EOMBs returned, there was a 76 percent increase in credible allegations received, with 1,179 recipients reporting not receiving services, or concerns with the services billed

Explanation of Medical Benefit (EOMB) Reviews

OMIG uses data analytics to detect possible subjects for generating EOMBs by identifying providers who are outliers by the number and types of claims they are submitting. OMIG also uses data to identify specific fraud schemes.

In 2020, OMIG expanded its use of EOMBs to investigate transportation claims. For example:

- Over the course of the year, OMIG generated EOMBs to investigate transportation claims billed on days without a corresponding medical service being billed.

- In another project, OMIG investigated Medicaid transportation costs related to providing transportation services to and from methadone maintenance clinics during the COVID-19 pandemic. Prior to the pandemic, methadone maintenance treatment required a daily visit to the clinic; however, during the COVID-19 pandemic, many methadone maintenance clinics were requiring only one in-person visit per week, where the recipient could pick up a week's worth of medication. Data analysis showed that transportation providers continued to bill for daily transportation services when recipients were attending weekly.

- The use of EOMBs during the pandemic was also helpful at identifying quality of care or health and safety concerns. For example, during the public health emergency, when a recipient reported that a driver wasn't wearing a required face mask, OMIG referred the matter so that it could be addressed as a public health and safety issue.

Pharmacy

OMIG identifies, prevents, and deters pharmacy and prescription medication fraud and abuse, leading to significant savings for the NYS Medicaid program. Clinical expertise is utilized to investigate quality of care issues such as inappropriate drug therapy. Subject matter experts are also used to target inappropriate claims, false claims, and quality of care issues.

Collaborative relationships have been established with other pharmacy oversight agencies such as the NYS Education Department's Office of Professional Discipline, DOH's Bureau of Narcotic Enforcement and the NYS Board of Pharmacy.

DMI works with several other internal units to identify aberrant pharmacy and prescription practices. These practices include billing for services not rendered, inaccurate data submissions on claims, duplicate billings, rendering unnecessary services, unlicensed or excluded providers rendering services, as well as quality of care issues. Referrals are also received from outside agencies. Additionally, on-site enrollment inspections of pharmacies are performed as a part of the Medicaid program application process, as well as CVRs which are conducted at enrolled pharmacies, work that continued during the COVID-19 pandemic remotely and through the previously identified electronic exchange of information.

Data analytics is also used to confirm aberrant patterns in data and EOMBs were sent in 2020 to selected recipients. EOMB projects included personal protective equipment (PPE) supply billing and recipients receiving refills of high-cost topical creams, nasal sprays, and other highly priced drugs.

- *Case File: New Moon Pharmacy*. OMIG was contacted by the NYPD Intel Unit regarding a potential money laundering scheme by an individual appearing to be the owner of a pharmacy. OMIG's investigation identified the subjects as New Moon Pharmacy, owner Harris Hussnain, and supervising pharmacist Nisha Diler. OMIG also found that Ms. Diler was paid to not show up and Mr. Hussnain acted as a pharmacist despite not being licensed, resulting in fraudulent Medicaid billing and drug diversion. The NYPD and OMIG then worked collaboratively with the HHS-OIG, DEA, and the IRS on the investigation. In December 2019, search and arrest warrants were issued and executed against New Moon Pharmacy, Mr. Hussnain, and Ms. Diler.

  On September 16, 2020, Ms. Diler waived her right to a trial and appeal, pleading guilty to conspiracy to commit health care fraud and subscribing a false tax return, Ms. Diler was sentenced on December 11, 2020 to six months in jail, six months in home confinement, and two years of supervised release.

  On September 29, 2020, Mr. Hussnain pled guilty to conspiracy to commit health care fraud, distribution of narcotics, and two counts of unlawful financial transactions and was sentenced to 36 months in prison, 3 years probation, and

$3.2 million in restitution of which Medicaid will receive $1.5 million and will surrender to the United States Marshals on September 1, 2021.

Additionally, New Moon Pharmacy was shut down and the DEA license was revoked. Ms.Diler's NYS Pharmacy license is in the process of being revoked based on her plea.

OMIG excluded New Moon Pharmacy and Ms. Diler, and Mr. Hussnain will be excluded once he is sentenced.

Physician

OMIG investigates physicians identified as having aberrant billing patterns, as well as patterns of ordering services and pharmaceuticals that aren't medically supported. OMIG utilizes data analytics, peer review, investigative field work, and clinical reviews in these investigations.

EOMBs were generated for services ordered by low billing providers with high levels of ordered services. EOMBs were also generated for inappropriate COVID-19 testing billing and for telehealth services billed by physicians.

- *Case File: Selling Prescriptions.* On November 24, 2020, the Office of the Special Narcotics Prosecutor (OSNP) for the City of New York announced the arrests of psychiatrist Dr. Leon Valbrun and medical assistant Po Yu Yen for allegedly selling prescriptions for addictive-controlled substances Xanax and Adderall. The investigation was conducted through a collaboration between NYPD, OSNP's Prescription Drug Investigation Unit, NYC HRA, and OMIG. OMIG investigative and clinical staff assisted in the investigation by conducting fieldwork, obtaining pharmacy records and data, performing clinical reviews, and meeting with investigating agencies.

  OMIG excluded Leon Valbrun and Po Yu Yen based on the indictments.

- *Case File: Fraudulent Medical Practice.* OMIG assisted with the FBI's Health Fraud Task Force investigation of multiple providers involved with operating a $30 million health care fraud scheme. OMIG collected and provided documentation that showed fraudulent evidence of ownership and control of various clinics that was in direct violation of NY State Law requiring medical practices to be owned by physicians only. In addition, OMIG was able to provide documentation that enabled the investigators to identify the bank accounts utilized by the defendants to hide their fraudulently obtained cash and assisted in tracking the money that was paid in the form of bribes and kickbacks. OMIG performed extensive data mining and claims analysis which was essential in demonstrating that there was wholesale fraud being perpetrated by the providers.

As a result of the investigation, there were a total of 15 defendants who were all excluded from the Medicaid program. The following are examples of the sentencing as a result of the investigation:

- Lina Zhitnik was sentenced to 14 months in prison, three years of supervised release, and ordered to pay restitution of $1,369,554, which includes $103,930 for Medicaid, and forfeit $89,682. Ms. Zhitnik was alleged to have falsely certified to performing medical services that were not done or were not medically necessary.

- Dr. Paul Mathieu was sentenced to 48 months in prison, three years of supervised release, and was ordered to pay $596,823 in restitution and forfeiture.

- Marina Burman was sentenced to 36 months in prison and was also ordered to forfeit six condominiums and pay $3,415,363 in restitution to Medicaid. At this time, Ms. Burman has paid $2.25 million to Medicaid. Ms. Burman was released from prison May 15, 2020.

- Hatem Behiry was sentenced to incarceration of 24 months, three years of supervised release, restitution of $5,757,961 to Medicare, and forfeiture of $808,975.

- Natalya Grabovskaya was sentenced to time served, three years of supervised release, and restitution in the total amount of $7,157,700, consisting of $4,269,533 payable to Medicare and $2,888,167 payable to NYS Medicaid, along with forfeiture of $93,379.

- Diana Rubenstein pled guilty and was sentenced to time served, one year of supervised release, restitution in the total amount of $2,107,997 payable to Medicare, and forfeiture in the amount of $168,305.

- Valerie Volsky was sentenced to time served, three years of supervised release, and ordered to pay restitution to the Medicaid program in the amount of $4,985,126.

- Olga Kharuk was sentenced to time served, no supervised release, and forfeiture in the amount of $148,164, and restitution in the total amount of $11,950,380, consisting of $6,965,254 payable to Medicare, and $4,985,126 payable to NYS Medicaid.

Home Health Agency

Home health providers deliver essential services to NYS's most fragile citizens. OMIG utilizes a variety of tools to ensure that those dependent on these services, are receiving the care that they need. In addition to investigating allegations, OMIG

proactively reaches out to recipients to verify that they are receiving home health care. EOMBs are regularly sent on home health services. OMIG also works with law enforcement partners in investigating schemes involving home health fraud.

- *Case File: Fraudulent Billing*. OMIG was contacted by the Federal Bureau of Investigation (FBI) to provide assistance and documentation as evidence to support allegations of a home health care investigation. OMIG provided information showing that two providers had ownership and control of the entities involved, as well as records showing claims for which Medicaid payments were made. Using this information, the FBI was able to identify billing for no-show aides, which led to interviews exposing a massive scheme encompassing multiple health care providers. Allegedly ten defendants were part of a scheme that fraudulently billed Medicaid and Medicare for home health and personal care services when aides were no-shows and had not provided services to patients. Billing for home health services was concurrent with times when the defendants were away, including while at a New Jersey winery, and on a Caribbean cruise. Some of the recipients were part of the scheme, and the fraudulently obtained wages were split between the recipients and the no-show aide. Kickbacks were also paid to conspirators referring no-show cases to aides employed at the two agencies. OMIG is in the process of reviewing the case for unacceptable practices and possible sanctions.

  On December 16, 2020, Audrey Strauss, the Acting United States Attorney for the Southern District of New York, and William F. Sweeney Jr., the Assistant Director-in-Charge of the New York Office of the FBI announced the unsealing of an indictment charging Marianna Levin, Tetyana Golyak, Elena Lokshin, Svitlana Rohulya, Marina Zak, Alina Kuptsova, Maliha Ijaz, Makinibonu Narzukkaeva, Natalya Shvarts, and Inna Gekelman with conspiracy to commit mail, wire and healthcare fraud; substantive counts of mail fraud, wire fraud, and healthcare fraud; and conspiracy to violate the Anti-Kickback Statute. The subjects were excluded from the NYS Medicaid program.

Recipient Initiatives

OMIG conducts reactive investigations for all statewide Medicaid eligibility and prescription drug diversion complaints and referrals received from the general public, other State, Federal, and local governmental and law enforcement agencies. OMIG also conducts pro-active investigations generated through internal data mining and data analysis.

OMIG coordinates with New York's 58 LDSS, NYSoH, as well as local, county, State, and Federal law enforcement and regulatory agencies to advance the integrity of the Medicaid program. Corrective actions can range from prosecution, fiscal recovery, or other administrative action, including closing of the beneficiary file so the recipient is no longer eligible for Medicaid benefits.

Creates Partnerships with DAs to Prosecute Medicaid Eligibility Cases

OMIG works closely with county district attorneys on recipient fraud cases, referring potential fraud and assisting with ensuing legal actions.

Throughout 2020, OMIG staff led Medicaid fraud discussions with the Nassau County District Attorney's staff, Nassau County LDSS investigators, and the Rockland County District Attorney's (RCDA) office. OMIG and the RCDA established a newly revised partnership in pursuing Medicaid recipient fraud joint investigations in support of Rockland County Crimes Against Revenue Program (CARP). OMIG provided procedural guidance for interpreting NYS Medicaid application documents used to determine eligibility following the Affordable Care Act (ACA) and CMS guidelines, and suggestions on prosecuting Medicaid eligibility related fraud cases. Additional participants included the Senior Assistant District Attorney, District Attorney Investigator, and Nassau County Department of Social Services/SIU Investigators. Sharing this guidance aided the district attorneys to gain a better understanding of the complexities related to Medicaid rules and assist with formulating strategies to successfully prosecute these cases. Presently, OMIG has three joint Medicaid recipient fraud investigations pending prosecution with the Nassau County District Attorney's Office, and two joint recipient Medicaid fraud investigations with the RCDA's Office, as a result of these meetings.

Partner with Law Enforcement Partners during the Pandemic

In April and June of 2020, staff participated in the Suffolk County COVID-19 task force. Other participating agencies included staff from the United States Postal Inspection Service, HHS-OIG, Suffolk County District Attorney, Suffolk County Police Department, United States Treasury, NYS Tax Enforcement, US Food and Drug Administration, United States Department of Justice – Homeland Security Investigations, United States Internal Revenue Service, and United States Housing and Urban Development. The purpose of this work group was to discuss in real time, issues and schemes stemming from COVID-19, stimulus checks, testing, PPE price gouging and to disseminate authentic information with other law enforcement or administrative partners. This work group met via WebEx on a weekly basis between April and June of 2020.

Additionally, at a meeting hosted by HHS-OIG's Special Agent in Charge, OMIG presented a high-level overview of the current state of OMIG's investigative work during the COVID-19 pandemic. The meeting consisted of health care law enforcement partners from across the state and country. The various teams are provided an opportunity to share updates about current schemes they are seeing, or cases they are working on, as well as requests for partnering together on projects.

Investigations of Out-of-State Recipients

The Federal Families First Coronavirus Response Act (FFCRA), ensured that no Medicaid beneficiaries lost coverage on or after March 18, 2020 unless the individual voluntarily terminated coverage or was no longer a resident of NYS. In response to FFCRA, OMIG improved communications and processes with DOH to facilitate the removal of ineligible individuals from the Medicaid program. Individuals were identified as no longer residing in NYS but continued to have managed care capitation payments made on their behalf. During the COVID-19 pandemic, OMIG continued to refer investigative findings and supporting evidence to DOH, recommending that identified Medicaid recipients who are non-NYS residents are no longer eligible to receive continued benefits.

OMIG also continues to investigate and notify DOH of individuals who intentionally withhold or understate income in order to obtain benefits. When confronted with evidence of egregious fraudulent financial reporting, subjects can voluntarily request the closing of their Medicaid case while entering into a voluntary repayment agreement. If justified, OMIG will coordinate prosecution and restitution efforts with local, State, and Federal law enforcement partners.

Prior to the pandemic, OMIG would conduct in-person interviews with recipients at either their residence or at LDSS offices. This aided in substantiating a complaint and allowed for better communication between the investigators and the subject of the investigation. The process now relies heavily on data driven sources for information and phone interviews when possible.

Case Files: Recipient Investigations

- In May of 2020, OMIG participated in a joint investigation with the Suffolk County Police Department, Financial Crimes Bureau, pursuing an allegation of alleged identity theft against a Nassau County resident. Investigative efforts included procurement and examination of the state Medicaid application, medical records, claims data, video footage, and a sworn admission statement. The joint investigation proved that the recipient stole the identity of another recipient and fraudulently obtained a Pennsylvania driver's license, a Visa card, and NYS Medicaid benefits in the name of the victim. The recipient was subsequently charged with three felonies including identity theft and two counts of possession of a forged instrument.

- OMIG utilizes data analytics for identification of potential recipient fraud in situations where owners of transportation companies submit claims to NYS Medicaid while also receiving Medicaid benefits. OMIG evaluates the data and billing to ensure the recipients are reporting their correct income to qualify for benefits. Being a Medicaid provider does not preclude one from receiving Medicaid benefits as long as eligibility requirements are met. Factors used to further narrow the scope of the project include how long the provider was

enrolled and billing NYS Medicaid, the number of owners of the transportation company, and the number of family members on the recipient case. In cases where unreported income is identified, making the recipient ineligible to receive Medicaid benefits, OMIG seeks prosecution and/or administrative action to recoup Medicaid funds billed on behalf of the recipient.

- OMIG identified that an Orange County husband and wife were co-owners of Ataxi Corporation and were also receiving Medicaid benefits. Over a two-year period Ataxi Corporation received more than $450,000 for providing transportation services to Medicaid recipients. Investigative efforts included securing and analyzing bank and tax records and interviewing both recipients and their accountant. The investigation proved that both recipients submitted inaccurate income information from August 2018 through January of 2020, and that if reported, would have deemed them ineligible for Medicaid benefits. In February 2020, the recipients' requested and entered into a voluntary repayment agreement to repay the Medicaid program $19,198.

- OMIG investigated a recipient after a referral was received from Suffolk County Department of Social Services, who was investigating the recipient for not reporting income in order to qualify for public benefits. OMIG conducted a parallel investigation and found that the recipient had substantial income that was not reported in order to fraudulently obtain NYS Medicaid benefits. The Suffolk County DA pursued criminal charges and charged the recipient with two counts of Welfare Fraud. The recipient pled guilty to the reduced charge of Welfare Fraud in the Fifth Degree in January 2020. On September 15, 2020 the former recipient appeared in court and provided a check to the court in the amount of $14,687 and the court awarded DOH a Restitution of Judgement Order in the amount of $20,763.

Medical Care Uninterrupted for Restricted Recipients

RRP restricts recipients to an assigned physician, or other service provider, after determining that the recipient has engaged in behaviors that are detrimental to either the Medicaid program, or to themselves. This restriction is based on the outcome of a thorough analysis of services billed and rendered, conducted by an OMIG team of health care professionals and analysts. During the COVID-19 pandemic there were many physicians' offices that were closed leading to clinics being overwhelmed caring for patients. To ensure access to care, RRP adjusted the claims edits to ensure recipients were able to receive care from a provider that may have been outside of their assigned primary care/clinic provider restriction during COVID. While there was a cost savings loss for the RRP program due to this change, NYS recipients continued to have access to medical care during this time. In October, as healthcare clinics became less burdened by the volumes they had recognized in the spring, the recipients were again restricted to an assigned provider/clinic.

Processing of MCO Referrals

OMIG assesses referrals received from managed care entities for compliance with the reporting requirements outlined in the managed care contracts. These referrals are reviewed for accuracy and completeness, and the assessment results are considered by OMIG as part of their reviews of the plans.

OMIG also corresponds with plans to notify them of the determinations in connection with referrals received and requests for clearance to recover identified overpayments following the referred matter. In 2020, OMIG processed 97% more referrals than in 2019, supporting the agency's ability to pursue fraud, waste, and abuse referrals. The increased referrals followed OMIG's outreach to plans along with the monthly meetings with liaisons. In December 2018, OMIG concluded its on-site visit initiative to all mainstream MCOs in the NYS Medicaid program. The visits provided an opportunity to discuss program integrity-related processes and procedures, gain a greater understanding of each MCO's business processes, and analyze their fraud, waste, and abuse prevention activities and reporting documents. This outreach may have had a sentinel effect on mainstream managed care reporting as reflected in the increased referral numbers.

OMIG is heavily reliant upon and utilizes various Medicaid information technology systems to conduct oversight of the Medicaid program, confirm the appropriateness of provider payments and provide timely, accurate, and defensible data and analysis to support Medicaid program integrity initiatives throughout the agency.

This includes resources such as eMedNY (the Medicaid Management Information System) and the Medicaid Data Warehouse (MDW) a central data repository of all Medicaid paid and denied claims. OMIG also has an internal system, the Fraud Activity Comprehensive Tracking System, to collect and organize data received in the course of performing program integrity activities, this is an invaluable resource for OMIG staff in conducting their activities.

These activities are supervised by OMIG's Division of System Utilization and Review (DSUR). DSUR is comprised of 53 staff that are located in the Albany office.

2020 DIVISION OF SYSTEM UTILIZATION AND REVIEW HIGHLIGHTS

- Nearly $2 billion in cost savings from Pre-Payment Insurance Verification
- Over a 40 percent increase in Third-Party Retroactive recoveries
- Over a 20 percent increase in RAC recoveries
- Ran more than 31,000 queries of Medicaid data systems

Third-Party and Payment Oversight

Medicaid is intended to be the payor of last resort. However, due to data limitations, processing timeframes or inaccurate reporting the availability of alternate third-party health insurance coverage may not be known at the time of Medicaid service delivery and billing. To enforce this requirement, OMIG regularly works to identify new third-party health insurance coverage and other payment sources, confirm available coverage and recover Medicaid overpayments or prevent future overpayments for fee-for-service and managed care encounter claims.

Third-Party Liability Match and Recovery Services (TPLMRS)

OMIG uses a third-party liability contractor (HMS) to conduct this oversight. HMS was chosen for their expertise and has served NYS for over 25 years. They provide valued services to 40 other Medicaid state agencies and 300 Medicaid MCOs.
The contract contains three modules:

1) Pre-payment Insurance Verification Services (PPIV):

PPIV includes the identification of insurance coverage for medical, dental, pharmacy, and vision. HMS verifies insurance segments and updates the Medicaid claim processing system by either adding or end-dating insurance coverage information. When this information is added to eMedNY, edits are put in place, which

will then deny any claim that is submitted for which a third-party is liable for payment. In 2020, nearly $2 billion in inappropriate Medicaid payments were averted because of the implementation of the edits for insurance coverage identified by PPIV.

2) Third-Party Retroactive Recovery Projects:

After identification of third-party insurance, if Medicaid was erroneously billed, post-payment reviews and recovery efforts are initiated. Third-party coverage is updated in the Medicaid claiming system and claims processing edits are applied to prevent future Medicaid payments. Provider recovery reviews that direct the billing of third-party insurance carriers and Medicaid managed care reviews are conducted. Consistent with the increase in Medicaid enrollment during the COVID-19 pandemic, third-party recoveries of claims for Medicaid recipients who also had commercial insurance increased more than 40% during 2020.

3) Casualty and Estate (C&E) recoveries:

C&E recovers funds on behalf of OMIG from Medicaid recipients in cases involving the award of a personal injury settlement and/or from their estates. When a Medicaid recipient passes away, the estate and any assets owned by the recipient are subject to recovery for any Medicaid expenses associated with services provided prior to the recipient's death. When a Medicaid recipient receives a settlement because of a personal injury, and Medicaid paid for the treatment of those injuries, any amounts paid by Medicaid are subject to recovery out of the settlement funds. C&E recoveries decreased nearly three percent (3%) since 2019. Much of this decrease can be attributed to the closure and limited operation of courts, county department of social services offices, and law firms statewide in response to the COVID-19 pandemic. Additionally, estate cases involving a recipient who passed away due to a COVID-19 diagnosis were placed on hold.

Recovery Audit Contract

ACA enacted in 2010 directed states to establish a RAC to identify Medicaid underpayments and overpayments; recoup overpayments; report any suspected fraud/criminal activity; and implement actions to prevent future improper payments. The state contracted with HMS to perform this function. Utilizing data mining to identify improper payments and working with providers to recover any overpayments helps to dissuade providers from submitting future improper claims. The RAC expanded the number of reviews in 2020 for the Same Plan Project, generating an increase of more than 20% in recoveries over 2019. The Same Plan Project recovers premiums paid to MCOs when a recipient has Medicaid managed care but also has third-party commercial health insurance coverage with the same MCO. This project continues to be the largest recovery project for RAC.

Home Health Care Medicare Maximization

Through its contractor, University of Massachusetts (UMass), OMIG works to maximize Medicare coverage for dual eligible recipients who receive home health care services paid by Medicaid. To determine Medicare's portion of the home health services charges, traditionally a case-by-case approach through the Medicare appeals process was used. Once a favorable coverage determination was made, Medicare paid the appropriate share of the claim. A settlement made with Medicare in 2018 allows OMIG and its contractor to recover an agreed-upon percentage of the value of the dual-eligible claims, which would ordinarily have been determined through the traditional appeals process. This settlement has continued through addendums and has improved the processing time of payment by Medicare from years to months and has also saved valuable resources previously expended on hearing preparation and testimony.

As a result of significant Medicaid reform efforts, the enrollment of dual-eligible recipients into MLTC plans has steadily increased in NYS, and additional enrollments are anticipated. This shift of recipients receiving home health services into Medicaid MLTC plans and the Fully Integrated Duals Advantage Demonstration Program has resulted in a decrease in the volume of FFS Medicaid cases available to appeal for Medicare coverage. This has resulted in a concurrent decrease in recoveries of 45 percent from the prior year. As most of home health services delivered to dual-eligible recipients are now covered by Medicaid managed care, OMIG is developing initiatives to evaluate MCO compliance with contractual requirements to identify and coordinate third-party insurance coverage and report third-party recoveries on managed care cost reports.

Data Mining and Technological Support

Many initiatives throughout the agency depend on data driven analytics. DSUR utilizes the MDW and many associated applications for various analytical tasks which support management decisions and audits. The data analysis provided covers a wide range of provider types and program areas and supports OMIG and other state agency operations. DSUR staff provide technical support and training to the agency's audit and investigative staff, which include the extraction and analysis of varied datasets to identify patterns and guide agency initiatives. In addition, staff share expertise in computer programming and documentation, system analysis, data analysis, program research and information gathering, report writing, and presentation.

In 2020, DSUR completed 2,261 data requests comprising over 31,000 queries of the MDW, which consisted of Medicaid FFS and MC data extraction and analysis in support of 2,026 internal sources and 235 external sources including:

Audit projects supported by data analytics:

- Incompatible Services audits
- Health Home audits
- Assisted Living Program audits

- Diagnostic and Treatment Center audits
- Home Health
- Inpatient Crossover/Clinic/Emergency Room
- Ordering/Prescribing/Referring/Attending (OPRA)
- Transportation
- Vaccines for Children
- Managed Care Projects
    - Match-based projects
    - Managed care program integrity reviews
    - MLTC and Waiver Services

Investigation activities supported by data analytics:

- Transportation Pre-payment Reviews
- MCO Referrals
- Dental Reviews
- Recipient Investigations
- Collaboration with Health Fraud Task Force

Compliance Certifications Transition

BUREAU OF COMPLIANCE

- Finalized 13 Compliance Program Reviews
- Issued four Compliance Related Publications
- Over 600 emails and telephone calls handled from the provider community

Pursuant to NYS SOS § 363-d, providers are required to certify to the DOH upon enrollment in the Medicaid program that they are satisfactorily meeting the requirements of SOS § 363-d. In 2019, OMIG identified inefficiencies in the annual certification process on OMIG's website and sought opportunities to improve the process while also reducing an administrative burden on providers.

To address this issue, staff worked with DOH to include the compliance certification as part of the Statement for Provider Billing Medicaid form. Effective December 1, 2020, providers were no longer required to complete the annual certification using the form located on OMIG's website. Instead, a provider adopting and maintaining an effective compliance program now attests to this as part of their annual "Certification Statement for Provider Billing Medicaid." This annual certification occurs on the anniversary date of the provider's enrollment in the Medicaid program. Incorporating the certification into the pre-existing annual certification managed by the DOH reduces time needed for providers to comply with the compliance program certification obligation.

Additionally, the Deficit Reduction Act (DRA) requirements have been incorporated into SOS § 363-d. As a result, there is no longer a separate DRA certification requirement. By submitting the annual "Certification Statement for Provider Billing Medicaid," providers are attesting to satisfactorily meeting the requirements of SOS § 363-d, which includes the DRA.

The change to providers attesting to the adoption and maintenance of an effective compliance program as part of their routine annual certification process for Medicaid billing directly supports the requirement for an effective compliance program as a condition of payment under the Medicaid program.

Office of Counsel

The mission of OC is to support and enhance the statutory responsibilities of OMIG by providing quality legal representation and counsel. OC is comprised of 18 staff spread among three regional offices, primarily located in Albany and NYC. The OC attorneys serve two primary functions: representing the agency at administrative hearings and in litigation proceedings and providing legal support to all of OMIG's divisions and executive staff. This legal support includes, but is not limited to reviewing audit reports, notices of agency action, and audit protocols; drafting regulations and legislation; drafting and/or negotiating contracts and contract amendments; conducting legal research; and issuing legal opinions.

2020 HIGHLIGHTS

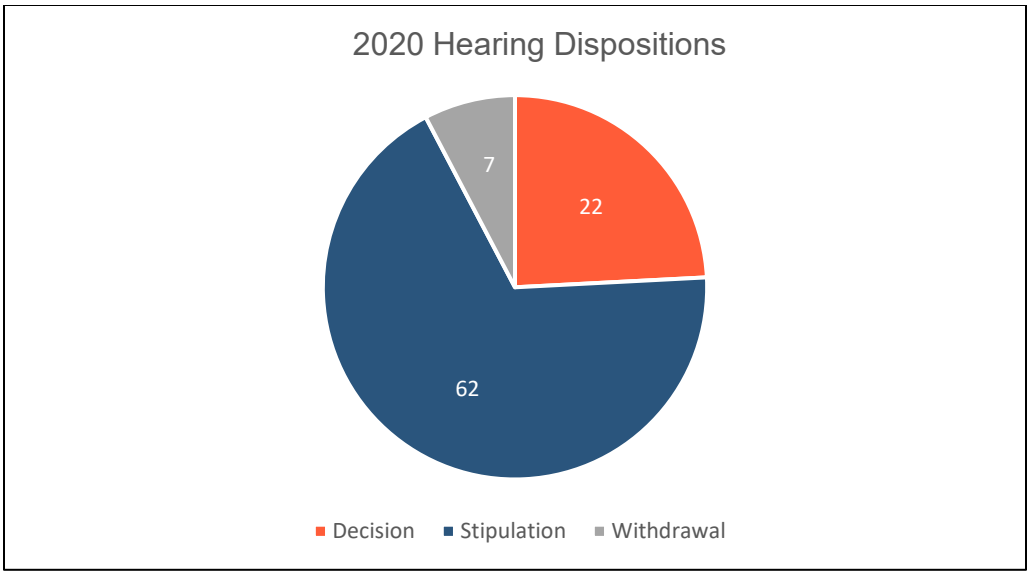
- 91 hearings completed or settled in lieu of full hearing
- 62 stipulations in lieu of hearing
- Participated in 38 administrative hearings

Administrative Hearings

Providers who have received a Final Audit Report, or a Notice of Agency Action (collectively referred to as the “final determination”) are entitled to challenge OMIG’s final determination in an administrative hearing. Such hearings are conducted by DOH Administrative Law Judges in the Bureau of Adjudications. OMIG attorneys are responsible for defending OMIG’s final determination in the hearing. Conducting administrative hearings is a core function of OC and is critical to the overall mission of OMIG.

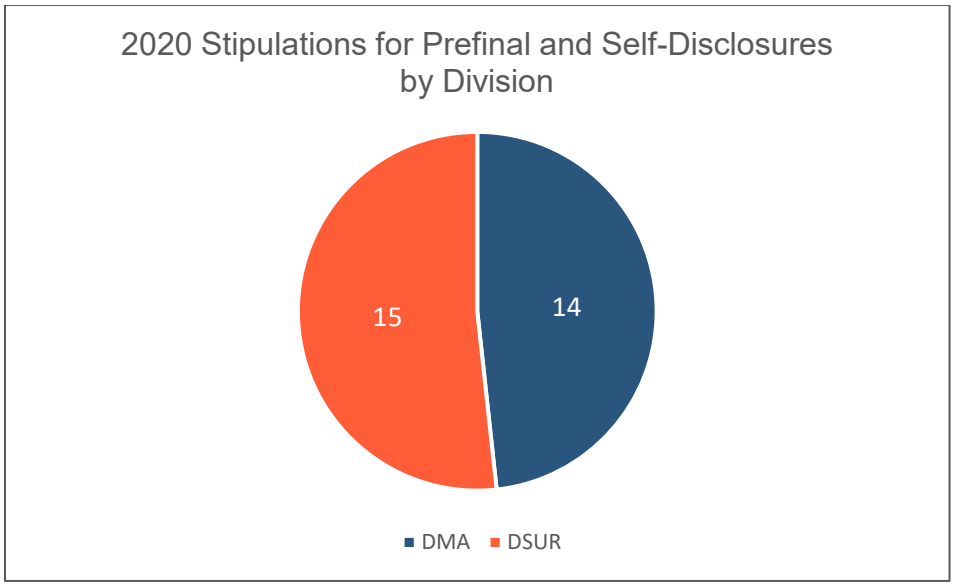
Hearings may be requested by the provider at the final determination. Hearings must be requested within 60 days. All requests for hearing are assigned to an attorney who actively engages in discussion with the provider, or their representative, and manages the progress of the case. Certain factors outside of the control of OMIG determine the length of the matter. Whether a hearing moves forward or results in a settlement in lieu of a hearing depends on several factors. Some requests are withdrawn by the provider while others are settled to the satisfaction of OMIG and the provider without the need for a hearing. Attorneys work towards the most efficient solution in resolving audit or investigative actions and negotiate with providers (individually or through their representatives) to reach a fair and mutually agreeable resolution for both parties.

In 2020, 26 hearing requests were received, and 91 hearings were completed or settled in lieu of proceeding to a full hearing. During this period hearings were conducted remotely rather than in person as a result of the COVID-19 pandemic. Despite the challenges, OC was able to defend agency actions efficiently while affording providers the ability to exercise their due process rights. This graph illustrates the total number of hearings resolved in 2020 and their outcomes:



Stipulations of Settlement

OC attorneys negotiate and facilitate settlements on behalf of OMIG. Stipulations of settlement may result from a provider agreeing to resolve an audit following an exit conference or issuance of a draft audit report, to resolve a request for hearing following the issuance of a final determination, or to resolve a self-disclosure. Stipulations of Settlement are formal written documents executed by the provider and OMIG. The stipulations define the terms of settlement, including but not limited to, the review period in question, the overpayment amount owed, and the repayment terms. In 2020, OC received 29 requests for stipulation unrelated to hearings, finalized 12 stipulations for pre-final and self-disclosure cases, and finalized seven stipulations in lieu of proceeding to an administrative hearing. This graph illustrates the total number of stipulations received by Division in 2020:



APPENDIX

Powers and Duties (Public Health Law (PBH) Article 1, Title 3)

- Conduct and supervise activities to prevent, detect, and investigate Medical Assistance (MA) program fraud and abuse amongst DOH; OMH, OASAS, OTDA, and the Office of Children and Family Services, and OPWDD.
- Coordinate, to the greatest extent possible, activities to prevent, detect, and investigate MA program fraud and abuse amongst State agencies, local governments, and entities; and to work in a coordinated and cooperative manner with, to the greatest extent possible, the deputy attorney general for Medicaid fraud control; other law enforcement entities, managed care plans, and the State Comptroller.
- Meet quarterly with representatives of social services districts to discuss the status of ongoing cooperative efforts between the office of OMIG and districts, including demonstration programs, the potential for additional and/or for improved or innovative techniques to be employed, and any issues of concern to such districts with respect to the prevention and detection of fraud and abuse in the MA program.
- Solicit, receive, and investigate complaints related to fraud and abuse within the MA program.
- Keep the Governor, Attorney General, State Comptroller, the Legislature, and the heads of agencies with responsibility for the administration of the MA program apprised of efforts to prevent, detect, investigate, and prosecute fraud and abuse within the MA program.
- Review and audit contracts, cost reports, claims, bills, and all other expenditures of MA program funds to determine compliance with applicable Federal and State laws and regulations, and take such actions as are authorized by Federal or State laws and regulations.
- Pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts within the MA program.
- Subpoena and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony.
- Require the production of documents relevant or material to an investigation, examination or review, or necessary for the inspector to perform its duties and responsibilities that are prepared, maintained or held by or available to any state agency or local entity the patients or clients of which are served by the MA program, or which is otherwise responsible for the control of fraud and abuse within the MA program.
- Conduct, in the context of the investigation of fraud and abuse, on-site facility and office inspections.
- Recommend and implement policies relating to the prevention and detection of fraud and abuse; provided however, that the consent of the Attorney General shall be obtained prior to the implementation of any policy that shall affect the operations of the Office of the Attorney General.

- Work with the fiscal agent employed to operate the Medicaid management information system to optimize the system.
- Monitor the implementation of any recommendations made by the office to agencies or other entities with responsibility for administration of the MA program.
- Prepare cases, provide testimony, and support administrative hearings and other legal proceedings.
- Work in a coordinated manner with relevant agencies in the implementation of information technology relating to the prevention and identification of fraud and abuse in the MA program.
- Conduct educational programs for MA program providers, vendors, contractors, and recipients designed to limit fraud and abuse within the MA program.
- In conjunction with DOH, develop protocols to facilitate the efficient self-disclosure and collection of overpayments and monitor such collections, including those that are self-disclosed by providers. A provider's good faith self-disclosure of overpayments may be considered as a mitigating factor in the determination of an administrative enforcement action.
- Receive and investigate complaints of alleged failures of State and local officials to prevent and prosecute fraud and abuse in the MA program.
- Implement and amend, as needed, rules and regulations relating to the prevention, detection, investigation, and referral of fraud and abuse within the MA program and the recovery of improperly expended MA program funds.
- Take appropriate actions to ensure that the MA program is the payor of last resort.
- Develop training materials with respect to the office's audit standards and criteria for identifying fraud or waste, for use by social services districts who are engaged with the office in demonstration programs or other collaborative efforts; and
- Perform any other functions that are necessary or appropriate to fulfill the duties and responsibilities of the office in accordance with Federal and State law.

2020 Initiated Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	1	0	0	0	1
Managed Care	271	71	107	0	449
Provider	325	72	94	5	496
Rate	139	68	31	0	238
Self-Disclosure	64	56	80	1	201
System Match and Recovery	41	16	12	3	72
Total	841	283	324	9	1,457

2020 Finalized Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	3	0	2	0	5
Managed Care	259	62	98	0	419
Provider	117	38	44	0	199
Rate	64	32	26	0	122
Self-Disclosure	85	71	92	2	250
System Match and Recovery	119	35	48	43	245
Total	647	238	310	45	1,240

2020 Overpayments Identified by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	($3,206,842)	($35,747)	$472,598	$0	($2,769,992)
Managed Care	117,698,865	43,047,295	8,187,656	0	168,933,816
Provider	1,061,037	1,244,855	10,861,952	(1,945,124)	11,222,720
Rate	16,584,009	3,916,385	190,398	0	20,690,792
Self-Disclosure	9,252,766	1,334,178	3,718,879	855	14,306,678
System Match and Recovery	1,899,246	283,276	268,389	416,441	2,867,353
Total	$143,289,080	$49,790,242	$23,699,873	($1,527,828)	$215,251,367

2020 Overpayments Recovered by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	$2,421,837	$145,353	$438,941	$0	$3,006,131
Managed Care	111,369,468	40,264,808	8,175,240	0	159,809,517
Provider	12,088,251	1,113,423	1,830,359	(2,087,635)	12,944,398
Rate	14,683,512	4,309,095	819,114	0	19,811,722
Self-Disclosure	10,626,844	1,082,344	4,046,738	(14,513)	15,741,412
System Match and Recovery	2,364,050	331,835	318,343	702,249	3,716,476
Total	$153,553,963	$47,246,857	$15,628,735	($1,399,899)	$215,029,655

Audit Summations	
Audit Department	Amount
County Demonstration Program	2
Provider	158
Rate	51
Total	211

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	94	114	65	66	1	1	160	181
District Attorney	6	15	0	0	0	0	6	15
Enrolled Recipient	27	41	27	18	2	2	56	61
Federal Agencies	66	54	11	6	1	1	78	61
General Public	129	119	98	87	2	1	229	207
Law Enforcement	25	25	5	4	0	0	30	29
LDSS	20	22	60	61	0	0	80	83
Managed Care Plans	337	110	100	73	34	9	471	192
Managed Long Term Care Plans	67	40	65	18	0	0	132	58
Non-Enrolled Provider	0	0	1	2	0	0	1	2
Non-Enrolled Recipient	0	1	0	0	0	0	0	1
OMIG	227	215	532	533	6	6	765	754
Other State Agencies	115	70	120	97	169	115	404	282
Provider	35	42	30	33	0	0	65	75
Total	1,148	868	1,114	998	215	135	2,477	2,001

Referrals to MFCU	
Provider Type	Amount
Clinical Social Worker (CSW)	1
Consumer Directed Aide	5
Dental Groups	1
Dentist	3
Diagnostic and Treatment Center	1
Home Health Agency	8
Home Health Aide	2
Laboratory	1
Long Term Care Facility	1
Non-Enrolled Provider	6
Nurse	4
Optometrist	1
Pharmacy	3
Physician	6
Physicians Group	5
Podiatrist	1
Recipient	16
Transportation	22
Total	87

Referrals to Other Agencies	
Agency	Amount
Internal Revenue Service	1
Law Enforcement Agency	17
LDSS	30
Local District Attorney	6
MAS-Medical Answering Service	3
NYC Department of Health	9
NYC Department of Sanitation	1
NYC HRA Bureau of Client Fraud Investigations	22
NYS Department of Health	124
NYS Department of Justice	3
NYS Division of Human Rights	1
NYS DOH Office of Professional Medical Conduct	8
NYS Education Department – Not Professional Discipline	3
NYS Education Department – Office of Professional Discipline	21
NYS Office for People with Developmental Disabilities (OPWDD)	9
NYS Office of Children and Family Services	1
NYS Office of Health Insurance Programs (OHIP)	3
NYS Office of Mental Health (OMH)	1
NYS Justice Center	1
Out of State	2
US Attorney	18
US Health and Human Services (HHS-OIG)	21
Total	305

Exclusions	
Reasons for Exclusions	Number of Actions
18 NYCRR 504.1(d)(1) – Affiliations	27
18 NYCRR 515.2 – Unacceptable Practice	4
18 NYCRR 515.7(b) – Indictments	26
18 NYCRR 515.7(c) – Convictions	67
18 NYCRR 515.7(d) – Imminent Danger	1
18 NYCRR 515.7(e) – Professional Misconduct	103
18 NYCRR 515.8 – Mandatory Exclusion	219
Grand Total	447

2020 Third-Party Liability and RAC Recoveries	
Activity Area	Amount
Casualty & Estate	$115,128,038
Third-Party Liability	137,097,664
Recovery Audit Contractor	83,005,559
Home Health Care Medicare Maximization Project	11,581,266
Total	$346,812,527

2020 Recoveries	
Activity Area	Amount
Managed Care	$159,809,517
Third-Party Liability	137,097,664
Casualty & Estate	115,128,038
Recovery Audit Contractor	83,005,559
Rate	19,811,722
Self-Disclosure	15,741,412
Provider	12,944,398
Home Health Care Medicare Maximization Project	11,581,266
System Match and Recovery	3,716,476
County Demonstration Program	3,006,131
Investigation Financial Activities	13,918
Total	$561,856,100

2020 Cost Savings Activities	
Activity Area	Amount
Dental Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	$221,684
Enrollment and Reinstatement Denials	82,563,589
Exclusions – Internal	12,232,600
Exclusions – External	14,476,114
Medical Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	1,440,278
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	9,410,793
Pre-Payment Insurance Verification Commercial	1,905,645,570
Pre-Payment Insurance Verification Medicare	393,833,143
Recipient Medicaid MC Benefits – Case Closures for False Information	130,853
Recipient Restriction	32,234,830
Total	$2,452,189,454

New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
Phone: (518) 473-3782
www.omig.ny.gov
twitter.com/nysomig
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(877) 87-FRAUD / 877-873-7283