

**New York State
Office of the Medicaid Inspector General**



**2011
New York State
Office of the Medicaid Inspector General
Medicaid Work Plan**

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FOREWORD

In 2010, the executive staff of the Office of the Medicaid Inspector General (OMIG) collaborated to develop a vision plan for the agency.

Mission Statement

Our mission is to enhance the integrity of the New York State 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.

Vision Statement

To be *the* national leader in promoting and protecting the integrity of the Medicaid program.

Core Principles of the OMIG Vision Plan

These core principles of the OMIG vision plan are those tenets we hold to form the foundation on which we perform our work. They are the guiding practices we should use every day in everything we do.

While following these core principles in our efforts to preserve the integrity of the Medicaid program, OMIG will treat its employees, the providers and enrollees fairly and respectfully with professional integrity. The OMIG will be responsive, honest and fair in all communications and collaborative efforts with our various partners – state and local governmental officials and agencies, the provider community, enrollees and citizens.

The OMIG is committed to following these identified core principles:

Collaborate with Providers to Enhance Compliance

OMIG will collaborate with the provider community and their representatives to require adoption of effective compliance programs establishing internal systems to prevent, or identify, disclose and address, inappropriate conduct, poor care, or improper billing.

Develop Innovative Data Mining Capabilities

OMIG will develop data mining capabilities using both state and federal resources and best available private practices and systems. OMIG will use data tools and systems to identify outliers on quality, cost and outcomes, and to encourage improvements in provider and agency practices. OMIG will support and encourage its employees in their data mining efforts, including training, education, access to tools and databases, and exposure to alternative approaches. OMIG will demonstrate to agencies, providers and the public the impact of data mining tools and encourage use of data mining by providers, provider groups and oversight organizations.

Promote High Quality Care

OMIG will protect the health and welfare of the people of the State of New York by promoting Medicaid program integrity at all levels of health care. OMIG will collaborate with provider oversight agencies to ensure appropriate access to healthcare in the provision of medical care, services and supplies that meet professionally recognized standards for health care within the scope of each provider's professional qualifications or licensure.

Promote Transparency

OMIG will be transparent and fair in its efforts to preserve the integrity of the Medicaid program. OMIG will disclose data, methods and results without compromising patient privacy obligations.

Promote Accountability

OMIG will be a good steward of the taxpayer's dollar and use available resources to efficiently and effectively accomplish its mission. OMIG will clearly articulate and define new, accurate and defensible methodologies for measuring the agency's progress.

Coordinate with State Agency Partners

OMIG will coordinate fraud and abuse control activities in a cooperative manner with state agency partners in order to fully maximize our ability to identify and prevent fraud, waste and abuse in the Medicaid program. OMIG will collaborate with state partners to articulate and enforce consistent interpretations of regulations, build in integrity on the front end of the Medicaid program and pursue the recovery of improperly expended funds.

Achieve and Exceed Established Goals

OMIG will achieve success by demonstrating increased provider compliance with Medicaid standards while emphasizing high quality care to enrollees.

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EXECUTIVE INITIATIVES

For federal fiscal year 2011, the fifth full year of the Office of the Medicaid Inspector General's operations, we are pleased to issue this work plan.

This work plan focuses on the following areas:

- Compliance
- Governance and its relationship to the compliance responsibility for organizations
- Payments due from third parties
- Mandatory reports, refunds, and explanations under the Affordable Care Act (ACA), Section 6402
- Pharmacy, devices and prescription drug issues
- Home health and personal care issues
- Evaluation and review
- Employee training and professional standards
- Outreach to beneficiaries and beneficiary organizations

Completion of this work plan required knowledge of the goals and resources assigned to OMIG during the budget process, as well as an understanding of work being performed at the federal level, in response to the requirements of the Affordable Care Act and in the Office of Inspector General (OIG), Department of Health and Human Services (DHHS) FY 2011 work plan (which contains 26 pages of reviews specific to Medicaid program integrity). The OMIG workplan was developed with these issues in mind.

The first four years of OMIG's operation have involved challenges for OMIG, the programs it oversees, and the providers responsible for services to Medicaid enrollees. OMIG has been assigned responsibility for audit and investigation of programs where very limited oversight had occurred for 15 years or more. Federal and state budget pressures and a national recession have resulted in significant reimbursement reductions and closer scrutiny of claims by providers. Audit findings have shown significant weaknesses in some providers' compliance with Medicaid regulations and integrity controls.

During FFY 2011, OMIG will continue to focus on metrics for program integrity, investigation of Medicaid fraud and abuse, and development of compliance techniques designed to improve the Medicaid program for beneficiaries and taxpayers, and reduce and collect improper payments. OMIG will work to assure that the enhanced program integrity provisions of the Affordable Care Act, signed by President Barack Obama in March 2010, and the New York False Claims Act signed by Governor David A. Paterson in August 2010, are effectively implemented and used to prevent and prosecute fraud and abuse.

OMIG will measure the performance of providers and their governing bodies in compliance, the performance of specific OMIG interventions in increasing compliance and reducing costs, and the performance of its own leadership in working with providers, other state agencies and staff.

On October 1, 2009, OMIG became the first program integrity agency in the United States to require every major health care provider receiving more than \$500,000 annually in Medicaid reimbursement to have an effective compliance program. The statute and regulation which imposed mandatory compliance programs are attached as exhibits 1 and 2 to this work plan.

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OMIG's most significant executive initiatives relate to implementation and oversight of these compliance obligations.

The statute and regulation require that each covered provider assure that their compliance program has:

- a specific structure—that is, an eight-element program with organizational requirements;
- a series of processes—a method of addressing allegations, an audit plan designed to assess and monitor assess risk areas, a process for identifying, reporting and refunding improper payments to government payers;
- outcomes—a requirement that the compliance program be effective; and
- an annual certification of effectiveness—attesting to the program's effectiveness.

This unique compliance approach, mandated by the New York State Legislature, draws from the strengths of the analytic processes developed in health care to review health innovations and medical errors and adverse outcomes, as well as the experiences of other jurisdictions in identifying and prosecuting health care fraud and abuse.

New York's approach to mandatory compliance has been adopted in the Affordable Care Act (ACA). That act will impose similar national requirements on nursing homes beginning in 2013, and gives the Secretary of Health and Human Services the discretion to extend mandatory compliance requirements to other providers after that date.

For many New York providers, a health care compliance program is not the result of a legal requirement, but rather a reflection of their commitment to their patients, their mission, and their community. In OMIG's opinion, the best health care compliance programs in New York lead to improved operations and higher quality care.

THE FOCUS ON COMPLIANCE

Social Services Law § 363-d and 18 NYCRR Part 521 requires, as of October 1, 2009, that providers meeting established statutory and regulatory thresholds adopt and implement effective compliance programs. Covered providers were required to certify to OMIG by December 31, 2009 that they did adopt and implement effective compliance programs. OMIG has been following up with those providers who were required to certify but failed to do so, and to assure that they have or are developing effective compliance programs. OMIG will also conduct compliance program effectiveness reviews for those providers discovered to have significant findings during the course of audits or investigations.

OMIG will continue to draft and publish compliance guidance to assist providers in meeting their obligations under Social Services Law § 363-d and 18 NYCRR Part 521, including issuing "compliance alerts," which will be available on OMIG's Web site.

During this year, senior OMIG staff will be visiting and talking with healthcare providers to identify and communicate best practices, to assess implementation, and to identify impediments to successful compliance programs.

OMIG's intention and expectation is to reduce the burden of audits and investigations on providers who have demonstrated effective compliance programs, recognizing that they have developed effective internal processes to identify and address compliance issues.

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During FFY 2011, OMIG will continue to conduct a series of Webinars concerning specific compliance issues, allowing compliance officers and other healthcare professionals to learn about and ask about significant compliance issues from their offices. OMIG has already offered or plans to conduct the following Webinars:

- compliance issues involving excluded persons (held June 8);
- compliance obligations under Section 6402 of ACA (mandatory reporting, refund, and explanation of overpayments) (held July 14);
- Self-disclosure issues (held September 14);
- Compliance issues in third-party billing and payment (held October, 2010);
- compliance issues for home health providers in billing patients who are dually-eligible for Medicare and Medicaid;
- Compliance lessons and best practices from OMIG on-site reviews of mandatory compliance programs. (November 17);
- Medicaid in education compliance issues;
- Compliance issues in billing for Medicaid early intervention services; and
- Compliance issues in home health care.

The materials for these Webinars (including the PowerPoint presentation and a recording of the presentation), as well as a series of questions and answers following the session, are made available on OMIG's Web site, following the actual session. The subjects listed reflect both OMIG's workplan and suggestions from providers and other government agencies. OMIG welcomes additional suggestions for Webinar topics.

OMIG has begun to identify providers who need additional direction in their compliance efforts. All providers required to have a compliance program (other than certain education providers) under 18 NYCRR 521 were required to certify by December 31, 2009 that they had an effective program in place. Several hundred providers subject to this requirement had failed to file the required certification as of July 1, 2010, six months after the deadline. OMIG staff has and will continue to reach out to these providers and will advise providers of their obligations under 18 NYCRR 521. Continual failure to certify will result in a corporate integrity agreement (CIA) or in the imposition of sanctions.

During 2010, OMIG was advised by a number of large providers that they were unaware of their compliance obligations and the duty to certify that they had an effective compliance program. OMIG maintains careful records of compliance visits and telephone calls, and has been following up with these larger providers to assure that such compliance failures are remedied. In some cases, OMIG will require documentary evidence related to compliance vulnerabilities and undertakings, and will make written findings of the compliance issues identified.

OMIG has also begun using data mining to identify compliance weaknesses:

- Billings for deceased patients. Compliance programs are intended to reduce the number of improper claims submissions. In December 2009, OMIG began contacting providers who had submitted claims for services to deceased patients, asking for information about these claims. The contacts are designed to identify and assign specific responsibility to the individual who allegedly provided the service, and to the individual who billed for the service, to improve their practices. The first mailing revealed issues with both the claims filed by some of these providers, and the

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records upon which OMIG relied in identifying deceased patients. During FFY 2011, OMIG expects to continue to identify claims for services to deceased patients with a series of mailings, and to focus compliance and enforcement efforts on providers and provider categories who continue to bill for deceased patients after being put on notice of this compliance weakness. In addition, OMIG will require written corrective plans for specified providers. The billing for the deceased patients project is not limited to paid claims; it also addresses claims which were billed but not paid, since an important objective of an effective compliance program is the prevention of submission of improper claims, whether or not the payer's systems detect and prevent payment. OMIG maintains careful records of the responses of providers to these contacts, as well as subsequent telephone calls, and will be following up with these larger providers to assure that these compliance failures are remedied. In some cases, OMIG will require documentary evidence related to compliance vulnerabilities and undertakings, and will make written findings of the compliance issues identified. Repeated appearance by an individual, an organization, or a billing entity on the deceased patient list will result in an enhanced focus on that organization for audit, investigative, and compliance efforts.

- Billings for services ordered or provided by excluded persons. OMIG and the federal OIG exclude providers to protect Medicaid enrollees and the Medicaid program from individuals who have been convicted of a crime, lost their licenses, demonstrated that they are unable to provide quality services, or have engaged in conduct which puts patients at risk. Keeping these individuals and entities out of the program is an important priority. OMIG will be reviewing through other data sources the activity of excluded persons, and identifying providers who employ them or rely on their orders. OMIG will also review the providers who show up frequently on an edit report showing orders from excluded providers. As discussed in the June 8 Webinar, providers are forbidden by both state and federal law from billing for services provided by excluded persons, and prohibited from billing for services ordered by excluded persons, and are required to disclose to OMIG when they discover that billed services were ordered or provided by excluded persons. Providers are also expected to check employees, contractors, and ordering providers against OMIG, HHS/OIG and GSA exclusion lists on a regular basis.
- Billings for services provided to hospital in-patients: Double billing occurs when Medicaid patients are receiving care in a hospital and Medicaid is simultaneously being billed for services in the community. OMIG will examine these situations to determine why and where they have occurred and will recover improper payments resulting from this practice. OMIG data mining in this area has begun with home health care and pharmacy claims.
- Failure of providers to make required disclosure of payments by third parties and third-party obligations. As discussed in the October Webinar focusing on third-party liability, OMIG has substantially expanded efforts to identify patients who have other health insurance coverage in addition to Medicaid, and to identify credit balances due to Medicaid. OMIG will look at major providers for whom we have identified credit balances, duplicate payments, a failure to bill appropriate insurers (including Medicare) first, entry of a false "zero-fill" on claims to Medicaid where the patient has other insurance, billing for additional Medicaid money after a healthcare provider has received its full contractual payment from another payer, and retention of Medicaid payments following receipt of payments from another insurer.

THE FOCUS ON GOVERNANCE AND ITS RELATIONSHIP TO THE COMPLIANCE FUNCTION

Materials developed by industry groups, the federal HHS OIG, and consultants and scholars have emphasized the critical role of trustees and board members in directing and supporting compliance. In an article in the July 2010 issue of *Trustee* magazine, HHS Inspector General Daniel Levinson emphasized the important role of hospital trustees and board members:

“Every hospital should have an effective compliance plan as well as a compliance officer on staff. Trustee leadership is critical for both. A successful hospital compliance plan establishes a culture of ethical and legal standards of behavior. Compliance plans promote the prevention, detection and resolution of actions that do not conform to federal and state law, as well as the hospital's ethical and business practices. An effective compliance program not only articulates an institution's commitment to high standards of conduct, but also sets out specific and practical steps to achieve and maintain those standards. Hospital trustees' commitment to and promotion of these ongoing efforts greatly enhance their opportunity for success. The [HHS] OIG has in-depth publications to help hospitals establish effective compliance programs.

“The compliance officer is the hospital ombudsman who monitors the institution's legal and ethical response to issues as they arise. This critically important position is a signal to the staff and community at large that the hospital takes its mission seriously. Most hospitals have compliance officers on staff. But in the coming years it is likely that government regulations will require hospitals to hire them, particularly with the implementation of the Patient Protection and Affordable Care Act.”

OMIG has found governance weaknesses in its reviews of healthcare organizations which contribute directly to compliance failures. OMIG is and will be conducting investigations of significant compliance failures to determine the potential governance weaknesses, and to determine appropriate action, including the possible censure and exclusion of board members. OMIG will also be evaluating board responses to identified compliance failures to determine what systems boards had in place to inform themselves of compliance issues and to provide reasonable assurances of compliance.

THE FOCUS ON PAYMENTS DUE FROM THIRD PARTIES

OMIG has emphasized and will continue to enforce the requirement that Medicaid providers identify and bill other payers first where Medicaid enrollees have other insurance coverage. OMIG also has emphasized and will continue to enforce the obligation of Medicaid providers to refund money to Medicaid when payment is later received from another payer.

OMIG will focus during FFY 2011 on the obligation of payers to provide coverage information and to honor and pay claims due providers where a patient has other coverage. Federal and state laws require payers to relax certain requirements for prior approval and other payment restrictions where a patient's dual coverage includes Medicaid. In 2009, New York State enacted changes to Social Services and Insurance Law based on Deficit Reduction Act of 2005.

- The definition of “insurers” was expanded to include all entities that are “by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service”

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- The “retrospective” time period for third-party liability was expanded from two years to three years
- Insurers were required to provide information on “benefits paid” (e.g., paid claims data)
- “Insurers” were prohibited from denying claims based on reasons which are issues in the “retrospective” TPL environment:
 - Carrier timely filing
 - Missing prior-authorization

Based upon OMIG’s experience after initial implementation of these changes, OMIG will track insurer compliance with these requirements in their dealings with providers as well as OMIG, and will take action against insurers whose performance is significantly poorer than expected.

THE FOCUS ON REPORTING, REFUNDING, AND EXPLAINING OVERPAYMENTS BY PROVIDERS WITHIN 60 DAYS OF IDENTIFICATION AS REQUIRED BY SECTION 6402 OF THE AFFORDABLE CARE ACT

Healthcare providers are very complex businesses; even the best and most conscientious organizations will make mistakes, and discover them after receiving payment. OMIG maintains a disclosure protocol for providers to report and refund these payments. Providers who show up in other OMIG and Department of Health (DOH) projects, but have never reported an overpayment through the disclosure protocol or identified and reversed a payment through the void process, will be identified and reviewed. As discussed in the July Webinar, beginning January 1, 2011, OMIG will begin enforcing Section 6402 of the Affordable Care Act (ACA). Providers who retain overpayments more than 60 days after identifying the payment will be reviewed for enforcement action. OMIG is undertaking efforts to identify these providers, communicate the requirements of the New York law and regulations, and assess and improve the performance of those providers. The duty of reporting identified overpayments is not limited to those overpayments identified by OMIG. Every provider has a legal responsibility under Section 6402 to report, refund, and explain overpayments identified within its organization, or identified through the efforts of other persons, within 60 calendar days of identification.

THE FOCUS ON PHARMACY, DEVICE AND PRESCRIPTION DRUG ISSUES

In order to focus on pharmacy issues and their relationship to proper business and professional practices, OMIG established a new pharmacy unit within the Division of Medicaid Investigations (DMI) to manage these investigations.

- In 2010, OMIG requested and received Medicare Part D data related to prescriptions for atypical antipsychotics for Medicaid enrollees in nursing homes: During 2011, OMIG will review utilization patterns by individual nursing homes to identify off-label use of these drugs and patient outcomes. OMIG will also examine Medicaid data related to prescribing of atypical antipsychotics for children.
- Use of “brown-bagging” by Medicaid providers: “Brown-bagging” is the practice of requiring patients who receive certain costly drugs as part of an inpatient or outpatient treatment to obtain the drugs from an outside pharmacy and to bring the drugs with them for their treatment. The treatment facility then submits a claim for the total services, including the cost of any drugs provided during the treatment, and the Medicaid program pays twice.

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- Kickbacks and incentive payments to nursing homes, pharmacy consultants, and physicians in connection with prescription drugs and medical devices: The federal settlement of the Omnicare litigation in 2009 revealed the extent of payments by pharmaceutical manufacturers to pharmacies for switching patients to favored prescription drugs, and payments by Omnicare to nursing homes relating to prescription drugs. Public disclosure of payments by pharmaceutical manufacturers to physicians during 2010, and the availability of public searchable databases through investigative Web sites, allows for the first time an opportunity to examine the relationship between payments to physicians and prescribing patterns.

THE FOCUS ON HOME HEALTH AND PERSONAL CARE ISSUES

OMIG's audits have disclosed significant disparities between services ordered by treating physicians for home health patients, services contained in the patient evaluation and nursing treatment plans, and services actually provided by home health staff. In some cases, patients fail to receive ordered and needed services. In other cases, patients receive services far in excess of those ordered by the physician, or contained in the patient evaluation and treatment plan. OMIG will use the services of its professional nursing staff to assess and report on these failures of care, to recover overpayment and to evaluate compliance weaknesses. OMIG will use its data mining capabilities to identify specific geographic and referral relationships for further review.

THE FOCUS ON EVALUATION AND REVIEW

Working closely with the Office of Health Insurance Programs (OHIP), OMIG has begun to undertake initiatives in program evaluation and review for fraud and abuse risks. This function parallels the evaluation role that the federal HHS OIG completes. OMIG will report on program weaknesses and program abuses identified through OMIG's audit, investigation, data mining, or compliance activities, which result in a potential for fraud, or in services which fail to meet recognized business, financial, or professional standards. OMIG also will develop program implication reports to identify and recommend practice improvements.

THE FOCUS ON EMPLOYEE TRAINING AND PROFESSIONAL STANDARDS

During SFY 2009-10, OMIG developed audit protocols and training programs for certain significant audit areas. During FFY 2011, OMIG plans to continue and expand these efforts through core competency trainings in each division. A new learning management system database is being implemented to track employee training and individual training program progress. OMIG will encourage staff to benefit from training opportunities made available through the Medicaid Integrity Institute operated and financed by the Center for Medicare and Medicaid Services, and to lend their expertise to course design and instruction for state Medicaid program integrity staff. OMIG has also reached out to provider organizations to include OMIG employees in their training programs, both as speakers and as attendees.

THE FOCUS ON OUTREACH TO BENEFICIARIES AND BENEFICIARY ORGANIZATIONS

During FFY 2011, OMIG plans to expand its beneficiary outreach efforts to encourage Medicaid enrollees to identify fraud, abuse, and improper practices in the Medicaid program. OMIG plans to develop a pilot project involving direct calls to beneficiaries to confirm that billed services were provided as claimed in certain provider areas where previous OMIG work had suggested the

risk of improper payments. We will also continue our outreach to patient advocacy organizations, focusing on those who represent vulnerable populations.

ADVISORY COMMITTEE ON OMIG AUDIT PROCESS

In OMIG's continuing effort to operate in an open and transparent manner, and consistent with our commitment to continuous performance improvement, we are engaging the provider community and legal, accounting, and compliance professionals in discussing OMIG's efforts to promote and protect the integrity of the Medicaid program. OMIG has convened an advisory group with the goal of facilitating candid discussions on audit processes and systems:

- The role of OMIG auditors and OMIG's perspective on auditing as an activity;
- Expectations of OMIG auditors;
- Review of OMIG's audit process;
- An explanation and discussion of OMIG's statistical sampling/extrapolation process;
- OMIG's role relative to quality of care; and
- Considering methods which can reduce the burden of audit activities on providers while preserving audit accuracy and program integrity

Consistent with OMIG's statutory mission and responsibilities, OMIG will assess feedback and implement appropriate changes to our processes to enhance the efficiency, effectiveness and professionalism of our operations.

CORPORATE INTEGRITY AGREEMENTS

OMIG executed its first four corporate integrity agreements (CIAs) in December 2009. OMIG will continue to identify those providers who refuse or fail to meet their obligations but whose removal from the program would nonetheless negatively impact access to necessary services. OMIG will execute additional CIAs and, in many cases in collaboration with independent review organizations (IROs), will monitor provider compliance with the provisions of existing CIAs. Providers who breach their CIA obligations will face sanctions in the form of stipulated penalties and/or exclusion.

REVIEW OF ATYPICAL ANTIPSYCHOTIC MEDICATIONS

Over the last several years, the scientific and health care communities and the federal government have raised concerns over off-label uses of atypical antipsychotics. In particular, the off-label use of atypical antipsychotics to treat symptoms of dementia among the elderly has come under scrutiny as studies have demonstrated that this use is associated with an increased risk for death among elderly patients. In response to these concerns, the Food and Drug Administration (FDA) has issued "black box" warnings, starting in 2005, announcing the increased mortality rates in elderly patients with dementia related to psychoses treated with atypical antipsychotic drugs.

In light of these increasing safety concerns, OMIG has conducted a review of atypical antipsychotics used in the treatment of Medicaid recipients of all ages and prescribed between January 1, 2007 and December 31, 2008.

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To further expand its review of off-label use of atypical antipsychotics in skilled nursing facilities, OMIG requested from the Centers for Medicare and Medicaid Services (CMS) the Medicare Part D data for antipsychotic drugs prescribed for all New York State Medicaid recipients residing in skilled nursing facilities for service years January 1, 2007 to December 31, 2008.

CMS approved the request, and receipt and review of this data began in July 2010. The purpose of this review is to more precisely determine the number of residents who are receiving these atypicals without having a concurrent diagnosis of psychosis. We are reviewing to determine which skilled nursing facilities have the highest percentage of recipients prescribed atypical antipsychotics and which physicians are the highest prescribers of these drugs. Once these facilities have been identified, OMIG will communicate with the administrators of the identified facilities to encourage appropriate prescribing activity for their residents and ask that the providers explore alternative treatment options that do not have the potential to endanger the general welfare of the patients.

REVIEW OFF-LINE MEDICAID EXPENDITURES

The Department of Health (DOH), which administers New York State's Medicaid program, and its fiscal agent, Computer Sciences Corporation (CSC), uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay most of the claims submitted by providers who render services to eligible Medicaid recipients.

Certain types of claims, however, are handled outside of MMIS because of special processing requirements or MMIS limitations. These claims are referred to as "off-line" payments. The off-line Medicaid claims include, but are not limited to, payments to providers from public goods pools established to reimburse providers for services rendered to indigent persons, payments of Medicare insurance premiums on behalf of Medicaid recipients, and reimbursements to local governments and state agencies for off-line claims they have submitted for reimbursement or received payment based on claims from other providers.

EXTERNAL COMMUNICATIONS

OMIG is committed to increasing transparency with its various constituencies, including the members of the New York State Legislature and other policymakers, other state agencies, Medicaid providers and the general public. To that end, we have expanded outreach efforts on a variety of levels, and are focused on investigating new avenues of communication during FFY 2011.

Web Site

In 2010-11, the Public Information Office, in conjunction with the Division of Technology and Business Automation (DTBA), expects to accomplish the following goals:

- Webinars: Scheduled Webinars will be posted on the Web site. Completed webinars will be available on the Web site, including audio, PowerPoint presentations, and frequently asked questions.

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- Fraud alerts: In conjunction with staff from all divisions, we will develop a new “fraud alert” section on the Web site, to communicate with providers and the public alike information about areas of potential fraud or abuse within the Medicaid program. The goal is to encourage providers, ordering physicians, billing companies, consultants, and compliance officers to focus on program risk areas, and to increase reports of potential fraud through the toll-free hotline number or via the form available on the Web site
- Listserv: allows individuals to receive updates of OMIG information and announcements of upcoming events (e.g., Webinars and registration information, press events, etc.). OMIG now has more than 2,300 subscribers.

External Communications

Outside organizations, including those associated with provider groups, community organizations, professional associations and public benefit agencies, often invite OMIG staff to speak about OMIG-related topics at various events. In the past, these groups have included local, regional, statewide and national organizations. We will continue to be proactive and seek appropriate forums for OMIG staff to present information about the agency’s activities, and will respond to requests from outside groups looking for experts in areas covered by OMIG staff.

OFFICE OF LEGISLATIVE AND INTERGOVERNMENTAL AFFAIRS (OLIA)

The Office of Legislative and Intergovernmental Affairs (OLIA) serves as OMIG’s liaison with the New York State Legislature, as well as county and local government officials. OLIA also interacts with other state agency legislative and intergovernmental affairs offices involved in Medicaid program integrity and policy-related issues. This includes the Attorney General’s office, the Office of the State Comptroller, the Office of Mental Health (OMH), the Office of Persons with Developmental Disabilities (OPWDD), the Office of Children and Family Services (OCFS), the Office of Temporary Disability and Assistance (OTDA), and the Office of Alcoholism and Substance Abuse Services (OASAS) (the “O” agencies), as well as the Department of Health (DOH), and the Executive Chamber.

Outreach Activities

Local Government

In addition to this action, OLIA has diversified its outreach to other partners. OLIA’s regular work has been expanded to county executives, county comptrollers, district attorneys, individual county legislators, county legislative committees, as well as interest groups representing these and other entities. As a result of OLIA’s administration of the County Demonstration Project, this work has served to improve relationships and further the discussion of issues pertinent to local government partners. Over the course of the next year, OLIA will undertake activities to examine innovative, potential cost saving opportunities at the local level in keeping with OMIG and County Demonstration’s statutory mandates.

Other Agencies

The OLIA will also continue to initiate and coordinate activities with OMIG’s agency partners on behalf of OMIG staff in other bureaus, and continue to provide support in interagency collaborative efforts.

COUNTY DEMONSTRATION PROJECT

The County Demonstration Project was authorized by Chapter 58 of the Laws of 2005. It was created to further New York State's efforts to combat fraud and abuse in the Medicaid program by enlisting the local districts to act as agents of OMIG, thus ensuring post-payment provider accountability.

To date, 11 counties and the City of New York are actively engaged in conducting audits; five of those counties became operational during SFY 2009-10. Currently, 298 active audits are underway within the 12 participating local jurisdictions.

During FFY 2011, OMIG anticipates the following improvements to the operations and outcomes of the project:

- Issue an administrative directive to local districts regarding fiscal reporting under the project
- Expand audit specialties that can be undertaken
- Collect recoveries under the project
- Collaborate with counties to expand pilot activities
- Offer additional training
- Complete a formal evaluation of the project

DIVISION OF MEDICAID AUDIT (DMA)

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

OMIG's field staff has a broad range of experience in health care programs. This affords DMA the opportunity to organize and coordinate statewide projects to address the spectrum of Medicaid-covered services and the various program initiatives of DOH, OMH, Office of Persons with Developmental Disabilities (OPWDD), and the Office of Alcoholism and Substance Abuse Services (OASAS). OMIG's professional staff performs audits and reviews of Medicaid providers augmented by outside contractors and staff from the local districts through the County Demonstration Project.

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

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Medicaid program participation is a voluntary, contractual relationship between the provider of service and the state (NY Soc. Serv. Law § 365-a; 18 NYCRR Part 504). Satisfactory compliance with program rules and regulations is a condition of continued participation in the Medicaid program, and is expected in order to receive payments for Medicaid claims.

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

DOH regulations (18 NYCRR Subchapter E) define the requirements for participation, as well as the rules, regulations and statutes of general applicability to the provider type in question. The rules governing the establishment of Medicaid rates by DOH are enumerated in 10 NYCRR Subpart 86-2. The complete Medicaid certification statement is included as Appendix B.

AUDIT PROCESS

The Medicaid program requires participating providers to maintain adequate records to support their billings to the program. Cost-based providers must maintain financial and statistical records which are used for the purpose of establishing reimbursement rates. This includes all underlying books, records and documentation that form the basis for the financial and statistical reports which the provider files with the Bureau of Long Term Care Reimbursement (BLTCR) and OASAS. The BLTCR and OASAS are responsible for establishing the payment rates based upon their review of information supplied by the provider. The established payment rates are then subject to OMIG audit to assure the accuracy and consistency of provider submissions.

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

OMIG uses a system of paperless audits for rate-based provider audits. OMIG chose the TeamMate audit software program to facilitate more efficient and consistent rate-based provider audits statewide. This program was implemented in rate-based provider audits during SFY 09-10. In conjunction with the implementation of TeamMate software, OMIG developed a training manual and outline for all rate-based provider audits; the implementation process was completed in July 2009.

OMIG publishes its work plan to assist compliance offices in developing their own organization-specific audit and monitoring activities. Certain desk audits are also conducted based upon data mining; the selection and audit methods may differ from DMA's process.

Selection of Audit Subject Areas, Providers and Methods

OMIG uses a variety of analytical tools and data mining techniques to identify providers for audit purposes. We consider successful initiatives in Medicaid program integrity in other states, current academic and public policy organization analyses of health care issues, and program ideas

and directives from the CMS Medicaid Integrity Program, which has federal responsibility for guiding and overseeing our work. We work closely with DOH, the Department of Law and the Comptroller's Office in identifying program vulnerabilities.

We also receive recommendations for audits from HHS, OIG, oversight agencies, news articles and our hotline. An integral part of the selection process is a review of oversight agency survey reports or other provider reviews. We use this information to determine whether to perform an audit, and, if so, the type of audit to employ. For example, we have the option of performing a documentation and coding audit, a clinical audit of fee-for-service providers, or a combination of those audit approaches.

Project Notification

An on-site audit begins with OMIG's sending a project letter to the provider as an official notification. The project letter asks for certain audit documents in advance of an entrance conference. The requested documents assist OMIG in establishing the scope of work, type of audit and procedures to be performed. In addition, the documents enable OMIG to complete audit procedures prior to beginning the on-site audit. The information includes, among other things, audited financial statements, tax returns, a list of related parties and selected analysis of work. In addition, OMIG staff directs the provider to notify its outside accountants in writing, so that OMIG can gain access to their work papers.

OMIG may require a copy of provider tax returns (including IRS 990 information returns) and information on the provider's compliance program. We will also review enrollment records and may require copies of current licenses, certifications, credentialing materials, and exclusion and debarment checks. In some cases, other information will be required and will be specified in the project letter.

Entrance Conference

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

Statistical Sampling

Accounting firms, national healthcare consulting firms, HHS, and the OIG use statistical sampling techniques for audit purposes. In many instances, statistical sampling allows an audit of an account to be conducted that would otherwise be too voluminous or complex to audit in its entirety, or would impose an undue burden on the provider in collecting and delivering records. Some of the sampling techniques generally used by auditors, including OMIG, are as follows:

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

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- **Sampling unit**—the individual elements that comprise the population or sampling frame: In the case of an insurer audit, the sampling unit might be the insurance recipient or the individual insurance claim or transaction.
- **Probability sample**—a sampling procedure in which the probability that any member of the population will be included in the sample is known in advance: For example, in a simple random sample, each member of the population has an equal chance of being included in the sample. Valid estimation procedures require probability samples.
- **Random sample**—a group of sampling units from a population where each unit has an equally likely chance of being independently selected from the population or sampling frame.
- **Sampling procedure or technique**—the method used to select units for inclusion in a probability sample, for instance, choosing every tenth unit (systematic sampling), or using a random number table.
- **Estimator**—the mathematical rule by which an estimate of some population characteristic is calculated from the sample results.
- **Estimate**—the value obtained by applying the estimator to the random sample, and projecting it to the larger population: A point estimate is an estimate in which a single number is used as an estimate of a population characteristic. An interval estimate is one in which the estimate is given as a confidence interval within which the population characteristic will lie with a certain confidence level.
- **Unbiased**—an estimator is unbiased if the average value of the estimate, taken over all possible samples, is exactly equal to the true population value.
- **Confidence interval, confidence level**—the confidence interval is the range of values in which a population characteristic will lie with a given level of certainty (confidence level, expressed in percent). For example, we might be “95 percent confident” that the mean of a sampling frame is between two values, X1 and X2, which are the upper and lower bounds of the confidence interval.

OMIG uses the services of a recognized, university-based PhD statistician to assist in developing sampling techniques and analysis and identification of the results of a statistical sample. Under governing law (18 NYCRR § 519.18(g)), the provider has the right to challenge the sampling methodology in an administrative hearing concerning an audit.

Exit and Draft Reports

OMIG is streamlining the audit process based on comments from trade associations and providers. Our goal is to share preliminary findings, including work papers during field work. We believe this will resolve some differences before an exit conference.

OMIG has incorporated into its audit process a review of medical necessity for services rendered to eligible recipients and billed to the Medicaid program. The purpose of the medical necessity

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review is to determine, as required by governing law, if services are reasonable and necessary, and, therefore, reimbursable through Medicaid.

OMIG will, as part of field work, give the provider preliminary findings, including work papers, to resolve, if possible, any audit findings.

Upon completion of a field audit, OMIG staff conducts an oral exit conference with supporting schedules with the provider to discuss preliminary findings. Afterward, OMIG will issue a draft audit report in writing to identify any proposed recoupment and the basis for action. The provider has 30 days to respond to the draft audit report. If the provider fails to reply within that time frame, OMIG will issue a final report. If the provider objects to the draft audit report, OMIG will consider the provider's response, including any supporting documentation, before issuing a final written audit report.

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

ADULT DAY HEALTH CARE

Adult day health care (ADHC) is a community-based long term care program that provides comprehensive health care services in a congregate day setting. ADHC is designed to meet the health care needs of chronically-ill, frail elderly and disabled adults who require certain primary, preventative, diagnostic, therapeutic, rehabilitative or palliative services. Currently, more than 15,000 New Yorkers receive ADHC services through 184 programs statewide.

The ADHC program assesses a registrant's needs and designs an individualized care plan that is developed and implemented by an interdisciplinary team of medical professionals, including the registrant's personal community physician. ADHC provides nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. ADHC provides services according to the assessed needs of the registrant and range from monitoring, observing and maintaining an individual's health status to aggressive interventions and utilization of resources.

Rate Audit

The operating component of the Medicaid rate for an ADHC program which has achieved 90 percent occupancy is computed on the basis of allowable reported costs divided by total number of reported visits by ADHC residents. For programs that have not achieved 90 percent occupancy, the operating component is calculated utilizing allowable reported costs divided by visits imputed at 90 percent occupancy. The capital component utilizes the same cost basis as was utilized for the operating component. Rates are subject to the maximum daily rate provided by Pub. Health Law 2808.

OMIG will conduct audits of ADHC Medicaid rates to ensure appropriateness of the rate and, where necessary, to recover overpayments.

ASSISTED LIVING FACILITIES

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An assisted living program (ALP) is an entity approved to operate pursuant to section 485.6(n) of the Social Services Law. The ALP was established and is operated for the purpose of providing long-term residential care, room, board, housekeeping, personal care, supervision, and providing or arranging for home health services to five or more eligible residents unrelated to the operator (18 NYCRR § 494.2).

OMIG's historical review of ALP providers identified documentation and coding issues. In addition, we have identified through data mining activities a variety of goods and services billed to Medicaid by other providers that were included in the ALP payment rate. Per 18 NYCRR § 505.5(d)(1)(iii), Medicaid will not pay for any items furnished to a facility or organization when the cost of these items is included in the facility's rate. OMIG will expand its audits of ALPs focusing on PRI coding and timely medical evaluations and interim assessments. In addition, we will review goods and services billed to Medicaid that are included in the ALP payment rate.

CONSUMER-DIRECTED PERSONAL ASSISTANCE PROGRAM

The purpose of the Consumer-Directed Personal Care Assistance Program (CDPAP) is to allow chronically-ill and/or physically disabled individuals receiving home care services under the Medicaid program greater flexibility and freedom of choice in obtaining such services while reducing administrative costs. In general, local social service districts enter into a contract with providers to provide CDPAP to consumers. OMIG will target selected CDPAP providers for compliance with the responsibilities identified in the local district contracts. Audits will verify that services billed to Medicaid were actually delivered to the CDPAP participant. OMIG will also ensure that the consumers of service are adhering to contractual and program responsibilities.

CROSSOVER PAYMENT MATCHES

A series of reviews are planned to determine the accuracy of claims for deductibles and coinsurance for dual-eligible (i.e., Medicare and Medicaid) recipients. The purpose of these audits is to compare the amounts paid by Medicare Part B with the amounts reported on New York's Medicaid system. Specifically, the amounts Medicare approved and paid are matched to the Medicaid claims, as are the coinsurance and deductible amounts. We obtained Part B Medicare payment information from HHS's Center for Medicare and Medicaid Services (CMS). The review has identified instances where Medicaid overpayments have been made to providers due to misreporting or failure to report correct Medicare payments. Preliminary reports have been developed for a number of physicians, with plans to include analyses of hospital and laboratory claims.

DIAGNOSTIC AND TREATMENT CENTERS

In prior audits, OMIG identified significant documentation, coding and medical necessity issues of diagnostic and treatment centers (D&TC) services. OMIG will continue to review Medicaid payments for services provided by D&TCs to determine compliance with applicable rules and regulations found in 10 NYCRR and 18 NYCRR. A key component of the review will be to determine the appropriateness of payments for physical, speech, and occupational therapy services and HIV primary care services.

OMIG will review D&TCs participating in products of ambulatory care (PAC) reimbursement to verify that documentation meets PAC payment criteria. In addition, OMIG will expand its review to encompass new rate codes for federally qualified health centers (FQHCs).

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OMIG's review will determine whether the services were rendered by an unqualified practitioner. OMIG will also review D&TC compliance with Medicaid conditions of participation. Claims for payment will be reviewed to ensure that they were submitted within 180 days from the date of service.

Prior audits have found significant problems, including reviews of plans of care for rehabilitation services not being completed on a timely basis, no explanation of benefits (EOB) for Medicare/third-party health insurance (TPHI)-covered services and insufficient documentation for the rate code billed.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

OMIG will review durable medical equipment (DME) and other supply claims submitted by selected providers to determine compliance with 18 NYCRR § 505.5. OMIG will review a sample of payments to ensure that the equipment and/or supplies were properly authorized, products delivered, and the claim amount falls within Medicaid payment guidelines.

OMIG will focus on items dispensed to institutional residents and the accuracy of Medicare coinsurance claims. OMIG will use system matches to identify claims for institutional residents and for inappropriate claims for dual-eligible (i.e., those covered by both Medicare and Medicaid) recipients. OMIG will also conduct medical reviews of high-ordering DME physicians to support the need for the DME and to determine if the physician had seen and treated the recipient on the date of service or during the six-month period prior to the DME date of service, as required.

EARLY INTERVENTION

Counties in New York State provide services to children at risk between birth and three years of age by contracting for the services with providers and therapists in the community. The providers bill the counties for the services provided. The counties, in turn, bill third-party insurance, Medicaid and state early intervention (EI) funds for the services for which counties paid. Claim information shows that counties are the Medicaid providers of record. Inquiries to the data warehouse suggest that some children are receiving what could be excessive services in a single day. Also, small samples of claims reviewed by EI audit staff in DOH have uncovered findings of lack of documentation.

OMIG audits the county, which is the Medicaid billing provider: OMIG's approach will be to examine the claims counties submit to Medicaid for reimbursement by providers contracting with the county and sample claims submitted by contractors to the county for the contractors providing most of the services. Audit findings will be turned over to the counties to recoup overpayments for the Medicaid program, or, in appropriate cases, may be the basis for further audit or investigation by OMIG. The purpose of these reviews is to ensure that contractors are following Medicaid requirements for providing services. Because of the complexity of EI billing, OMIG will work with DOH, the Department of Education, and county public health officials to ensure that OMIG has a complete understanding of EI reimbursement rules and claiming processes.

OMIG plans to review the rejection or non-payment of EI claims by third-party payers for patients who have both third-party and Medicaid coverage, and to determine what further action may be required.

EXCEPTION CODE PROJECT

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OMIG's Exception Code Project establishes the propriety of late claims submission to the Medicaid program. Regulation 18 NYCRR § 540.6 and the eMedNY provider manual state that claims for payment for medical care, services or supplies furnished by any provider under the medical assistance program must be initially submitted within 90 days of the date the medical care, services or supplies were furnished to an eligible person to be valid and enforceable, unless the provider's submission of the claims is delayed beyond 90 days due to circumstances outside of the provider's control. All such claims must be accompanied by a statement of the reason (exception code) for such delay and must be submitted within 30 days from the time submission came within the control of the provider. Regulations also state that any claim returned to a provider due to data insufficiency or claiming errors must be correctly resubmitted within 60 days. CMS requires states to impose a maximum one-year time period in the Medicaid program between the date of service and the date of the claim; DOH regulations prescribe a 90-day requirement, with allowance of later submissions based upon articulated exception codes. During FFY 2011, OMIG will review pending Exception Code Project audits to assure compliance with current OMIG policy.

FREESTANDING AMBULATORY SURGERY SERVICES

The Medicaid program reimburses ambulatory surgery centers at a higher payment rate than it does if the same services were to be performed in a physician's private office. If the service is performed in an ambulatory surgery center, it must be justifiable for reasons of patient safety and administration of anesthesia.

Title 10, Section 755.1 defines ambulatory surgery as a service organized to provide those surgical procedures which need to be performed for safety reasons in an operating room on anesthetized patients requiring a stay of less than 24 hours' duration. These procedures do not include those outpatient surgical procedures which can be performed safely in a private physician's office or an outpatient treatment room. Ambulatory surgery services may be provided in a freestanding ambulatory surgery center or a hospital-based ambulatory surgery center. Hospital-based ambulatory surgery centers may be on-site or off-site, as described in section 405.20 of this title. The provisions of Section 405.20 shall be applicable to freestanding ambulatory surgery centers and off-site hospital-based ambulatory surgery centers.

The Policy Guidelines Manual for Article 28 Certified Clinics states: "...Ambulatory surgery patients utilize the operating room, recovery room, anesthesia services and other related ancillary services in the course of their treatment. Outpatient surgical procedures typically performed in a physician's office or ambulatory treatment room setting are not considered ambulatory surgery...if patient complications require that a procedure needs to be performed in an ambulatory surgery setting, then the facility must obtain prior approval."

OMIG will review physician and ambulatory surgery center medical charts to ascertain if documentation demonstrates that the procedure needed to be performed in an ambulatory surgery setting. Reimbursement methodology for ambulatory surgery is found in NYCRR § 86-4.40. Ambulatory surgery is defined in 10 NYCRR §§ 405.20, 709.5 and 755.1.

HOME HEALTH SERVICES

Adult Home Setting

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Adult home residents may be eligible to receive Medicaid-reimbursed services rendered by a certified home health agency (CHHA) in accordance with a comprehensive assessment prepared by a licensed registered nurse, physical therapist or speech therapist, evaluating the individual resident's medical, social, mental health and environmental needs, and ordered in a plan of care approved by a physician. Who prepares the comprehensive assessment should be determined by the modality of care the resident requires. The CHHA must provide only those services which are authorized under its operating certificate or other authorizations, and which are provided for the actual needs of the resident consistent with the physician's plan of care.

Since an adult home is responsible for providing certain personal care services for its residents, a CHHA may not bill Medicaid for the services that an adult home is required to furnish and that are actually furnished. Personal care services rendered to adult home residents by a CHHA are appropriate for reimbursement by Medicaid if a resident needs personal care services beyond those required to be furnished by the home. In this way, a CHHA shall not be reimbursed by Medicaid for personal care services that are the responsibility of an adult home and are actually furnished.

Certified Home Health Agencies

OMIG will conduct audits of CHHA cost reports to verify per-visit and hourly rates calculated for the various ancillary disciplines in accordance with 18 NYCRR Part 517 and Subparts 86-1. OMIG will review direct patient costs, overhead costs, related party costs, Medicaid patient visits, total visits and related hours with an emphasis on high Medicaid utilization providers. OMIG will validate the direct costs through inspection of invoices and payroll records, and will verify cost-allocated statistics for reasonableness. Patient visits and hours will be verified against supporting patient logs and/or census data to ensure proper reporting.

Claims Audits

OMIG will review home health agency (HHA) claims to determine whether the claims meet the criteria outlined in 18 NYCRR § 505.23, Article 36 Pub. Health Law, and in 10 NYCRR Article 7. This review will determine if the services were provided, ordered by a qualified practitioner in a timely manner, adequately documented, third-party coverage was pursued, and that the personnel met all regulatory requirements.

Medical Surpluses

Medical surpluses occur where patients qualify for Medicaid after they have incurred monthly medical bills that exceed a predetermined excess income amount. In some counties, the responsibility for applying the excess income is assigned to specific CHHA providers who are required to bill the net of the patient's monthly liability. OMIG's review will analyze billing for affected recipients to ensure that CHHA billings were submitted as appropriate.

Workforce Recruitment and Retention

OMIG will audit rate add-ons, such as the worker recruitment and retention; recruitment, training and retention, and accessibility, quality and efficiency adjustments, to ensure compliance with regulatory requirements contained in Public Health Law 3614..

HOSPICE SERVICES

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OMIG will review Medicaid payments to hospice providers to determine compliance with 18 NYCRR § 86-6, and Sections 792, 793, and 794. A medical record review will be completed to determine whether the services were properly authorized, appropriately provided and documented, and if third-party coverage was pursued.

Auditors will review personnel records to verify that provider staff met all regulatory, educational, medical and experience requirements, and perform a documentation review to determine whether the recipient met the hospice admission criteria.

HOSPITALS

Duplicate Clinic Claims Audit

OMIG has identified, through data mining activities, Medicaid clinic rate code billing combinations, billed by hospital outpatient clinics and diagnostic and treatment centers, which constitute duplicate payments. The services were billed on the same date of service for the same recipient. Areas to be reviewed include rate codes in the HIV/AIDS, Community Health Assessment Process (CHAP), PCAP, OASAS and OPDD specialties. OMIG will issue reports to affected providers requesting repayment for the service which constitutes a duplicate payment. During FFY 2011, OMIG will finalize all outstanding duplicate clinic claims audits.

Low Birth Weight

Diagnosis-related groups (DRGs) serve as a basis of payment for some inpatient stays, including neonatal (newborn) care. Neonatal claims are assigned a DRG code based on various factors reported on claims, including birth weight, diagnosis, length of hospital stay, and type of discharge. Newborns with very low birth weights are likely to be hospitalized longer and require more complex levels of care before they can be discharged. The DRG system allows higher Medicaid reimbursement to hospitals that provide more complex and expensive medical care for newborns, particularly those with low birth weights. Hospitals that bill for very low birth weight babies generally receive higher payments than those billing for normal birth weight babies.

OMIG will identify newborn claims that were paid under 12 different DRG codes, contained low birth weights for the babies involved, and indicated that the newborn was discharged home after an unusually short hospital stay when compared to the average length of stay for each of the DRG codes. OMIG will review hospital medical records related to each of the newborn claims selected to ensure the birth weight on the Medicaid claims corresponds to the hospital's medical records.

Non-Emergency Services to Undocumented Citizens

Federal law limits payment of claims for services to undocumented persons to "emergency medical conditions." An emergency medical condition is defined as a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the person's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ part. Under governing law, a treating physician must certify that the patient is suffering from an emergency medical condition in order to obtain Medicaid payment.

OMIG will utilize data mining activities to identify potential provider billings to the Medicaid program for non-emergency services to undocumented persons, and review the records of those

patients to determine that the appropriate certification was completed timely by a treating physician.

Outpatient Department Services

OMIG will review Medicaid payments for selected hospital outpatient services provided by hospitals licensed under Article 28 of the New York State Public Health Law and certified by the New York State DOH, to provide preventive, diagnostic, therapeutic, rehabilitative or palliative items or services furnished by or under the direction of a physician. OMIG will select a sample of services for emergency room or clinic, ordered ambulatory-other than labs, ordered ambulatory-labs and review the underlying documentation such as physician orders and test results to ascertain compliance with Medicaid regulations.

In addition, OMIG will focus on services performed on recipients who have Medicare or another form of third-party insurance coverage to ascertain that Medicaid was the payer of last resort. The specific standards and criteria for outpatient department services are principally found in various parts of 10 NYCRR Chapter V and 18 NYCRR Chapter 11, as well as the separate MMIS provider manual for each type of service—i.e., clinic, laboratory, and hospital-based ordered ambulatory, etc.

Payment for Medicare Coinsurance and Deductibles

OMIG has identified instances prior to implementation of the Medicare crossover programs in 2010 in which providers are billing Medicaid for Medicare coinsurance and deductible amounts that are suspect. Through data mining, OMIG has identified billings where a Medicare-approved amount in excess of the deductible is billed with a zero fill in the Medicare-paid field. OMIG will request from providers documentation of the Medicare claims, denials and payments by Medicare and a refund, where appropriate.

In addition, OMIG has also identified instances where the Medicare deductible has already been met for a patient and subsequent billings are made for the deductible amount. OMIG will initiate reviews of these claims for credit balances and recovery initiatives.

OMIG will continue to review and recover provider billings where the Medicare-approved amounts appear excessive or duplicative.

Readmissions

Potentially preventable inpatient hospital readmissions may occur because the patient is discharged too soon or too sick or because of a lack of follow-up care in the community following discharge. When a patient returns to the hospital for an illness for which they were hospitalized in the past 31 days, hospitals at certain times were required to combine the billing charges to Medicaid of the two admissions.

In a May 2010 review, the Office of the New York State Comptroller (OSC) found that some hospitals were not reviewing claims related to readmissions before submitting them to Medicaid; rather, they relied on state reviews after payment to capture overcharges. Failure to have a

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system in place to prevent billing for readmissions is inconsistent with hospital obligations under 18 NYCRR 521 to have an effective compliance program in place.

OMIG will audit claims data, looking at inpatient readmissions within 30 days of the original discharge.

Short Stays

The Medicaid program reimburses hospitals for covered inpatient services on a prospective payment system based on diagnosis-related groups. OMIG has identified certain DRG coding that indicates short-term stays.

OMIG will focus on these outliers and examine medical documentation to support the need for an inpatient stay.

Transfers

The OSC performed a compliance review of inpatient DRG payments and identified that hospital's request of Medicaid DRG payments for transfer cases. We identified through data mining numerous instances when hospitals requested DRG payments for transfer cases. We will request hospital medical records to determine the propriety of inpatient payments for patients transferred between acute care hospitals paid on a DRG basis. . Where a hospital has no effective system to identify and prevent over-billing for transfers, OMIG will review the hospital's compliance program.

HUMAN IMMUNODEFICIENCY VIRUS (HIV) SERVICES

OMIG will review Medicaid payments for HIV and AIDS-related services provided by diagnostic and treatment centers and designated AIDS centers (DAC) to determine compliance with applicable rules and regulations found in 10 NYCRR and New York State AIDS Institute policy directives.

Case Management Services

HIV/AIDS case management is a process which assists HIV-infected or high-risk persons who are Medicaid-eligible to gain access to necessary services in accordance with goals contained in a written case management plan. New York State DOH AIDS Institute community follow-up program standards and 18 NYCRR § 505.16 provide details of the regulatory requirements for HIV/AIDS case management services. OMIG will review providers rendering case management services to ensure that procedural requirements for the provision of services are met and that those services have been billed correctly. This will include an examination of supporting documentation for the units of service billed.

Drug Resistance Testing

Medicaid covers HIV drug resistance testing when clinically indicated, up to a maximum of three genotypic and phenotypic tests, in any combination, per year. OMIG has initiated data mining activities to identify laboratories that billed Medicaid for more than four covered tests per year. This is a follow-up to the 2009-10.workplan.

HIV Primary Care Services

The HIV primary care Medicaid program provides for enhanced Medicaid rates for hospitals and clinics which have entered into an agreement with DOH. Services include HIV counseling and testing, HIV medical evaluations, and HIV monitoring. In addition, DACs may bill under the HIV seven-tier outpatient visit criterion for HIV-specific care. The seven-tier intermediate visit requires the patient to have presented with a new problem or marked change in an existing problem. OMIG will inspect providers' underlying medical record documentation to ensure compliance with requirements for each visit type.

LABORATORY SERVICES

OMIG will review Medicaid payments for selected independent laboratories to assess compliance with 18 NYCRR § 505.7.

That section requires:

- Payment for laboratory services will be in an amount equal to the lower of: the amount specified in the Medicaid fee schedule for laboratory services or the fee charged for laboratory services provided to the general public by the laboratory.
- Payment for laboratory services will be made only when the results of the ordered tests have been provided in writing to the ordering practitioner.
- Payment for laboratory services will be made only to the laboratory services provider actually performing the test.
- Payment for laboratory services provided by independent laboratories will be made only for individually ordered tests. No payment will be made for tests ordered as groupings or combinations of tests or for individual tests ordered on a laboratory order form issued by an independent laboratory which also contains an order for one or more groups or combinations of tests. Each test must be separately ordered by a qualified practitioner
- No payment will be made for tests repeated at the request of the ordering practitioner when the results of the original test are not consistent with the clinical findings.

OMIG will select a sample of claims and review the underlying documentation such as physician orders and test results to ascertain compliance with Medicaid regulations.

In addition, OMIG will focus on tests performed on recipients who were residents of facilities where the laboratory tests are included in the rate, or unbundled laboratory services, or where the recipient did not have Medicare or another form of third-party insurance coverage.

MANAGED CARE AUDIT AND PROVIDER REVIEW

Managed care is a term used to describe a health insurance plan or health care system that coordinates the provision, quality and cost of care for its enrolled members. Many different types of managed care plans participate in Medicaid managed care in New York State, including: health maintenance organizations; prepaid health service plans; managed long-term care plans; primary care partial capitation providers; and HIV special need plans. Please note that Medicaid managed

care policy and billing procedures are generally found and referenced to the contract sections found in the Medicaid Managed Care/Family Health Plus model contract. The contract is the primary document which is used to describe and outline the responsibilities and agreements established between the managed care organization and the New York State DOH (Medicaid).

Capitation Payments Made When Enrollees are Institutionalized in a Skilled Nursing Facility

OMIG will review monthly capitation payments paid to an MCO in the same month that payments were made to a skilled nursing facility for the care of an enrollee, starting with the month following the initial month of institutionalization. We will identify and make recoveries of the Medicaid managed care capitation payments made in the months subsequent to the enrollee's date of institutionalization where the local district office has failed to facilitate the recovery. The fiscal recovery of institutionalized enrollees is described in the Medicaid Managed Care and Family Health Plus model contract, Section 3.6.

Family Planning Chargeback to Managed Care Organizations

As in previous years, OMIG will continue to identify claims that fall under family planning criteria, as set forth by the Division of Managed Care/OHIP pursuant to the Managed Care Contract, Appendix C, Part I, Section 2a, "Free Access to Services for the MMC Enrollees," specifically, free access to family planning and reproductive health services. In instances where the enrollee has chosen to go outside the health plan's network for family planning and reproductive health services, those claims are identified on an annual basis and are recoverable from the managed care organizations, as stated in the Managed Care Contract, Appendix C, Part II, and Section 2b. A report listing all claims for an MCO during a specified time period will be forwarded to the New York State Division of Managed Care for reconciliation with each MCO. When reconciliation is completed, OMIG will then issue a remittance advice to each MCO for payment of the agreed-upon amount.

Family Planning Chargeback to Managed Care Organization Network Providers

Managed care organizations have network provider contracts that outline services to be provided to MCO enrollees with instructions for the billing of those services to the MCO. OMIG will seek recovery of family planning and health reproductive service claims that should have been billed to the MCOs and not Medicaid. This review is in compliance with 18NYCRR § 540.6(e), which addresses the responsibility of providers to seek reimbursement from liable third parties before billing Medicaid directly for payment.

Review of Reported Costs by Managed Long-Term Care Organizations

A managed long-term care organization's (MLTCO) final capitation rate is determined using a multitude of costs as reported to DOH by the MLTCO. OMIG will continue reviewing the reported costs submitted by MLTCOs that are used to determine the capitation rate, and access the accuracy of the reported cost data. This review will focus on the analysis of related party costs and the administrative expenses reported in the MLTC cost report. A review of claims data submitted to the plan will be analyzed to verify the costs reported.

Payments for Incarcerated Enrollees

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This audit identifies capitation payments made to MCOs for individuals who were incarcerated for the entire payment month. OMIG receives a prison match report monthly from the New York State OHIP, produced in collaboration with the Office of Temporary Disability Assistance (OTDA), the Department of Corrections, and the Division of Criminal Justice Services. This report lists individuals eligible for Medicaid at the time of their incarceration.

OMIG will run a match using the data included in the report to identify capitation payments paid for individuals who were incarcerated for the entire payment month. We will notify each MCO of these inappropriate capitation payments and permit the MCO to provide documentation where it believes it was “at risk” and therefore paid properly. The fiscal recovery for incarcerated enrollees is described in the Medicaid Managed Care and Family Health Plus model contract, Section 3.6 (SDOH Right to Recover Premiums).

Inappropriate Payments for the same Enrollee with Multiple Client Identification Numbers

Using data mining, OMIG will continue reviewing, identifying, and recovering Medicaid payments made for the same enrollee with multiple client identification numbers (CINs). OMIG plans to work with OHIP and the local district social service offices to rectify any enrollment file issues and follow-up on overpayments which should be recovered through the retroactive disenrollment claim void process established by the OHIP/Division of Managed Care. The fiscal recovery for multiple CINs is described in the Medicaid managed care and Family Health Plus model contract, Section 3.6 (SDOH/ Right to Recover Premiums).

Payments for Deceased Managed Care Enrollees

OMIG uses data mining procedures to identify capitation payments made to MCOs after a client’s date of death. Based on successful recoveries in prior matches from this project, we will again target for repayment those capitation payments made subsequent to a recipient’s death. The fiscal recovery for deceased enrollees is described in the Medicaid Managed Care and Family Health Plus model contract, Section 3.6 (SDOH Right to Recover Premiums).

Supplemental Capitation Payments Made without Corresponding Encounter Data

In addition to monthly capitation payments, MCOs are entitled to supplemental newborn and maternity capitation payments in instances where the MCO paid a hospital for the newborn/maternity hospital stay and/or birthing center delivery. The newborn supplemental capitation payment is paid under the newborn’s recipient ID. The maternity supplemental capitation payment is paid under the mother’s recipient ID. The MCO is required to submit birth/delivery encounter data to the DOH and is required to maintain evidence of such payments.

As a result of successful recoveries from the 2008 project, OMIG will continue to target supplemental newborn and maternity capitation payments made to MCOs. Specifically, OMIG will focus on reviewing submitted encounter data, as well as other documentation, to confirm payment was made to the hospital/birthing center. If the MCO cannot provide documentation to support the newborn/maternity billing, OMIG will request repayment of the supplemental capitation payment.

Supplemental Newborn and Maternity Payment Errors

OMIG regularly reviews supplemental maternity and newborn capitation payments for appropriation of payments. In the past, several different types of payment errors have been discovered. For example, both a supplemental maternity capitation payment and a supplemental newborn capitation payment have been inappropriately made on behalf of the same enrollee. Similarly, one recipient has been the beneficiary of more than one supplemental maternity or more than one supplemental newborn capitation payment.

In addition, supplemental maternity capitation payments have been inappropriately made on behalf of recipients who were either too young (under 10 years of age) or probably too old (more than 50 years of age) to deliver newborns. Edits are being developed to prevent these erroneous payments from being made. The policy regarding these supplemental capitation payments is found in the Medicaid Managed Care and Family Health Plus model contract, Section 3.8 (Payments for Newborns) and Section 3.9 (Supplemental Maternity Capitation Payments). In FFY 2011, OMIG will continue to review, identify and recover these types of inappropriate payments.

Overlapping Inpatient Services and Managed Care Payments

OMIG will use data mining activities to review instances where, in the same month both a managed care capitation payment and an inpatient payment for a non-carved-out service was made. Managed care eligibility issues related to retroactive enrollment and deletion will be assessed to determine payment liability and necessary corrective actions. Recoveries will be made where appropriate.

Recovery of Capitation Payments for Retroactive Disenrollment Transactions

The Medicaid Managed Care and Family Health Plus contracts, Appendix H, requires MCOs to submit premium voids for any month(s) where the enrollee was retroactively disenrolled and the MCO was not at risk for the provision of benefit package services during the month. The local departments of social services and the New York City Human Resources Administration (HRA) identify these situations and instruct the MCOs to void the claims. Some MCOs, however, do not, or do not timely submit these premium voids. OMIG and DOH/OHIP Division of Managed Care have established a process to follow-up on these retroactive disenrollments on a quarterly basis and seek recovery from the MCO when it has failed to submit the premium void in a timely manner.

Hospital Newborn Fee-for Service – Managed Care Crossover Payments

OMIG will identify instances in which a hospital received a Medicaid payment while a newborn was enrolled in managed care and the MCO received a capitation payment in the month of delivery, indicating that the hospital was eligible to receive a payment from the MCO related to the newborn's birth. These reviews will be performed to ensure that hospitals are in compliance with 18 NYCRR §540.6(e), which addresses the responsibility of providers to seek reimbursement from liable third parties before billing Medicaid directly for payment.

Managed Care – Incorrect Locator Code Designations

Each managed care enrollee is assigned a three-digit number that identifies that enrollee's county of residence, termed the enrollee's "locator code," which assures that the appropriate capitation and/or supplemental payment(s) is/are made to the MCO on the enrollee's behalf.

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OMIG will identify instances where MCOs were receiving higher than appropriate capitation and supplemental payments as a result of incorrect and/or inaccurate identification of the enrollee's county of residence.

Review of Reported Costs by MCO Plan Companies

The MCO capitation rate is determined using multiple factors, one of which is the operational costs reported by the plan. OMIG will continue its review of MCOs to determine the accuracy of the information reported on an MCO's operational reports used by DOH in finalizing the MCO's capitation rates. This review includes but is not be limited to, electronic analysis of the MCO's reported paid claims, confirming the reported medical costs were incurred and paid in compliance with provider contracts; an analysis of the reporting and propriety of third-party recoveries; a review of the appropriateness and allocation of direct and indirect administrative costs; an analysis of related party transactions and contracted expenses; and a review of the accuracy of incurred but not reported (IBNR) accruals by product line.

AREAS OF FOCUS:

Office of Mental Health – Managed Care Recoveries

An MCO submits an encounter to DOH for those services paid by the MCO to a network provider, and the comprehensive outpatient programs (COPS) supplemental payment is subsequently billed on a fee-for-service (FFS) basis by the network provider who rendered the service. A COPS-only payment may only be generated where documentation exists to prove that a managed care-paid service had been provided for which the COPS-only claim is being made. OMIG will continue analyzing COPS supplemental payments that do not have an encounter form to validate that a managed care-paid service was provided. If the network provider cannot furnish documentation to support the fact that a managed care service was provided, OMIG will request repayment of the COPS payment. These reviews are in compliance with 14 NYCRR Part 592, which addresses the COPS program that enables a provider of licensed mental health outpatient services to be eligible to receive supplemental medical assistance reimbursement in exchange for the provision of enhanced outpatient services.

MEDICAID IN EDUCATION

As required by the compliance agreement signed by New York State and the Centers for Medicare and Medicaid Services, OMIG will audit every school district and county preschool provider that received at least \$1 million in Medicaid reimbursement in calendar year 2009. OMIG will also audit 35 additional school districts and county preschool providers with total paid claims of less than \$1 million in calendar year 2009.

The audits will review random samples of 100 claims, and the findings will be extrapolated to the universe of claims paid to the provider in calendar year 2009.

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES (OASAS)

The mission of OASAS is to improve the lives of New Yorkers by leading a premier system of addiction services through prevention, treatment, recovery. As overseer of one of the nation's

largest addiction systems, OASAS provides a full continuum of services to a large and diverse population with 1,550 certified or funded providers delivering prevention, treatment, and recovery services throughout the state. Approximately 35,000 paid and volunteer addiction professionals serve 110,000 individuals a day. Treatment services are provided in inpatient, outpatient, and residential settings.

OASAS continues to collaborate with OMIG and other audit agencies to reinforce effective and consistent fiscal management and compliance and quality service delivery.

Medicaid Compliance Resources

Through a variety of functions, OASAS works with providers to help strengthen their management/governance capacities as a foundation for a “gold standard” of services. A new Medicaid compliance guidance section is now available on the OASAS Web site to assist providers in understanding new Medicaid compliance requirements and to help structure effective quality management systems. Working with OMIG, OASAS also developed a series of four "Medicaid Mondays" Webcasts conducted from April 19 through July 12, 2010 on topics which included: Medicaid compliance planning; Medicaid audit process; Medicaid audits – provider perspectives; and guidance on “top 10” Medicaid audit issues.

Ambulatory Patient Groups (APGS)

As part of the overall state effort to reform Medicaid reimbursement and rationalize service delivery, OASAS is currently redesigning its outpatient Medicaid payment system by employing an ambulatory patient group (APG) methodology.

Clinical Service Delivery: Clinically, the implementation of APGs is an integral part of the evolutionary move by the addictions field toward one outpatient system of care. APGs support a range of medically necessary clinic services for patients based on the evidence of what works to promote recovery from chemical dependency.

Medicaid Billing: From a Medicaid reimbursement perspective, the new APG reimbursement methodology will replace the current threshold visit reimbursement system for clinic services. The APG payment methodology pays differential amounts for ambulatory care services based on the resources required for each service provided during a patient visit. In addition, APGs will: support discrete Medicaid reimbursement for some chemical dependence services that were not previously billable, and allow for some services that are integral to the treatment of patients in chemical dependency treatment, such as mental and physical health services.

Provider Technical Support: OASAS will provide extensive training and support to prepare providers for the transition. This will include, but not be limited to, a comprehensive clinical guidance and Medicaid billing document; an APG Medicaid revenue calculator; field-based trainings; and a Web site that lists the multiple resources.

Implementation: OASAS worked extensively with advocacy groups, providers, and other stakeholders to determine the services that will be reimbursed under APGs and identify the appropriate payments assigned to each service. The agency expects to begin APG implementation in early 2011 and phase it in over a four-year period. OMIG will work with OASAS to monitor issues arising in APG implementation, and to assure that OASAS providers are advised of identified APG issues.

Administrative and Fiscal Guidelines

OASAS released new administrative and fiscal guidelines for OASAS-funded providers in March 2010. These are available at: <http://www.oasas.state.ny.us/regs/documents/AFGuidelines.pdf>. These new guidelines, which took effect on July 1, 2010, will help to ensure a reasonable standard of accountability in the chemical dependence services system and establish a more viable basis for assessing provider compliance with OASAS fiscal requirements. The guidelines were developed through an extensive series of internal reviews within OASAS prior to the convening of a provider-based fiscal advisory panel in 2009

A new Web-based self-assessment instrument will also be available, which will enable OASAS providers to access, track and evaluate their financial compliance on an ongoing basis. The OASAS instrument should be used as part of an effective compliance program for OASAS providers. OASAS also developed guidance in areas that have recently been identified by the New York State Office of the State Comptroller as potential vulnerabilities, with a goal of improving overall provider accountability for public funds.

Chemical Dependence Inpatient Rehabilitation Services - Clinical

OMIG will continue a statewide review of Medicaid payments for chemical dependence inpatient rehabilitation providers to determine if providers claimed reimbursement in accordance with 14 NYCRR § 818. Prior and current OMIG audits identified non-compliance with applicable regulations relating to missing progress notes and treatment plans and a lack of required physician review and approval of treatment plans. OMIG has recently revisited the progress note documentation requirements with OASAS as expressed in 14 NYCRR § 818. OMIG received written guidance from OASAS that will assist audit and clinical staff in assessing what the provider has charted to meet the progress note requirements.

Chemical Dependence Inpatient Rehabilitation Services - Rates

OASAS inpatient rehabilitation providers are reimbursed for services by the Medicaid program through a prospective per diem payment rate system. OMIG will conduct audits of providers' promulgated rates to determine compliance with 14 NYCRR § 841. The reviews will focus on identifying inappropriate and unallowable costs included in the promulgated rates of free-standing OASAS inpatient chemical dependence rehabilitation providers and recovering Medicaid overpayments.

Outpatient Chemical Dependence Services

OMIG will continue to audit Medicaid payments for outpatient chemical dependence services to determine if providers claimed reimbursement in accordance with 14 NYCRR § 822. Medicaid reimbursement is available for outpatient chemical dependence services provided in hospital-based or freestanding clinics. OMIG will audit providers who receive the largest amounts of Medicaid reimbursement for these services. Prior and current OMIG audits identified non-compliance with regulations, including missing treatment plans, missing signatures on treatment plans and missing progress notes. OMIG also identified non-compliance with regulations limiting the number of participants for outpatient group therapy services. Through the use of OMIG's OASAS-trained clinical staff, OMIG can better focus on the medical necessity of services rendered to Medicaid recipients and will also consider if the services were clinically excessive. OMIG will also conduct audits or investigations of OASAS providers who are found

to be providing excessive services through OASAS reviews and are referred to OMIG by OASAS.

OFFICE OF CHILDREN AND FAMILY SERVICES

The Bridges to Health Home and Community-Based Services Medicaid Waiver Program (B2H) provides services not otherwise available through other programs to children with complex medical conditions who are in foster care or in the custody of the Office of Children and Family Services' (OCFS) Division of Juvenile Justice and Opportunities for Youth. The program consists of three waivers administered as a single program:

- Children with severe emotional disturbances
- Children with developmental disabilities
- Children with medical fragility

The services are rendered by not-for-profit voluntary authorized agencies known as health care integration agencies (HCIAs) and subcontracted qualified waiver service providers (WSPs).

OCFS Bureau of Waiver Management (BWM) has a comprehensive quality management system for the B2H program to assist and document that B2H operates in accordance with its design, meets statutory and regulatory requirements, achieves desired outcomes and identifies opportunities for continuous improvement. The quality management program includes standards for the provision of services and billing of Medicaid. In addition, OCFS provides ongoing communication and training for HCIAs and WSPs on those standards, and conducts provider reviews using those standards.

B2H was phased in over a three-year period beginning on January 1, 2008, with other regions of the state having been added to the program on January 1, 2009 and January 1, 2010. OCFS's Office of Audit and Quality Control (AQC) has begun the first cycle of provider field audits. The current B2H audit cycle consists of those providers who began providing services in 2008, the first year of B2H implementation. Subsequent audit cycles will incorporate providers who began providing services in 2009 and 2010. In 2009, OMIG approved AQC's initial audit program, which includes procedures for testing supporting documentation for Medicaid billings and recipient eligibility that may result in a financial recovery. AQC also performs tests of documentation for various areas of operation that may result in compliance findings that do not involve financial recoveries. These areas of operation include, but are not limited to, the waiver enrollment process, service provider qualifications, training and background checks, and waiver administrative oversight.

OFFICE OF MENTAL HEALTH

The New York State Office of Mental Health (OMH) has as its mission to promote the mental health of New Yorkers. Of particular focus for OMH is mental health service provision for adults with serious mental illness and children with severe emotional disturbances.

OMH's policy is to refer all matters relating to suspected Medicaid fraud and abuse to OMIG as such cases are identified.

Clinic Restructuring

OMH has continued a multi-year initiative to restructure the way the state delivers and reimburses publicly-supported mental health services. The goal is to develop a system of quality care that responds to the individual needs of adults and children and delivers care in appropriate settings, while simplifying Medicaid reimbursement rules for publicly-funded mental health services.

Clinic restructuring represents the first phase of this transformation process. Parallel initiatives are tackling the many challenges facing support services for children, rehabilitation and support services for adults, inpatient services, and the treatment of co-occurring disorders in both mental health and substance abuse clinics.

All of these efforts include significant stakeholder participation and input. Clinic restructuring is being done with the extensive involvement of an advisory workgroup consisting of a broadly representational range of local government officials, mental health providers, and mental health advocates. OMH charged the workgroup with advising the agency on ways to:

- Create a mental health system focused on recovery for adults and resiliency for children;
- Redefine clinic treatment services; and
- Restructure the financing of the mental health clinic treatment system.

This plan reflects the workgroup's advice and substantial efforts. It describes a redesigned clinic program, a new payment system, and a multi-year implementation plan.

Key Elements of Clinic Restructuring

This plan contains six key elements for reform:

1. **A redefined and more responsive set of clinic treatment services and greater accountability for outcomes.** "Clinic" is defined as a level of care with specific services. These services should enhance consumer engagement and support quality assessment and treatment. Clinic treatment should be part of a coordinated and accountable system of recovery and resiliency, which includes other Medicaid-reimbursable and non-Medicaid specialty services, such as case management, day and vocational services.
2. **Redesigned Medicaid clinic rates and phase out of the Medicaid rate add-on known as comprehensive outpatient programs (COPS).** Medicaid payment rates will be based on the efficient and economical provision of services to Medicaid clients. OMH will establish peer groups for payment. Payments will be comparable for similar services delivered by similar providers across service systems. Payments will also include adjustments for factors which influence the cost of providing services. **The new system will eliminate rate add-ons such as COPS.**

OMH is committed to integrating clinic restructuring with the New York State DOH's new outpatient reimbursement methodology called APGs, which will replace New York's current "threshold visit" methodology for reimbursement.

3. **HIPAA-compliant procedure-based payment systems with modifiers to reflect variations in cost.** The federal HIPAA Administrative Simplification Act requires the use of a HIPAA-compliant billing system. Billing codes for clinic services will be

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HIPAA-compliant, with modifiers to reflect differences in resources and related costs (e.g., service location, night and weekend hours, language other than English, etc.).

4. **Provisions for indigent care.** Article XVII of New York's Constitution gives the state a special responsibility to care for "persons suffering from mental disorder or defect and [for] the protection of the mental health of the inhabitants." Assuring access to outpatient clinic services is essential to meeting this objective and reducing the demand for other high-cost services, such as inpatient care. Currently, OMH clinics receiving COPS are required to serve all clients regardless of ability to pay. As part of restructuring, OMH will work to develop a comprehensive strategy for funding mental health outpatient services for the uninsured.
5. **Address Medicaid HMO/state insurance plan payments.** Medicaid managed care/Family Health Plus and Child Health Plus plans pay less for mental health clinic services than the Medicaid fee-for-service rate. Medicaid managed care alone (not including Child Health Plus) represents 12 percent of clinic visits. This percentage is expected to grow as the state expands mandatory managed care enrollment.

To ensure continued access to clinic services, OMH needs to address Medicaid managed care payment rates. Additionally, OMH and DOH need to monitor managed care plans to ensure appropriate member access to mental health services.

6. **Standards of Care.** OMH recently released standards of care for clinic treatment for adults and children. These guidelines are a first step in articulating the basic tenets of good clinical care and accountability. While these have been longstanding expectations, they have not been consistently communicated or met. These fundamentals of care should be occurring in all clinics now, as well as in the redesigned clinic of the future.

Community Residence Rehabilitation Services

OMIG will review payments made for rehabilitative services provided to residents, both child and adult, of community-based residential programs in accordance with 14 NYCRR § 593 and § 595. OMH licenses these programs for adults with mental illness and children and adolescents with serious emotional disturbances. OMIG is focusing on Medicaid recipients living in community residences. Rehabilitative service providers will be reviewed for compliance with regulations relating to service authorization requirements. In addition, OMIG will assess provider adherence to program documentation and staffing requirements. OMIG will also continue its review of Medicaid payments for claims submitted by providers more than 180 days after the date of service utilizing exception codes.

Case Management Services

Case management is a process which assists persons eligible for Medicaid to gain access to necessary services in accordance with goals contained in a written case management plan. 18 NYCRR § 505.16 provides details of the regulatory requirements for case management services. OMIG will review providers of case management services to ensure that procedural requirements for service provision are met and that those services have been billed correctly and have supporting documentation for the claimed units of service.

OMH COPS–Managed Care Recoveries

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The MCO submits an encounter to DOH for those services paid by the MCO to a network provider, and the COPS supplemental payment is subsequently billed on a fee-for-service basis by the network provider who rendered the service. A COPS-only payment is made if the MCO-enrolled recipient received a covered service from a medical health provider within the MCO network; in that case, the MCO is required to submit encounter data to DOH. OMIG will match COPS supplemental payments with MCO encounter information. If the network provider cannot provide documentation that a managed care service was provided, OMIG will recover the COPS payment.

COPS/CSP-Overpayment Recoveries

OMIG and the OMH performed a review of mental health providers who received COPS/CSP (community support programs) overpayments for the three years ended December 31, 2005 (June 30, 2005 for New York City-based providers). COPS are supplemental payments in addition to the provider's Medicaid rate. The amount of COPS reimbursement that a provider can receive is limited to a threshold amount, and any COPS received in excess of that amount can be recouped. CSP payments in excess of a formulated reimbursement rate are also subject to recovery. Recoveries of COPS and CSP overpayments will be for the period of local fiscal year (LFY) 2002/3-2004/5 for New York City providers and county year (CY) 2003-2005 for the rest of the state.

Based on the OMH-identified COPS and CSP overpayments for the three years ended December 31, 2005, (or June 30, 2005), OMIG has initiated the report production process, including appropriate posting to the FACTS tracking process, that will result in provider restitution.

Outpatient Services

OMIG continues to audit Medicaid payments for outpatient mental health services to determine if providers claimed reimbursement in accordance with 14 NYCRR §§ 587 and 588. These audits will include clinic, continuing day treatment, partial hospitalization, and intensive psychiatric rehabilitation program. While OMIG audits have determined that many providers are in general compliance with regulations, some providers have been identified with significant compliance issues, including non-compliance with regulations relating to treatment plans and program documentation requirements, the absence of progress notes, failure to bill a patient's primary insurance prior to Medicaid, or a lack of documentation for a session's duration. Additionally, for 2010-11, OMIG will perform reviews to determine whether or not providers billed pharmacological services were billed (unbundled) as a separate procedure, and will check for instances where unlicensed physicians may have approved treatment plans.

OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

The Office for People with Developmental Disabilities (OPWDD) will no longer conduct audits as the result of changes included in the 2010-11 state budget. Responsibility for audit of OPWDD facilities and providers has been transferred to OMIG. During FFY 2011, OMIG will continue to meet with OPWDD staff to make the transition of this audit function, including ongoing audits and disclosures by OPWDD providers. OMIG will review the overpayment disclosures by OPWDD providers to assure that all overpayments have been recovered, and work with the Commission on Quality Care to ensure that OPWDD providers are offering medically necessary care, and complying with their care and custodial obligations to enrollees.

OUT-OF-STATE PROVIDERS

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In 2009, New York State paid \$327 million to out-of-state providers for a variety of services rendered to New York State Medicaid recipients. OMIG is reviewing major out-of-state providers to assess compliance with the 18 NYCRR Part 521 compliance certification requirements and will focus on payments to out-of-state providers in the following categories:

Inpatient Services

New York State reimburses out-of-state providers the lowest of the following charges:

- the Title XIX payment for the hospital under the Medical assistance program in that state;
- the Title XVIII Medicare payment established for the hospital;
- the hospital's customary charge for public beneficiaries; and
- the maximum New York State Title XIX payment for inpatient care.

OMIG will review the propriety of inpatient claims submitted to New York State for Medicaid reimbursement.

Nursing Homes

OMIG will review the propriety of payments to out-of-state nursing homes.

PAYMENT ERROR RATE MEASUREMENT PROJECTS

New York State is part of the federal fiscal year 2011 Center for Medicare and Medicaid Services review of medical claims to determine a national payment error rate for the Medicaid program, known as the Payment Error Rate Measurement (PERM) Project. OMIG will be responsible for the Medicaid fee-for-service and Medicaid managed care universe submission, as well as mirroring CMS's medical review portion of the Medicaid fee-for service sample. OHIP has responsibility for the Medicaid and State Child Health Plus (SCHIP) eligibility portion of the PERM project, as well as the review of the SCHIP managed care claims. Fifteen other states and the District of Columbia are working with CMS to determine the extent of improper Medicaid payments by analyzing between 520 and 1,040 claims for review purposes.

The state will provide CMS with a universe of paid claims for each quarter in the 2011 federal fiscal year. Claims will be stratified and selected randomly. Any claim paid during the period has a chance to be selected for this project.

OMIG will monitor the CMS contractor claim review for fee-for-service payments and managed care capitation payments. To assist the CMS contractor, OMIG will contact providers to encourage appropriate documentation for each claim sampled, follow up with providers if additional documentation is needed, perform medical and payment reviews and dispute any CMS review contractor findings with which New York State disagrees. Disputes may occur if the state disagrees with the clinical assessment of the documentation provided. Disputes may also occur when the state disagrees with how CMS contractors applied laws, regulation or policies.

The dispute processes for the PERM project contain stringent time constraints. To dispute an error with CMS review contractors, states are allowed only 10 business days. To dispute an error with CMS, states are allowed only five business days. States are only allowed to appeal to CMS if they have appealed the claim with the review contractor first. Timeframes are non-negotiable and necessitate the review of the claims by OMIG prior to an error being assessed.

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PERM review is scheduled for every three years. Between cycles, OMIG will use the PERM model to continuously perform random sampling of Medicaid claims.

PERM-PLUS PROJECT

OMIG will use PERM samples to collect information that might not be required as part of the project, but which is useful to OMIG in identifying potential threats to the integrity of the Medicaid program. OMIG staff will look at each sample payment as it relates to the overall billing pattern of the provider, the utilization pattern of Medicaid recipients, and the health care relationships between the client, the provider and other health care providers dealing with the client and the sampled provider.

PERSONAL CARE AIDE SERVICE AUDITS

OMIG will conduct audits of claims submitted by licensed home care agencies for personal care aide (PCA) services. OMIG audits will ensure provider compliance with various regulations and policies including, but not limited to, 18 NYCRR § 505.14, 10 NYCRR Part 766 and the New York State Medicaid program manual. Audits will be conducted with a particular focus on the New York City area, where expenditures are significantly higher when compared with other regions in the state. Each audit will entail a detailed examination of randomly selected claims submitted by the provider.

The claims will be analyzed to verify the following: that services were rendered consistent with the patient's care plan; hours billed on the sampled service date were authorized by the care plan; documentation to support hours claimed has been maintained; supervision of aides was conducted as required; PCA staff rendering service were properly licensed; and other personnel regulatory requirements were met. Additionally, audit staff will determine if spend down cases were processed correctly and that claims submitted beyond 180 days were justified in using the appropriate exception codes. The role of the relevant local district, a critical entity in the PCA process, will be considered in the audit process.

PHARMACY AUDITS

OMIG conducts pharmacy audits to ensure provider compliance with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid program. OMIG will verify that prescriptions were properly ordered by a qualified practitioner, the pharmacy has sufficient documentation to substantiate billed services, appropriate formulary codes were billed, patient-related records contain the documentation required by the regulations and claims for payment were submitted in accordance with department regulations and appropriate provider manuals. OMIG audits various types of pharmacies, including retail chain pharmacies, retail independent pharmacies, and infusion/specialty pharmacies.

Global Pharmacy Audit

OMIG will conduct a global review of five pharmacy chains for services provided to eligible recipients. As part of this review, OMIG will select a statistically valid random sample of claims from the statewide universe of Medicaid payments. OMIG offices throughout the state will be responsible for gathering pharmacy chain documents for each sample selection. OMIG also will seek the assistance of the pharmacy chain's corporate compliance officers to assure timely submission of documents for audit purposes.

Pharmacy Audits–Out of State

OMIG has identified two out-of-state pharmacy providers with high-dollar Medicaid reimbursements located in Pennsylvania, New Jersey, and Tennessee. The drugs billed include HIV antivirals, blood products, human growth hormones, and Synagis for children. OMIG will determine if the pharmacies are in compliance with applicable federal and state laws, regulations, rules and policies governing the New York State Medicaid program. In addition, OMIG will perform tests to ensure that proper purchases are made to substantiate costs and appropriateness of the drugs billed and that no unreported discounts have been taken.

Infusion/Specialty Pharmacies

OMIG will pursue audits of infusion and specialty pharmacies, which generally have higher-dollar Medicaid reimbursements than retail pharmacies. Infusion and specialty pharmacies differ from retail pharmacies in the types of drugs they dispense. The majority of orders for services are received electronically (i.e., via fax or computer) or by telephone, and the pharmacies also dispense ancillary supplies along with the ordered drugs. OMIG will review for non-compliance with emphasis on missing documentation (especially for auxiliary supplies), inaccurate claim submissions (drug, strength, quantity), bypassing system edits (60- and 180-day edits), and excessive refills.

Long-Term Care Pharmacies

Long-term care pharmacies will also undergo audits for their compliance with regulations governing the Medicaid program. Orders received by these pharmacies typically resemble inpatient multi-drug orders rather than traditional prescriptions. OMIG will review ordering information and compare that to the claim information, with an emphasis on incomplete order information (e.g., quantity and refills). OMIG will review the timeliness of prescriber authorizations, and also whether Medicaid is being properly credited for unused medications for nursing home patients.

Other Areas of Interest

OMIG examines pharmacy claim reimbursements to ensure that prices charged to the general public reflect the charges billed to the Medicaid program. OMIG collaborates with OHIP on policy issues, such as electronic records, that relate to pharmacy. OMIG communicates with providers via the *Medicaid Update*, a DOH publication. OMIG contributes to the development of pharmacy-related program initiatives, such as the e-prescribing initiative. OMIG answers referrals for pharmacy claim-related issues such as incorrect prescriber or incorrect NDC by requesting an adjustment or repayment.

PHYSICIANS

OMIG routinely analyzes goods and services ordered by physicians using a variety of techniques, including data mining, in an effort to identify areas for audit purposes. Through this process, OMIG has identified certain physicians who appear to have ordered excessive goods and services, such as drugs, home health care, hospice, durable medical equipment and transportation. In order to ascertain the propriety and medical necessity of goods and services ordered by physicians, OMIG will inspect the physician's patient medical records to determine if adequate documentation exists to support ordered goods and services, including medical necessity.

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In July 2009, OMIG sent letters to high-ordering physicians alerting them to their ranking when compared to other physicians. Since then, OMIG has continued to monitor the ordering practices of those physicians and has initiated audits of physicians involved in ordering transportation as well. OMIG intends to initiate additional audits of other high-ordering physicians during FFY 2011, including physicians ordering home health or personal care services.

RESIDENTIAL HEALTH CARE FACILITIES

Residential health care facilities (RHCFs) are reimbursed for covered services to eligible recipients based on prospectively determined rates. RHCF rates effective April 1, 2009 and subsequent are all-inclusive rates, and reflect:

- Rebasing provisions of Public Health Law 2808, whereas the base year for the operating component of the rate is based on 2002 allowable reported costs adjusted for inflation, unless the facility utilizes a rebased period subsequent to 2002. (These rates are pending subject to CMS and New York State Division of Budget approvals.).
- The operating component consisting of the direct and indirect cost components utilizes a modified pricing system, which combines the aspects of a pure pricing system with the principles of a cost-based system by comparing a facility's allowable operating costs to a base (minimum) and ceiling (maximum) price. The facility receives the higher of the base price or its cost up to the ceiling price.
- The capital component of the rate reflects allowable reported costs two years prior to the rate year.
- The rates are also subject to numerous applications and provisions of various laws and reflect per diem add-ons.

For the FFY 2011, OMIG plans to conduct Medicaid RHCF audits in the following areas.

Rate Audits

Base Year

Since the same reported costs, with appropriate trend factors, are used for multiple years of reimbursement for the operating component until a new base year is set, OMIG will review new base years approved by the Bureau of Long Term Care Reimbursement. OMIG's audits will focus on inappropriate and unallowable costs included in the RHCF rates. OMIG will also audit add-ons, such as the Health Recruitment and Retention and the Nursing Home Quality Improvement Demonstration Program Grant per diems, to ensure compliance with regulatory requirements contained within PHL 2808. 10 NYCRR Subpart 86-2 and 18 NYCRR Parts 504, 515, 517 and 518 provide authority to conduct these audits.

OMIG will conduct risk assessments and perform audits of the new base year costs for RHCFs that are rated as high risk by OMIG.

Dropped Ancillary Services

Medicaid rates for RHCFs include various ancillary services as contained in their base year costs. OMIG will review whether RHCFs are providing the ancillary services included in their Medicaid per diem rate and whether any changes in billing have occurred. Some RHCFs have

elected to change the method of billing regarding ancillary services—for example, an outside fee-for-service provider bills Medicaid directly for the ancillary services as opposed to the RHCf doing the billing itself.

In cases where RHCfs have discontinued providing services included in their Medicaid rate, OMIG will reduce their per diem rate accordingly and recover related Medicaid overpayments. Where Medicaid is paying the outside fee-for-service provider in addition to the RHCf for the same ancillary services, duplicate reimbursement occurs. As required by 10 NYCRR § 86-2.27, RHCfs are required to notify DOH when any previously offered service is deleted, which may lead to a drop in a particular RHCf's rate because an ancillary service is no longer available on-site.

Medicaid Rate Part B Carve Out

Medicaid rates for nursing facilities include billable rates for Medicaid patients who are not eligible for Medicare Part B service reimbursement, as well as rates for those who are eligible. The difference between the non-eligible and eligible rates is called the “Part B carve-out.” OMIG is currently developing an approach to systematically capture the Part B reimbursement associated with Medicaid patients through data gathering and computer matches with CMS), the federal department responsible for oversight of the Medicare and Medicaid programs. Once the computer match process is developed and tested, OMIG plans to audit the Part B carve-out for facilities for any years within the statute of limitations, and any appeals processed by DOH's Bureau of Long Term Care Reimbursement. 10 NYCRR Subpart 86-2 and 18 NYCRR Parts 504, 515, 517, and 518 provide OMIG with the authority to conduct such audits.

Notice of Rate Changes (Rollovers)

Reported base year operating costs are increased by an inflation factor (also known as a trend factor) and used as a basis for RHCf Medicaid rates for subsequent years. OMIG intends to carry forward base year operating cost audit findings into rate year 2008 and January to March 2009 and adjust Medicaid rates accordingly.

Rate Appeals

RHCfs file rate appeals to contest their Medicaid rates as the result of a number of factors, including computational errors, additional costs, new services, new renovation projects, and new base years, among other issues. OMIG will review rate appeals that have been approved by DOH's Bureau of Long Term Care Reimbursement and, where indicated, audit underlying costs associated with those appeals to determine the appropriateness of each appeal issue. OMIG audits will make proper adjustments to the rates and recover applicable Medicaid overpayments. 10 NYCRR Subpart 86-2 and 18 NYCRR Parts 504, 515, 517 and 518 provide authority to conduct these audits.

Temporary Staffing Costs

As part of the base year audits, OMIG will focus on facilities using temporary staffing agencies for significant numbers of employees. This review will include the contract with the temporary staffing agency, documented invoices for staffing and the previous owner's payroll records. OMIG will also determine whether the owner or the nursing home has any interest in the temporary staffing agency, and whether the temporary staffing agency is a related party or an affiliate of the facility. In appropriate circumstances, OMIG will review the involvement of

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consultants and professionals in the temporary staffing agency arrangement and its reporting on cost reports.

Claim Audits

Bed Reserve Audits

When the qualifying criteria outlined in Title 18 NYCRR § 505.9(d) are met, the Medicaid program reimburses nursing homes on a per-diem basis to hold a resident's bed while that resident is temporarily absent from the home. OMIG will continue to review nursing home reserved bed payments to assure that facilities are in compliance with Title 18 NYCRR § 505.9(d) requirements, state laws, rules, regulations and policies that govern the New York State Medicaid bed reserve program.

Patient Review Instrument – Clinical Audit

The number of a nursing home's residents classified in the various resource utilization group (RUG-II) categories determines the facility's overall case mix index (CMI) and thus significantly influences its per diem Medicaid reimbursement rate. Consequently, it is essential for each resident's condition and functional ability to be assessed accurately. This is accomplished by means of the patient review instrument (PRI). The PRI was utilized through December 2006 to calculate the nursing home rate.

DOH's Bureau of Long Term Care Reimbursement utilizes PRIs to adjust a nursing facility's operating component per diem rate to recognize intensity of services. OMIG will examine the propriety of the preparation of the PRIs as they affect the nursing facility's case-mix index portion of its per diem rate of reimbursement. The last case-mix index calculated by the BLTCR for 2006 will be used for the 2007 and 2008 rates, per Public Health Law § 2808-2-b (a) (v). OMIG will continue to perform clinical reviews of PRI calculations for selected nursing homes for the final 2006 PRI.

SELF DISCLOSURES

The law which establishes OMIG requires that all providers must maintain effective compliance programs, and must make timely disclosure and repayment of overpayments obtained from Medicaid, as an aspect of such effective compliance programs. Effective October 1, 2009, this requirement applies to all providers who bill or order Medicaid services in excess of \$500,000 per year. See 18 NYCRR 521. OMIG has developed a self-disclosure protocol, which allows providers to make their disclosures to OMIG, and explains how those disclosures will be addressed. OMIG has done extensive outreach to communicate this process to the various provider, medical and legal associations, and has posted necessary forms and instructions on its Web site (www.omig.ny.gov).

Through this process, providers who identify internal billing or operational issues that might affect their right to Medicaid reimbursement come forward and disclose the parameters of the problem and its potential Medicaid financial impact. OMIG determines that the issue is a true disclosure (not the result of an audit or investigation), validates the parameters described and

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works with the provider for repayment, which may include extended repayment terms and/or forgiveness of some accrued interest. During FFY 2011, OMIG will begin enforcement of Section 6402 of the federal Affordable Care Act (ACA), which requires that “persons” who identify an overpayment of Medicaid funds must report, refund, and explain the overpayment within 60 calendar days of the identification.

As a result of self-disclosures received, OMIG is expanding its audit program to: (1) examine all-inclusive hospital clinic rates that were modified to remove physician costs from the rate and allow the physician costs to be billed separately; (2) expand pharmacy audits to include auditing for excluded pharmacists; (3) audit hospitals that received supplemental wraparound payments to ensure that the hospital and its federally qualified health centers had an actual written contract with the Medicaid managed care plan; (4) expand reviews of OPWDD providers; and (5) audit long-term home health care entities to ensure compliance with state regulations for documenting patient care.

TRANSPORTATION

OMIG has taken an analytical approach to transportation reviews by concentrating on high-ordering providers of transportation services and on transportation providers. With the assistance of OMIG nursing staff, we intend to focus increased audit efforts on these high-ordering providers. Physicians, methadone maintenance, pharmacies and adult day health care providers are just a few of the providers that OMIG plans to review in conjunction with transportation audits.

Transportation – Billing for Inpatients

As a result of prior successful recoveries in this area, OMIG will again initiate audits of transportation services billed to Medicaid when the recipient was a hospital inpatient. The audit scope will include a review of the transportation company’s records to support the transportation service provided, as well as validation that the company’s drivers met the required regulations to escort and bill for the transportation of Medicaid recipients. Providers will be asked to explain, in writing, how the entity billed for a patient who was an inpatient at the time, and what compliance and oversight measures the provider has put in place to prevent a recurrence.

Transportation – Non-Emergency Ambulance

OMIG will review Medicaid claims for non-emergency ambulance procedure codes to ensure that the Medicaid recipient actually needs services that can only be administered in an ambulance, and further, that the ambulance had the appropriate equipment and personnel to meet the needs of the recipient.

Claim Review

OMIG will review fee-for-service claims and supporting documentation of selected transportation providers. DOH regulation 18 NYCRR § 504.8 allows the department to examine a provider’s adherence to established department policy and procedures, as well as their conduct relative to unacceptable practices. OMIG will review transportation provider compliance with regulations governing the program as stated in 18 NYCRR Section 505.10.

Transportation –Taxi/Livery

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OMIG and counties participating in the demonstration project will review claims and supporting documentation of selected transportation providers who provide taxi and/or livery services to Medicaid recipients. OMIG will review for compliance with regulations governing the program as stated in 18 NYCRR § 505.10.

Vehicle Information

OMIG will review the driver's license and vehicle license plate numbers reported in Medicaid claims by transportation providers who use ambulettes to transport patients. If such numbers are found to be invalid or if the vehicle number as reported is not licensed by the appropriate authorities (New York City Taxi and Limousine Commission, for example), or if the driver as reported is not appropriately licensed (19A-certified, for example), OMIG will seek to recover the payments associated with such claims.

WAIVER PROGRAMS

Home and Community-Based Services (HCBS)–Medicaid Waiver for Individuals with Traumatic Brain Injury (TBI)

The Medicaid HCBS waiver programs allow states to provide alternative services for individuals who would otherwise require care in nursing homes. OMIG will continue to examine documentation of TBI claims in both electronic and paper formats to determine compliance with the HCBS/TBI Waiver Provider Manual, *Medicaid Updates*, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [NYCRR Titles 10, 14 and 18].

OMIG reviews have encompassed the detection of the following errors: lack of documentation for services, TBI provider services not included in the service plan, billing for more hours than documented, and untimely updates of service plans. Additionally, OMIG has determined that several provider staff members did not have the requisite qualification(s) to render services.

Home and Community-Based Services Waiver-Services Provided Under § 1915(c) of the Social Security Act

The purpose of the waiver is to allow OPWDD to offer supports and services that allow people with developmental disabilities to live richer lives in the community rather than in institutional settings. The services and supports offered by the waiver include, but are not limited to, choices such as day habilitation, residential habilitation, community habilitation, supported employment and respite.

Any waiver service provided to a participant must be included in the participant's service plan, along with the effective date, frequency and duration of each service. OMIG will review Medicaid payments to providers to determine if services provided to individuals with developmental disabilities were in accordance with § 1915(c) approved waiver agreements and 18 NYCRR Parts 624, 633, 635, 636, 686 and 671.

As of October 1, 2010, OPWDD ceased auditing providers for Medicaid-funded services, but OMIG continues to conduct audits and reviews of those providers.

Long-Term Home Health Care Program Waiver (LTHHCP)-Home and Community-Based Services

The waiver programs allow states to provide alternative services for individuals who might otherwise require care in a nursing home. LTHHCP providers supply a coordinated plan of services to ill or disabled persons in the individual's home, the home of a responsible adult or an adult care facility (other than a shelter for adults). Although the program services persons of all ages, it most frequently provides services to the frail elderly. Participants in the program must be medically-eligible for placement in a hospital or residential health care facility for an extended period of time if such a program were unavailable. Medical eligibility is determined by the New York State long-term care placement form medical assessment abstract (DSM-1) form or its successor.

Prior audits of LTHHCP providers found that the required waiver documents, the DSM-1 and home abstract, demonstrating the need for billed services, were not completed. OMIG will expand its review of LTHHCP providers focusing on timely completion of comprehensive assessments.

Long -Term Home Health Care Program-Rates

OMIG will conduct audits of LTHHCP cost reports submitted for LTHHCP to verify per-visit and hourly rates calculated for the various ancillary disciplines in accordance with 18 NYCRR Part 517 (provider audits) and Subpart 86-5 (LTHHCP). With an emphasis on both high Medicaid utilization and rate caps, OMIG will review direct patient costs, overhead costs, related party transactions, Medicaid patient visits, total visits and related hours. Where appropriate, OMIG will verify direct costs by comparing them to the necessary supporting documentation (e.g., invoices, payroll records, trial balance accounts, etc.).

OMIG will review statistics for reasonableness to ensure that indirect costs are properly allocated. OMIG will also audit rate add-ons, such as the worker recruitment and retention; recruitment, training and retention; and accessibility, quality and efficiency adjustments to ensure compliance with regulatory requirements contained within Public Health Law 3614. In addition, patient visits and hours will be verified to the supporting patient logs and/or census data to ensure proper reporting.

DIVISION OF MEDICAID INVESTIGATIONS

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

All DMI actions focus on four main areas addressing the integrity of the Medicaid program:

- Fraud and abuse
- Intra- and inter-agency cooperation

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- Deterrence, education, and outreach
- Quality of care.

Although DMI is divided into specific units, matters addressed by DMI have an impact on every section of the division and OMIG. While cases may begin in one unit, they frequently involve multiple units. Unraveling the complexities within the Medicaid system wherein the trajectory of fraud and deceit begins requires an overarching theory of investigation. The process is interconnected as findings in a provider case may simultaneously uncover recipient fraud, which in turn may lead to findings of yet another significant provider's involvement.

DMI, like all other divisions and bureaus of OMIG, utilizes Pareto's theorem, also known as the 80/20 rule. This rule is an integral component of OMIG's approach to the pathology of fraud. OMIG is committed to using taxpayer resources in transparent and cost-efficient ways. Pareto's 80/20 rule, when applied within the realm of healthcare fraud, finds 20 percent of providers engaged in fraudulent behaviors responsible for 80 percent of all fraud committed. This concept guides DMI's targeting practices and channels its staffing efficiently.

Governed by Pareto, DMI utilizes a variety of tools to discover fraud. Any patient could be a DMI undercover investigator. Recipient and provider records are scrutinized through surveillance, forensic accounting of subpoenaed bank records and billings, medical record reviews, witness testimony, site visits, and data mining.

Investigations in the fee-for-service or managed care arenas often commence with an allegation, complaint, or initiative, identifying unusual connections between providers, data analysis, referral, or even newspaper articles about particular issues in health care. Leads also come from the thousands of explanation of medical benefit (EOBs) forms sent to recipients, the fraud hotline, OMIG's Web site (www.omig.ny.gov), or even tips from other providers or their associations.

Cases involving providers and recipients conducting suspected illegal activities are forwarded to the New York State Deputy Attorney General for Medicaid Fraud Control (MFCU), the United States Attorney, or local district attorneys for civil or criminal prosecutions. If convicted, these providers and recipients may face confinement and/or restitution.

Providers who commit unacceptable practices may be subject to adverse administrative actions, which may include exclusion, censure, restitution or penalties. Under certain circumstances, OMIG may enter into a corporate integrity agreement (CIA) with a provider. Such agreements require that the provider meet specific performance standards and employ strict reporting requirements. OMIG investigators, working in concert with the Bureau of Corporate Compliance, monitor the providers, and take action if the CIA is violated.

If DMI identifies improper provider billing practices, OMIG's Division of Medicaid Audit may also begin an additional review, resulting in recoupment and systemic improvements.

DMI collaborates with other governmental agencies including the Department of Health's Office of Professional Medical Conduct (OPMC) and the Bureau of Narcotic Enforcement (BNE), State Education Department's Office of Professional Discipline (OPD) and the HHS OIG, when appropriate. Membership in the New York Health Care Fraud Taskforce facilitates sharing information regarding fraudulent practices and providers. DMI is also a participant in the U.S. Department of Justice, Medicare Fraud Strike Force operating in the Eastern Judicial District of New York.

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In addition, joint investigations with the Federal Bureau of Investigation, the United States HHS OIG, New York State Attorney General's MFCU, BNE, State Insurance Fund, New York State Insurance Department, Worker's Compensation Board Inspector General, local district attorney's offices, and the special investigation units of numerous health insurance providers lead to prosecution and administrative actions.

DMI is working to deter fraud through outreach initiatives with the provider community by communicating regularly with providers, their associations, and professionals who represent the interests of providers. DMI speaks with members of the provider community and taxpayers at numerous functions throughout the year. Recognizing that honest providers want an even playing field, DMI works with the provider community to establish best practices.

DMI participates in regular meetings with provider groups and works with the special investigation units of the major managed care organizations in New York State. Staff members make presentations at medical schools, colleges of pharmacy, and other educational institutions. DMI works with continuing education programs to provide accurate and important information to the provider community. Through OMIG speakers' bureau and in response to other invitations from community groups, DMI will also make presentations to taxpayers at civic events or town hall meetings and explain DMI's role in preventing abuses in the Medicaid program.

Honest Medicaid providers want the same thing as other New York State taxpayers: quality service without fraudulent activity or abusive practices. Many of these providers volunteer information regarding possible fraud in their field. At the same time, recipients may report schemes they witness in their communities. These sources have knowledge and expertise in their areas that can only be obtained through years of experience. DMI already receives *qui tam* or whistleblower allegations. This additional type of on-going detailed information that can be applied over sectors of the Medicaid program is integral to OMIG's success.

In July 2009, Governor David A. Paterson ordered the creation of a Stimulus Oversight Panel to ensure that the \$26 billion in federal funds provided to New York State under the American Recovery and Reinvestment Act (ARRA) is utilized with transparency and accountability. OMIG, along with the Offices of the New York State Inspector General, the Metropolitan Transportation Authority Inspector General, and the commissioner of the State Division of Human Rights, was appointed to the panel. With the signing of Executive Order No. 31 on November 25, 2009, the panel was formalized and provided jurisdiction over state agencies receiving ARRA funds. The Executive Order charges the panel with the "prevention and detection of waste, fraud, abuse and mismanagement of ARRA funds...." DMI dedicated investigative staff to investigations related to stimulus oversight.

ENROLLMENT AND REINSTATEMENT UNIT (EAR)

The first step in protecting the integrity of the Medicaid program is to ensure that only quality providers are enrolled in the program. The EAR Unit thoroughly reviews targeted provider enrollment and reinstatement applications to determine if applicants should be enrolled into the Medicaid program. Potentially abusive providers, as well as providers whose quality of care appears insufficient, are identified in these proactive front-end reviews that may disqualify them from enrollment or reinstatement. EAR's review process employed results in cost savings to the Medicaid program and discourages inadequate or abusive providers from even attempting to enroll.

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Pursuant to Pareto's 80/20 principle, EAR targets pharmacies, laboratories, transportation providers, and durable medical equipment (DME) providers where fraud and abuse are historically most prevalent. EAR determines if applications contain false, misleading or inaccurate information. Providers submitting applications containing deliberately false statements are referred for prosecution.

In order to determine whether a provider should be permitted to provide services to Medicaid recipients, EAR coordinates with other OMIG units to gather information through on-site investigations, undercover operations, and background checks. EAR also coordinates with the Edit 1141 (Pre-Payment Review) Unit when providers are enrolled but limited to certain services. Edit 1141 ensures that services outside of the limited area are not reimbursed. In addition, OMIG and the DOH are exploring revisions to the provider density policy for certain provider types.

EAR reviews ownership changes to establish if excluded individuals are purchasing businesses, or if excluded providers or providers undergoing audits or investigations are selling their businesses to affiliated individuals. A transaction that is not arms-length will be denied and will be referred for further action if false information regarding the sale is contained in the application.

Trained specialists review reinstatement applications to prevent excluded providers from returning to the Medicaid program unless OMIG is reasonably certain that the violations that led to exclusion will not be repeated. EAR examines documentation from court records, licensure hearings, and OMIG audits and investigations as part of this review. The nature of the violations, the length of time since the violations occurred, the provider's pattern of behavior, corrective actions taken and assurances made by the provider are all considered before a decision is made.

Practitioners are required to enroll in the Medicaid program if they order in excess of 4,500 services or more than \$75,000 in services in a 12-month period. EAR ascertains which practitioners reach these levels of activity and should enroll, and those who fail to enroll once notified of their obligation are placed on OMIG restricted/terminated/excluded list. EAR also notifies the Provider Investigations Unit of situations suggesting identity theft or a license number being used by another practitioner.

EAR works with the Undercover Investigations Unit to conduct surveillance on pharmacies in the process of enrolling in the Medicaid program. Pharmacies may be denied enrollment and excluded from future enrollment based on evidence obtained during these joint investigations. Any abuses or unacceptable practices discovered during an EAR review that may result in audits, investigations, and exclusions are reported to other units within OMIG. EAR expects that with increased undercover operations, more fraudulent behavior will be uncovered, thereby increasing the number of exclusions.

The unit coordinates its efforts with the Attorney General's MFCU, the United States HHS, DOH's Office Professional Medical Conduct (OPMC) and State Education Department's Office of Professional Discipline, the Board of Pharmacy, the New York State Department of Transportation and other state and local agencies, as well as staff within the DOH and OMIG. EAR also serves as the liaison between OMIG and the DOH OHIP's Bureau of Provider Enrollment.

In FFY 2011, EAR will apply newly designed initiatives to identify potential abuses. The DME Address Project, slated to commence this year, will investigate whether high-billing DME providers have unenrolled service addresses. Other planned initiatives, such as dental group enrollment reviews, an increase of on-site inspections around the state, and a revision of provider

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density standards, will all help fight fraud and abuse. Additionally, EAR will work with the Collections Unit in considering the increased use of surety bonds to enhance the financial security of the Medicaid program.

EAR's work ensures a high quality of care by choosing the best individuals and businesses to participate in the program, and deterring substandard providers from even attempting to enroll.

MEDI-MEDI PROJECT

Medi-Medi is a joint effort between CMS and OMIG to identify fraud and abuse by providers who render services to Medicare and Medicaid dual-eligible recipients. New York State and CMS work together in reviewing claims data from both Medicare and Medicaid in order to identify billing and quality of care issues. This process also enables the identification of problem areas only apparent when reviewing both sets of data simultaneously. These joint investigations have successfully led to identification of aberrant practices.

In the past, providers servicing recipients eligible for both Medicare and Medicaid were required to first bill Medicare before submitting claims to Medicaid. After Medicare paid its share, the provider would submit a crossover claim to Medicaid indicating the amount approved and paid by Medicare. As a result, some providers were able to submit inconsistent and fraudulent claims in order to increase their revenue streams. In an effort to improve this billing process and to eliminate the need for providers to submit claims to both programs, starting in December 2009, New York State receives crossover claims directly from the fiscal intermediary instead of providers.

Medi-Medi targets providers drawing on the 80/20 principle, focusing on specialized claim areas that may have the greatest anomalies. Trained specialists review claims involving ambulatory patient group codes relating to emergency room visits, durable medical equipment/diabetic supplies, and clinical psychologists treating residents in long-term care facilities.

DMI has Medi-Medi staff located in both its Albany and New York City offices. Medi-Medi staff consists of a combination of CMS federally-contracted employees working on-site with state employees dedicated to the Medi-Medi project.

Medi-Medi works together with other units within DMI toward ensuring high quality care for Medicare and Medicaid recipients and to ensure that fraudulent behavior is detected. Providers who commit fraud often defraud Medicaid and Medicare. Providers excluded from Medicaid for substandard care or fraud are referred by Medicaid to Medicare for investigation and vice versa.

PROVIDER INVESTIGATIONS UNIT

Detecting schemes to defraud, curbing unacceptable practices, and improving quality of care saves New York State's Medicaid program millions of dollars, returns wrongfully gained monies to New York State taxpayers, and improves the health and welfare of New York State Medicaid recipients.

The DMI Provider Investigations Unit monitors the Medicaid program for evidence of fraud and abuse, responds to detected frauds, imposes sanctions to protect Medicaid patients and taxpayers, and promptly remedies program vulnerabilities. DMI conducts investigations into providers furnishing dental, mental, medical care, and support services including prescriptions, transportation, personal assistance, counseling, and complete care in nursing home or hospital

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settings. DMI cooperates with the Attorney General's MFCU in reviewing and assessing *qui tam* cases filed under the federal and New York False Claims Acts, and in determining appropriate action against individuals and entities which have violated these acts.

Clinical comprehensive proactive reviews identify fraud and abuse in services rendered to Medicaid recipients. Health professionals target enrolled and non-enrolled providers for provided or ordered Medicaid services that are unusual, excessive, may not be medically necessary, not supported by the diagnosis provided, or are simply services that were never provided. Part of OMIG's statutory mandate to fight abuse requires placing a special emphasis on providers who engage in unacceptable practices by failing to provide services that comply with recognized professional standards.

The investigators in the Provider Investigations Unit collaborate on most cases with registered nurses, staff with coding skills, pharmacists, and medical experts to interview, understand, and analyze the information contained in each claim submitted by a provider.

Investigators, who frequently come to DMI with extensive experience with other law enforcement agencies, are then further trained in the arts of identifying deceptive behavior, interviewing uncooperative witnesses and uncovering complex financial schemes as related to Medicaid and healthcare fraud. Additionally, investigators consult with other federal and state agencies, sharing knowledge related to trends observed during investigations. Investigations are enhanced through access to multi-lingual staff throughout DMI, whose languages include English, French, Russian, Ukrainian, German, Yiddish, Hebrew, Arabic, Mandarin, Spanish and Portuguese.

Changing provider behavior and removing noncompliant providers from the Medicaid program is the overall goal that DMI effects by identifying fraud and abuse in the provider community. Billing and rendering unnecessary services, unbundling, accepting or sharing payments with another provider are unacceptable practices. Those engaged in these practices may be referred for criminal prosecution and/or administrative action including exclusion from the Medicaid program. As a result, those excluded may not treat, order, or bill for services rendered to Medicaid recipients. Further, they are generally not permitted to work for an entity that receives Medicaid payments.

Another tool used to check fraudulent behavior in cases where removal of a provider from the Medicaid program would negatively impact access for recipients is the corporate integrity agreement (CIA). Providers enter into a CIA with OMIG, subjecting the providers to specific performance standards and reporting requirements. OMIG investigators, working in concert with the Bureau of Corporate Compliance, monitor the providers, taking action if the CIA is violated.

Provider Investigations is also working to deter fraud through its outreach initiatives with the provider community. Face-to-face visits with providers establish an OMIG presence in the community while also facilitating interactive educational opportunities which benefit both OMIG and providers. In FFY 2011, investigators will visit providers and their facilities, talk with billing and servicing personnel, and provide a folder of materials including: a copy of NYCRR Title 18 Part 521 Provider Compliance Programs and information regarding the regulation; procedures for provider self-disclosure; the provider directory page from the *Medicaid Update*; and, a poster reminding providers that they should report fraud and abuse. Providers will be selected randomly, or based upon billing, service practices, or complaints. Providers can expect to receive visits from undercover or disclosed investigators any day of the week or at any time of the day that the provider is open or scheduled to be open.

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Provider Investigations operates out of main offices in both New York City and Albany, as well as from satellite offices located in Hauppauge, White Plains, Buffalo, and, anticipated in FFY 2011, Syracuse and Rochester.

Following are some of the many areas Provider Investigations will explore in 2010-11:

Managed Care Organizations (MCOs) – Provider Investigations intends to collaborate with MCOs to identify medical providers who violate the law, refer them for criminal prosecution, and prevent such providers from contracting with other MCOs. DMI has assembled staff in both upstate and downstate offices to address MCO issues. If DMI finds that any medical providers or MCOs are committing unacceptable practices or criminal offenses, such cases will be handled in accordance with the rules and regulations of New York State. Provider Investigations will also examine compliance with regulatory and contractual requirements governing MCO's facilitated enrollers (FE) to confirm the validity of the enrollment process, determine if applicants have been encouraged to falsify their applications, and assure that MCOs have taken reasonable compliance measures to prevent the hiring or retention of FEs who have engaged in misconduct.

Home Health and Consumer-Directed Aides – This area accounts for approximately nine million individual services annually in New York State. Although much direct responsibility for oversight of these programs rests with individual counties, OMIG is working to become a trusted source for information and guidance. Investigators from the Provider Investigations Unit will visit personal residences and check for aides who should be providing important services to recipients. Provider Investigations will conduct surveillance activities and determine whether the aide is providing services claimed on bills to the Medicaid program. Provider Investigations joined ranks with the Attorney General's MFCU, and expects to seek assistance from the New York State Department of Motor Vehicles (DMV) and the New York State Department of Taxation and Finance to identify aides who are not providing the services for which the Medicaid program is billed, are failing to provide adequate care, or are abusing Medicaid recipients. Provider Investigations will follow up on data mining efforts which have identified home health and personal care staff billing for services while recipient was hospitalized.

Long-Term, Personal Care and Transportation Agencies – These agencies account for more than 17.5 million individual services annually in New York State. OMIG will work with DMV, MFCU, and individual counties to identify the agencies that are not properly vetting employees or contractors through OMIG's list of disqualified individuals or entities (PVR 292), fail to maintain appropriate records, or do not comply with the New York State rules regarding 19A certification for drivers. Agencies should help protect Medicaid recipients by ensuring that staff is in good standing.

Nursing Homes – Providers who fail to provide basic services will be identified and removed from the Medicaid program. Further, nursing home administrators who allow unacceptable practices to occur will be held responsible for failing to properly supervise the facility.

Hospitals - DMI collaborates with the New York State DOH and the MFCU on certificate-of-need requests to ensure that no outstanding investigations into hospitals may be compromised if a certificate of need is granted. DMI and the Bureau of Compliance will develop a system for reviewing the effectiveness of a hospital's compliance program and visit with hospital administration. DMI will seek exclusion of responsible senior officers, responsible board leaders, and billing companies if patterns of intentional unacceptable practices are identified, or if identified compliance weaknesses are not corrected after appropriate notice to the organization.

New York State Office of Persons with Developmental Disabilities (OPWDD), Office of Mental Health (OMH), Office of Children and Family Services (OCFS), and Office of Alcoholism and Substance Abuse Services (OASAS) - These agencies are reviewed to ensure that the agencies are complying with their oversight obligations. DMI investigators may visit residences, treatment centers, and agency offices. Further, DMI, in conjunction with the OASAS internal investigations unit, will create a checklist of items to review and training modules so that DMI investigators develop skills in identifying issues at these specialized facilities.

DENTAL UNIT

In the past year, DMI investigated several dentists and groups who billed for services never rendered, rendered so poorly that the damage from the service necessitated additional work, or work that was completely unnecessary and violated codes of professional conduct and Medicaid rules and regulations.

One of the most successful investigations into pediatric dentistry in 2009 brought together the best minds from multiple divisions within OMIG and the Attorney General's MFCU and State Education Department's Office of Professional Discipline (OPD) in order to bring about a just result. OMIG's Division of Medicaid Audit, Division of Technology and Business Automation, Division of Medicaid Investigations and Office of Counsel learned investigating cases of dental abuse requires a comprehensive review. Auditors, data analysts, investigators, nurses, dental hygienists and attorneys from each division contributed their expertise to the investigation.

DMI has built a group for FFY 2011 to focus exclusively on dental investigations. The newly formed Dental Unit, within Provider Investigations, will dedicate significant resources to identifying dental providers delivering quality of care which fails to meet recognized professional standards, unnecessary services, or who are also defrauding the Medicaid program. This unit is staffed with a dentist, multiple hygienists, investigators and auditors who will work with the New York State Attorney General's MFCU and the State Education Department's OPD to ensure integrity among Medicaid's dental providers.

PHARMACY INVESTIGATIONS UNIT

Pharmaceuticals represent the third largest area of expenditure in the New York State Medicaid budget. The pharmacy program covers all Medicaid recipients and those enrolled in the Family Health Plus program. Unfortunately, unscrupulous persons are taking advantage of the system. As a result, DMI faces significant challenges dealing with fraud and abuse in this arena. In order to meet these challenges, DMI formed the Pharmacy Investigations Unit.

The Pharmacy Investigation Unit identifies, prevents, and deters pharmacy and prescription medication fraud and abuse, leading to significant savings for the New York State Medicaid program. The unit targets kickback schemes, false claims, and quality-of-care issues. The unit uses clinical expertise to investigate quality-of-care issues such as inappropriate drug therapy. The unit also reviews early refills, black box medications, and off-label use.

The Pharmacy Investigations Unit works with several internal OMIG 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. The unit

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also receives referrals from internal OMIG units and outside agencies. Additionally, it acts as a liaison to other pharmacy benefit payers such as Elderly Pharmacy Insurance Program (EPIC) and AIDS Drug Assistance Program (ADAP).

Pharmacy Investigations Unit staff are well versed in New York State pharmacy regulations, knowledgeable of current fraudulent pharmacy trends, and are building on their connections within the pharmacy community. Collaborative relationships have been established with other pharmacy oversight agencies such as the State Education Department's OPD, Department of Health's Bureau of Narcotic Enforcement, and the New York State Board of Pharmacy.

UNDERCOVER INVESTIGATIONS UNIT

Undercover investigations were at the top of President Barack Obama's list of proposals presented at the February 25, 2010 health care forum. President Obama, in his presidential blog after the forum, reiterated the need for "undercover investigations of health care providers that receive reimbursements from Medicare, Medicaid, and other federal programs." OMIG already had a unit dedicated to undercover investigations in place, and will expand undercover activities during FFY 2011.

The Undercover Investigations Unit serves as OMIG's "eyes and ears" on the street. Undercover investigators identify fraud using a variety of techniques. Undercover investigators seek services from Medicaid providers, are equipped with pseudonyms, and may utilize surveillance equipment to accurately record the provider's conduct during the undercover operation (UCO). Undercover investigators also blend into the recipient community, identifying and interacting with recipients knowledgeable of suspicious activity. Undercover investigators are also used by other DMI units to confirm alleged fraudulent activity.

Throughout New York State, undercover investigations result in arrests, prosecutions, exclusions, terminations, restitution and penalties. Numerous other entities rely on the undercover investigations unit in their investigations. The Undercover Investigations Unit has assisted or provided its findings to the State Attorney General's MFCU, the Federal Bureau of Investigation, DOH's Bureau of Narcotic Enforcement, and Office of Professional Medical Conduct, State Education Department's OPD, and OMIG's Division of Medicaid Audit.

The Undercover Investigation Unit works in concert with the Enrollment and Reinstatement Unit (EAR), conducting undercover operations on providers seeking to enroll in the Medicaid program. EAR-undercover operations may include evaluating services provided, billing irregularities, and surveillance. Further, undercover operations provide intelligence to aid EAR in deciding whether to enroll the provider.

Local districts of social services (LDSS) told DMI that the managed care organizations facilitated enroller (FE) program is vulnerable to fraudulent behavior. FEs can be independent contractors or employees of a particular MCO, paid to enroll Medicaid recipients in a particular plan.

In FFY 2011, OMIG will work in concert with LDSS and/or MCOs to identify FEs who violate the law, refer them for criminal prosecution, seek exclusion and thereby prevent them from moving to another MCO and perpetrating the same fraud. The cooperative efforts between OMIG, LDSS and MCOs will ensure that only those truly eligible are enrolled in Medicaid, thereby protecting the financial investment of taxpayer dollars in the Medicaid program.

In all areas, undercover investigators will continue to observe and report whether care provided to recipients fails to comply with recognized statutory, regulatory, and professional standards.

ADMINISTRATIVE REPORTING AND TRACKING SERVICE (ARTS) UNIT

Health professionals, language experts, investigators, researchers, and data specialists are all brought together in ARTS to support the overall DMI mission. ARTS employs a team approach, and all staff talents and skills are used to create innovative methods to achieve OMIG goal of transparency and accountability. As part of this overarching OMIG vision, ARTS provides outreach and education through presentations at conferences and universities.

The many units of DMI work in their specialized areas in their fight against fraud. ARTS gathers together DMI data regarding the efficacy of the multitude of investigations taking place. Information is compiled and reported monthly, quarterly and annually, measuring DMI's progress and accomplishments. ARTS orchestrates this data into a useful tool for management to measure accomplishments.

Explanation of medical benefit (EOMB) forms are an important tool in combating Medicaid fraud. EOMBs are sent to recipients to elicit feedback regarding their medical care paid for by Medicaid. In effect, ARTS receives tips from recipients who report having not received the services claimed by some providers. This important tool, monitored by ARTS, provides targets for investigation and confirms allegations of provider fraud. EOMBs serve a dual purpose, because providers know that not only is OMIG, but also their patients are tracking the services they receive, thereby helping to deter fraud.

ARTS also develops methodologies for targeting providers for DMI investigations. Data-based queries are used to identify outliers on quality, cost and outcomes in accordance with the 80/20 principle. These data mining techniques help determine cost avoidance, referrals, and other administrative action. Data mining also allows measurement of the "sentinel effect." Since the act of observing disturbs the observed, the existence of OMIG has affected the provider community. ARTS not only measures this deterrence factor, but is also able to measure outcomes of investigations, ensuring the most efficient use of time and resources.

ADMINISTRATIVE REMEDIES UNIT

OMIG has broad discretionary power to impose several different sanctions against "persons," as defined in its regulations¹ (including, but not limited to, Medicaid providers), based on its audit and/or investigative activities. Sanctions include censure, exclusion or conditional or limited participation in the Medicaid program (18 NYCRR § 515.3).

A sanction may be imposed upon finding that a person has committed an unacceptable practice pursuant to 18 NYCRR §515.2. In addition, OMIG may impose an immediate sanction when certain other conditions have been met in violation of the rules and regulations of the Medicaid

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

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program under 18 NYCRR § 515.7. Immediate sanctions are imposed based upon a finding that a person has:

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

Furthermore, OMIG may impose a mandatory exclusion when certain other conditions have been met in violation of the rules and regulations of the Medicaid program under 18 NYCRR § 515.8. Mandatory exclusions are imposed based upon a finding, that, among others, a person has been excluded from participating in the Medicare program.

Participants in the Medicaid program are required to check OMIG's list of restricted, terminated or excluded individuals or entities before hiring staff, and to monitor OMIG's updates at 30-day intervals. This list is accessible via OMIG's Web site (www.omig.ny.gov) as a link on the home page or under the Resources tab. Additionally, all providers must check the HHS OIG list of excluded individuals/entities (LEIE) and the Government Service Administration's (GSA) similar list. Healthcare organizations employing an excluded person may face recoupment of improperly expended Medicaid payments and/or administrative sanctions.

Tracking excluded persons to determine places of employment after they have been excluded ensures that they are not permitted to gain from the Medicaid program and service the state's most vulnerable populations. This is the crux of DMI's "where are they now" initiative for FFY 2011.

Each person who has been excluded and is subsequently identified as being employed by, or providing contracted services to, a healthcare organization, must be reported to OMIG through the self-disclosure program, found on OMIG's Web site (www.omig.ny.gov). Failure to check for excluded persons, or failure to report employed or contracted excluded persons, is a violation of each provider's obligation to have an effective compliance program.

RECIPIENT FRAUD UNIT

The Recipient Fraud Unit focuses on drug diversion, prescription forgeries and eligibility issues.

Drug diversion occurs when a recipient partners with a provider who orders unnecessary treatments or pharmaceuticals on behalf of the recipient. Ordering treatment or pharmaceuticals for those who do not need them is not only a misuse of taxpayer money but also places the recipient's health at risk. Identifying these providers is an important role of this unit. The Recipient Fraud Unit teams with the Provider Investigations Unit in locating such providers and identifying other potential recipients who might also be defrauding the program. An excellent example of an area where these two units are working in concert is that of organized crime and gangs. Recipients are being used by gangs and organized crime syndicates to obtain medication that is then diverted from its lawful intent and sold to unauthorized users.

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Recipients who use pharmaceuticals and services in atypically high patterns raise red flags. After identifying high-use recipients, the Recipient Fraud Unit reviews all services provided or ordered on behalf of the recipients. Prescriptions written for certain medications subject to abuse are tracked to the servicing pharmacy. Trends in prescribing patterns and recipients who may be “doctor shopping” to obtain narcotics and other prescription drugs are identified. After locating potential “doctor shopping” recipients and providers with questionable prescribing practices, the unit expands its analysis to other providers within the geographic area. During FFY 2011, OMIG will be expanding its analytic activities through the use of enhanced data mining and will cooperate with New York City’s Human Resources Administration (HRA) staff to address patterns of prescription pad thefts, prescription forgeries, and excessive utilization.

Forged prescriptions lead to thousands of illegal pills and drugs being disbursed into the community. Recipients may alter valid prescriptions or obtain lost or stolen prescription pads. Under DOH regulations, doctors are responsible for reporting lost or stolen prescription pads. While some enrolled pharmacies may unknowingly fill such prescriptions, others fill them without question. The proper response is to contact the purported physician to confirm the prescription, and to notify appropriate authorities when fraud is suspected. When pharmacies or physicians fail to notify Medicaid or DOH’s BNE, Medicaid pays for drugs that are either sold for cash to other people or wrongly used by the recipient. The integrity of the Medicaid program and the prescription pad system is violated while the community is placed at risk.

As a result of the Recipient Fraud Unit’s work, recipients are referred for prosecution and to the Recipient Restriction Program. Physicians who fail to report lost or stolen prescriptions will be considered for administrative action. Pharmacists who knowingly dispense drugs based on forged prescriptions are referred for further investigation. Detecting forgeries early prevents additional prescriptions from being filled and thereby keeps illicit drugs out of the community and saves taxpayers money.

The Recipient Fraud Unit monitors recipient eligibility issues. New York State does not have a centralized enrollment system, and local districts are required to determine eligibility for its recipients. The Recipient Fraud Unit conducts outreach and training programs to the local social services districts to increase prosecutions, identify weaknesses in the Medicaid application process, and coordinate consistent regulations and policy interpretation.

Knowingly providing a benefits card for another’s use is illegal, and the unit refers these cases for prosecution. The Recipient Fraud Unit investigates cases where recipients loan or rent their benefits card to others to obtain medical benefits for which they are not entitled. In addition to being illegal, the card may be used to fill forged prescriptions or “doctor shop” for narcotics.

In FFY 2011, newsletters will be sent to every commissioner of social services, county executive, and district attorneys, identifying patterns observed throughout New York, and citing best practices used to combat fraud.

RECIPIENT RESTRICTION PROGRAM

To advance OMIG’s mission of ensuring integrity within the Medicaid program, this unit is responsible for controlling recipient access to Medicaid-funded care and services which are found to be duplicative, excessive, or contraindicated.

Referrals from the Recipient and Provider Fraud Units, local districts, or other agencies automatically initiate a full review of a recipient’s health care plan. A specialized computer

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program reviews paid claims and identifies recipients who may be abusing the Medicaid system by possibly obtaining unnecessary or excessive services. The information for these recipients is thoroughly reviewed by a team of physicians, nurses and pharmacists, who make recommendations about whether to restrict a recipient to one primary care caretaker such as a physician, clinic, inpatient hospital, dental clinic, or podiatrist, and to a primary pharmacy and/or durable medical equipment vendor. Local districts implement the restrictions for an initial two-year period. After two years, a case is reevaluated and the restriction is continued for three- and six-year periods, if warranted.

In discovering recipients who engage in fraud, RRP also uncovers Medicaid providers who may be engaged in unacceptable practices. After locating such providers, RRP may investigate that provider's other patients and refer the provider for investigation. Accordingly, RRP cooperates with all divisions within OMIG and numerous outside agencies.

RRP specialists train and instruct local district staff and work with numerous law enforcement entities and groups that suggest recipients for restriction. During State Fiscal Year 2009-10, an average of 8,000 recipients was restricted at any given point, resulting in improved quality of care for recipients. RRP revamped processes and procedures for increased operational efficiency, and initiated targeting algorithms in accordance with Pareto principles to produce an 80/20 result of restriction activities.

RRP is concerned with the health, safety and well-being of recipients. RRP issues health conference letters to local districts identifying recipients whose health outcomes might be improved through education or improved management of their care and services.

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION (DTBA)

BUREAU OF PAYMENT CONTROLS AND MONITORING

The Bureau of Payment Controls and Monitoring is focused on maintaining the Medicaid program's integrity through the use of point-of-service controls, prepayment edits and developing and monitoring changes to the Medicaid systems. In the coming year, the bureau will continue its efforts to enhance communication and maintain periodic meetings with other OMIG divisions, DOH-OHIP, OMH, OPDD, and OASAS. Through these efforts, we will share perspective, create greater rapport and enlist support for program integrity, vigilance and support.

Medicaid Systems Control and Review Unit

This unit facilitates the implementation of edits, front-end system enhancements to control inappropriate Medicaid payments, and other requests for data sources and functionality on the systems which support the Medicaid program. The unit serves as the liaison between OMIG's different bureaus and the Medicaid systems, which include:

- eMedNY and its data warehouse
- DOH OHIP data mart
- Welfare Management System (WMS) and other external systems.

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These sources contain vast repositories of information that investigators and auditors need to identify, investigate, audit, and monitor Medicaid providers who may be involved in aberrant practices.

Edit Review

The unit will continue its detailed review of 709 eMedNY system edits. This review entails a review of edits that are currently set to “pay” to identify opportunities to change the edit setting to “deny.” We will also review each edit to determine if there are claims types that are not included in the edit logic, but should be. The unit has submitted evolution projects proposing modifications to these existing edits. We expect that these projects will be implemented in FFY 2011.

New Data Sources

The Medicaid Systems Control and Review Unit will continue to identify new opportunities to obtain external data which will help in identifying inappropriate Medicaid payments. New or evolving data source efforts include:

1. DMV License Data. During SFY 2009-10, unit staff worked with the Department of Motor Vehicles to obtain data for carriers and drivers licensed under Article 19-A section 509-a of the New York State Vehicle and Traffic Law (ambulette carriers and drivers). Data such as carriers’ and drivers’ information will be obtained on a monthly basis. During FFY 2011, staff will explore the use of these data for targeting purposes, as well as to formulate new eMedNY system edits.
2. E-Prescribing. During SFY 2009-10, unit staff worked collaboratively with DOH’s OHIP staff on their e-Prescribing initiative. This initiative would provide a monetary incentive to encourage Medicaid providers to submit prescriptions to pharmacies electronically. This initiative will reduce the number of fraudulent prescriptions and also reduce medication errors. The evolution project to develop the e-Prescribing Initiative (EP 1373) was implemented on December 3, 2009. OHIP staff expects that the incentive process will begin later in FFY 2011. For FFY 2011, the unit’s staff will continue to work with OHIP to ensure that there is an adequate audit trail over electronic prescriptions.
3. Serialized Prescriptions. During SFY 2009-10, unit staff worked with DOH’s Bureau of Narcotic Enforcement to develop a process for identifying inappropriate serialized prescription numbers on the front-end of Medicaid claims processing. We created an evolution project request (EP 1369) to create processing controls that will determine if the serialized prescription number is a valid prescription. The resulting edit should prevent some of the incomplete or false data that is being entered by providers in the serialized prescription field. We expect that this initiative will be completed during FFY 2011.

Lost/Stolen Prescriptions

Lost/stolen prescription information is received from the BNE. Unit staff enters this information into the eMedNY claims processing system on a real-time basis, preventing these prescriptions from being paid by Medicaid. During 2009-10, the Medicaid Systems Control and Review Unit (MSCR) began working with OMIG DMI staff to obtain lost/stolen prescription information on a

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more timely basis. This information will come from DMI investigators who identify individual prescriptions that are reported as forgeries. Updating this prescription information will prevent any refills from being processed or paid for by Medicaid. We expect additional Medicaid cost-savings associated with this initiative. For FFY 2011, we will continue to work with BNE and DMI to identify lost/stolen prescriptions on a timely basis and will ensure that Medicaid does not pay for these prescriptions.

Deceased Recipient Project

During SFY 2009-10, the Medicaid Systems Control and Review Unit began identifying deceased recipients on a more timely basis. Beginning with claims with dates of service in the month of October, 2009, we sent a series of letters to Medicaid providers who had billed for recipients who were previously reported as deceased. These letters requested an explanation of the circumstances that led to the billing. Names of providers who failed to respond have been posted to our Web site.

Based on our correspondence and discussion with the other providers, we have revised our match algorithm; in other cases OMIG's DMI will pursue more detailed reviews. For FFY 2011, we will continue to refine our processes, mail letters on a regular basis and post the names of unresponsive providers. The deceased recipient project will serve as a significant discovery and measurement technique to identify providers with weaknesses in their compliance programs. Providers who appear in more than one month will be referred to OMIG's Bureau of Compliance for follow-up.

Providers who receive a letter from the deceased recipient project are required to respond to the project's information requests, but they are expected to examine the claims submitted to determine the cause and extent of compliance weaknesses which led to submission of the claim, to report other identified overpayments to OMIG, and to undertake remedial measures.

The deceased recipient project will also serve as a rich source of information about the actual operation of mandatory compliance programs, and the weaknesses and problems they must address. OMIG plans to share this learning with compliance officers during the work plan year.

Oral Prescriptions

During SFY 2009-10, the Medicaid Systems Control and Review Unit worked collaboratively with OMIG's pharmacists to develop a proposal to change DOH pharmacy policy regarding the overuse of oral prescriptions. This issue represents a significant exposure to the Medicaid program. For example, when a pharmacy receives an oral prescription, the only information that they verify is the prescriber's provider identification number and license number. However, both pieces of information can be easily obtained through public Web sites or through a previous prescription.

As a result, Medicaid has no assurance that a claim based on an oral prescription is valid. Since approximately one-third of pharmacy claims billed to Medicaid indicate that the pharmacy received an oral prescription, there is a significant risk of inappropriate Medicaid payments. For FFY 2011 we plan to continue to work together with DOH pharmacy policy staff to develop a method for limiting the use of oral prescriptions.

Prepayment Review Unit

The staff in the Prepayment Review Unit can pend claims for specific providers and specific categories of claims. This process allows staff to review the claim and supporting documentation prior to claim payment. The benefits derived from this process are unique, and prepayment review can be used as compliance and provider training tool, a deterrent to a specific activity and as a powerful fraud detection tool.

Prepayment Review Process

When an issue is identified for potential prepayment review, we review paid claims data to identify the providers that are practicing the suspect billing pattern. At this point, we have the option of building pre-audit criteria and putting the provider on review or taking a sample of paid claims and reviewing the documentation. In FFY 2011, we will have a focus in the following areas:

1. Analysis and review of up-coding or incorrect coding of ambulatory patient groups (APGs) for clinic claims to maximize Medicaid reimbursements.
2. Smoking cessation programs
3. Orthopedic shoes
4. Ambulatory surgery – hospital-based
5. Misuse of National Provider Identifier (NPI) as a prescriber ID
6. Misuse of facility IDs as a prescriber

In addition, PPR is collaborating with OMIG's DMI to review the inappropriate prescribing of Vusion ointment and are planning an additional collaborative project on fraudulent prescriptions.

Point-of-Service Controls Unit

Cardswipe

The cardswipe program is designed to enforce and verify the presence of the Medicaid recipient at the point of service. It also offers providers a quick, automated process to determine the current eligibility of a Medicaid recipient. Providers are required to swipe the common benefit identification card (CBIC) for a significant number of their transactions. OMIG's expectation is that providers will swipe 85 percent of their transactions. The major initiatives for FFY 2011 are as follows:

1. Enhanced Monitoring. Through coordinated efforts with DOH and the local districts, OMIG aims to reinforce the awareness, both for the Medicaid recipients and providers, of the requirement for recipients to present their CBIC to receive services. As part of this effort, OMIG is sending periodic letters to more than 750 cardswipe providers, advising them of their latest swipe compliance level. OMIG will also continue to monitor the experience of providers assigned to the cardswipe program, and their customers, to assure that both cards and machines are working properly.
2. Landline Expansion. Staff is currently adding pharmacies, roughly 40 per month, which have significantly lower than average levels of claims voids. An abnormal level of claim voids can indicate prescriptions which were not picked up and were returned to stock without reimbursing the Medicaid program.

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3. Cardswipe Mobile Unit Expansion. OMIG staff has completed a procurement to facilitate the purchase, service and deployment of mobile cardswipe terminals. These terminals will be deployed to transportation providers operating ambulettes in New York City and private-duty home health nurses across the state. This project includes new functionality which will capture time-stamps for the start and end times of each service. The timestamp associated with these services will be compared to claims submitted by billing providers, and assure that the units billed correspond to swipe times. Rollout is scheduled to begin in December 2010 with an anticipated pace of 80 units per month.

Post and Clear

The post-and-clear program implements a set of checks and balances, ensuring that an ordering provider posts an order and a billing provider clears the order before the claim will be paid. This check ensures that stolen and forged orders (i.e., prescriptions) will not be paid unless the order has been posted. During FFY 2011, we anticipate a gradual expansion of providers on post and clear, based on a variety of factors; including high-ordering practices, having lost/stolen prescriptions, comparison of drugs to diagnosis, and specialty not matching the orders.

BUREAU OF BUSINESS INTELLIGENCE

The Bureau of Business Intelligence will continue to support the data needs for OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert services consultants.

Data Mining

Desktop Graphical User Interface Tool. OMIG has completed a software license purchase of Salient Corporation's Medicaid MuniMinder product. In addition, we have also completed a procurement of a full suite of data center services to support the computing platform that the software will run on. OMIG and its vendors are involved in training staff to use the system. The software will provide a rich graphical environment which will allow subject matter experts to directly access this powerful data analysis tool. The tool supports a range of options, many point-and-click driven, allowing staff to perform a nearly endless range of analysis, from simple queries, to complex relationships. In all cases, staff can quickly change results or drill down into results and display results graphically or geographically.

Link Analysis Software. In conjunction with a vendor providing expert services, OMIG began implementing the IBM Entity Analytics Solutions (EAS) in late 2009. This software specializes in resolving entity relationships (i.e., identity attributes) from disparate data sources. The database is currently configured to alert staff on a number of entity relationships which include: duplicate recipient identification numbers, deceased recipients, duplicate providers, providers/associates with sanctions, deceased providers, providers who are recipients and relationships between current providers and those with a history of sanctions.

Staff is refining the initial results and the algorithms and also needs to build the business processes with the relevant stakeholder agencies to ensure that the proper corrections and monitoring occur.

A second phase is under consideration that would incorporate additional informational data along with claim and prescriber information. This additional data would be used to further identify relationships that involve inappropriate behavior among entities.

Employee Sanction Matches. OMIG is working with OPWDD, OMH, OASAS and DOH to develop controls, processes and matching to ensure that all of their state and contract staff has not previously been sanctioned. OMIG continues to perform a quarterly analysis of staff contracted by the above agencies and has already identified staff with previous sanctions. OMIG expects to use the same tools to review employment and contracting relationships for selected Medicaid providers, and to recover funds paid for services rendered or ordered by excluded persons.

System Match Recovery Unit (SMR)

Specific matches scheduled to be performed during FFY 2011 are:

1. Inpatient Clinic/ER Crossover (2008-2009). Inpatient, emergency room, and clinic services provided by a hospital can be individually billed to Medicaid under the same provider number. During a Medicaid client's hospital stay, the inpatient rate is an all-inclusive rate, and no emergency or clinic billings by the hospital for that client should be submitted during their hospital stay. This match identifies the Medicaid payments and the providers who have billed Medicaid for either clinical or emergency room services during the patients stay in the hospital.
2. General Clinic (2008). This project will identify laboratory and referred ambulatory services delivered in relation to a clinic visit but billed separately. Ancillary services are included in the threshold clinic rate and should not be billed separately.
3. Products of Ambulatory Care (2007-09). PAC clinic rates are all-inclusive clinic reimbursement rates associated with procedures, diagnosis and recipient age. General clinic visits are not allowable when PAC codes are submitted for payment. Also, ancillary testing and physician services are included in the all-inclusive rates and should not be billed as fee for service.
4. Prenatal Care Assistance Program (2009-10). This match addresses multiple issues of erroneous billings for Medicaid clients who are receiving prenatal care services (PCAP). Billing issues surrounding the PCAP program include clinic, physician, laboratory services, and ordered ambulatory services for clients participating in the PCAP program. The match includes multiple initial visits; post-partum services billed at initial or follow-up rates; PCAP service for inpatients; physician services; laboratory services, ordered ambulatory services and prenatal vitamins billed as fee for service which are included in the PCAP rate.
5. Physician Office Visits (2009-10). This project identifies claims submitted by physicians for office visits that were actually performed in a clinic setting. OMIG will seek to recoup the difference in fees for these services.
6. OB/GYN (2009-10). The billings from OB/GYN physicians are reviewed for duplicate delivery billing, physician billings for PCAP patients, and global delivery charges for PCAP patients. Physician services are included in the PCAP rate. Physicians serving PCAP patients are entitled to delivery-only charges, and not the global fees which include ante-partum care.
7. Inpatient Crossover with Home Health, Nursing and Personal Care (2008-09). OMIG has found that some home health, nursing and personal care agencies continue to bill Medicaid for services while a client is receiving inpatient services. This match identifies

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- any billings from these types of providers during the inpatient stay of the Medicaid recipient.
8. Nursing Home Residents with Home Health and Personal Care Billings (2008-09). Some home health and personal care agencies continue to bill Medicaid for services while a client is residing in a skilled nursing facility (SNF). This match will identify any billings from these providers during the stay of the Medicaid recipient in the SNF.
 9. Chemotherapy Clinic Code Review (2005-08). Chemotherapy clinic rate code 3092 is a specialty clinic rate that allows the facility to bill an enhanced clinic rate and bill separately for the drugs administered under their ordered ambulatory category of service (0163 or 0282). The rate is established for the treatment of cancer. The provider can expand usage for treatment of hematology, anemia and other disorders through an appeal to the Bureau of Primary and Acute Care Reimbursement. Our review identifies chemotherapy clinic rate billing for diagnosis and conditions beyond the facility's approval by DOH.
 10. DME in Skilled Nursing Facilities (2005-09). A SNF is required to provide residents with medical/surgical supplies and medical equipment. Our review identifies durable medical equipment billed separately for skilled nursing home residents.
 11. Same Day Physician/Clinic Billing (2005-09). This review seeks to recover physician billing of ancillary testing and injections delivered to clinic patients on the same day as a clinic billing. The physician billing under his own provider ID is the same physician listed as the attending physician at the clinic. These services should be included in the clinic threshold visit and not billed separately by the physician.

BUREAU OF THIRD-PARTY LIABILITY

The bureau's primary mission is to assure that Medicaid is the payer of last resort after other payment sources have been identified and exhausted, as required by federal law.

Third-Party Liability Unit

Pre-Payment Insurance Verification. This activity is the foundation of our cost avoidance efforts. By identifying third-party coverage and updating the third-party file on eMedNY prior to payments made by Medicaid, claims are rejected until third-party resources are utilized.

Liable third parties are added to the eMedNY database after matching Medicaid recipient files with commercial insurance, Medicare, military and any other available third-party files. Identified and verified third-party client/carrier-specific eligibility information is provided to the front-end of the state payment system for categories of service including major medical, dental, prescription drug and optical claims.

The Deficit Reduction Act (DRA) of 2005 clarified the definition of "third-party insurers" and "health insurers" to include employer self-funded ERISA plans, third-party administrators (TPA), and pharmacy benefit managers (PBM), and required states to enact legislation to require insurers to provide coverage, and eligibility and claims data to identify liable payers. New York, at OMIG's urging, enacted the required legislation last year (Social Services Law, Section 367-A and Insurance Law, Section 320). OMIG has identified a number of "major insurers" subject to

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the DRA of 2005 definition, and is enforcing the requirement that they provide the eligibility data required by law. This will enhance our identification and recovery efforts.

Third-Party Retroactive Recovery Projects. A comprehensive periodic retroactive recovery process is in place as the primary part of OMIG's efforts for recovering Medicaid expenditures. The recovery process utilizes many sources such as known third-party liability (eMedNY) that has been identified through various means, including local district input, matching with the Social Security Administration and the contracted third-party file matches (commercial insurance companies, military carriers, state and federal files and input from employers, etc). The updated third-party file is matched against the eMedNY claims extract file to identify claims for which potential or verifiable third-party liability exists.

The claims are separated into rate-based claims and fee-based claims. Rate-based claims—primarily for inpatient and clinic services—are printed with insurance information on review letters that are sent to providers. The review letter instructs providers to bill the insurance carrier and submit to the contractor—within 90 days—documentation of a denial, or indicate they have voided/adjusted the Medicaid claim.

Fee-based claims (i.e., practitioner, laboratory and pharmacy claims) with potential third-party coverage are directly billed to the insurance carriers by the contractor.

Based on successful negotiation of data agreements relative to the new third party insurers discussed previously under pre-payment insurance verification, HMS will re-bill these ERISA-sponsored health insurance plans, TPAs or PBMs for medical claims paid by Medicaid for those members enrolled in these plans. Current law allows New York to go back three years to recover claims, which should have been paid by insurers.

In addition to Medicaid, the current contract includes third-party recovery for the New York State EPIC program.

Credit Balance Reviews. OMIG third-party payment integrity initiatives continue to expand. Our credit balance reviews are now predicated on integrating various aspects of our Medicaid match and recovery program. More specifically, we take the following three-pronged approach:

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

Credit balance reviews play a crucial role in our ability to effectively leverage data mining capabilities, as well as improve the enforcement of New York's Medicaid billing and reimbursement policies. For example, a claim that is satisfied during one of our third-party reviews can be fed into our credit balance process for a secondary review if there is sufficient evidence to merit such review. Another example consists of analyzing payments and denials that we receive as part of our direct billing to detect providers who are engaging in potentially fraudulent or abusive billing practices.

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We have expanded our credit balance review scope to now include long-term care facilities. During FFY 2011, credit balances will be subject to Section 6402 of PPACA, which requires every Medicaid provider to report, refund, and explain identified overpayments within 60 calendar days of identification. OMIG will be reviewing its self-disclosure protocol and its credit balance procedures

e-Review Expansion. We are continuing to work with commercial carriers and pharmaceutical benefit managers on suspected duplicate payment reviews using the carrier claim information as our source data. This e-Review initiative is a more in-depth forensic analysis of the return information of our routine third-party reviews and direct billing efforts payments. This is basically reverse engineering the current process. In the future, we hope to extend this to include an analysis of Medicare reported amounts as well. These new initiatives are reshaping the thinking that, historically, this is just third-party work. Again, passage of the state legislation previously discussed has given OMIG more authority to demand that all insurers share paid claim information with the state.

HHA Overlapping Payment Review. OMIG continues to examine the "overlapping payment" universes excluded from the HHA demonstration project. Findings from data analysis of the Medicaid paid claims show that within the overlap of Medicare and Medicaid coverage, Medicaid is paying an excessively large portion of home health aide services—services that represent the highest utilization dollars in most cases. A probe review of three certified home health agency providers was initiated with 10 home health care cases per agency that show the highest utilization cost to Medicaid, while also under a Medicare prospective payment system (PPS) payment(s). We will use these findings to refine our review protocol. We will target future reviews based on the information provided from the demonstration project and then request provider-specific detail through the Medi-Medi project.

Managed Care Third-Party Recovery. Managed care (MC) plans are currently responsible for the collection of third-party revenues pursuant to respective MC contracts. These recoveries must be reported on MC cost reports, and our review of the last three years reveals nominal recoveries had been reported. Accordingly, OMIG is proposing to conduct these third-party recovery activities. This will generate additional cash recoveries and provide accurate revenue information for actuarial use to determine prospective premiums. This proposal will require OMIG to obtain MC encounter and paid claims data. MC contract language changes are under review, and we expect to start this work very soon.

Estate Recovery and Accident and Casualty Recovery. A pilot project has started with three local districts. Several more districts are interested in joining the project. The pilot involves using a proprietary case management system and contractor staff (HMS) to identify, evaluate and provide case tracking information.

Home Health Unit

Home Health Care Demonstration Project – UMass. The federal Center for Medicare and Medicaid Services (CMS) has been working with Connecticut, Massachusetts, and New York under a pilot demonstration project that uses a sampling approach to determine the Medicare share of the cost of home health services claims for dual-eligible beneficiaries who were inadvertently submitted to and paid by the Medicaid agencies. This demonstration project replaces previous third-party liability review activities of individually gathering Medicare claims from home health agencies for every dual-eligible Medicaid claim the state has possibly paid in

error. This represents an enormous savings in resources for home health agencies, as well as the regional home health intermediaries, and for the participating states.

The demonstration includes an educational component to improve the ability of all parties to make appropriate coverage determinations in the first instance; and an audit sample drawn from each project year's universe of dual-eligible home health claims paid by Medicaid that the state believes should have been paid by Medicare. The sample results are extrapolated to the universe of claims in determining a Medicare settlement payment for each FFY. Reconsideration appeals and arbitration procedures are included in the project to resolve cases where the states and CMS disagree on Medicare's denial of coverage. Subsequent payments are made after final determinations on disputed cases are resolved.

Based on demonstration findings, OMIG is continuing to develop a Medicare/Medicaid overlapping payment review of the top providers with high utilization cost to the Medicaid program.

Medicare Maximization Project – CMA. Working with our legal staff, we are developing settlement offers for the Medicare Maximization Project for FFY93 through FFY97. The offer informs of the restitution and programmatic action required as a result of the Center for Medicaid Advocacy (CMA) review of dual-eligible claims for the home care services paid during the above referenced fiscal years.

Challenges

Home Health Demonstration Project. In August 2003, New York State entered into a waiver-only project entitled "Demonstration of Home Health Agencies Settlement for Dual Eligibles." This project replaced the administratively burdensome traditional case-by-case review with a sampling methodology used to determine appropriate liability and payment for dual eligibles. This demonstration project was scheduled to run for five years, covering claims through FFY2005. At the states' request, the demonstration was extended twice to include claims through FFY 2007. Our request for another extension to cover claims for FFY 2008 was rejected in September 2008.

The elimination of the demonstration project forced the state to return to the traditional case by-case methodology and placed an enormous and expensive administrative burden on home health care providers, as well as the CMS regional home health intermediaries responsible for claims processing. More than 30,000 cases (more than 100,000 episodes) were billed to the regional home health intermediary (RHHI).

We are continuing to seek an extension of the demonstration project and subsequent federal legislation that would make what was a waiver-only demonstration project, a permanent part of the Medicare program with respect to determining Medicare's financial liability for dual-eligible home health care expenditures.

Medicare Part B Billing. New York State lost its ability to bill Medicare directly for Medicare Part B claims due to the establishment of the National Provider Identifier. Medicare will not accept Part B claims without this unique identifier. The volume of claims prohibits the state from seeking providers to re-bill Medicare for these Medicare-eligible services related to retroactive enrollment.

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This has resulted in diminished recoveries for the state. The state, on numerous occasions, has requested that CMS establish a separate NPI or an alternative workaround for direct billing. Ironically, the state was issued an NPI (for our state-operated medical facilities) in January 2008. The CMS has rejected the state's requests to use this NPI and refused to even offer a meeting to discuss the issue.

We are seeking federal legislation (with appropriate governor's office/Congressional support) that would require CMS to allow the state to use their NPI or direct CMS to develop an alternative direct billing protocol.

DIVISION OF ADMINISTRATION

BUREAU OF COLLECTIONS MANAGEMENT

The Bureau of Collections Management (BCM) is responsible for the recovery of overpayments and penalties as identified by the Divisions of Audit, Technology and Business Automation, and Medicaid Investigations.

The BCM's primary goal is to establish a proactive approach to collections to enable accounts to be liquidated in an efficient manner. Accounts that have no collection activity for a defined period are put on notice and, if necessary, referred to the Office of Attorney General's Civil Recovery Unit for further action.

BCM activities focus on providing administrative and resource support to meet OMIG's collection needs and may include coordination with the Department of Health Fiscal Management Group (FMG), New York State Office of the Attorney General, other state agencies, as well as Medicaid providers and their representatives.

RECOUPMENT OF OVERPAYMENT PROTOCOL

OMIG has established a recoupment of overpayment protocol to expedite the recoupment of overpayments, including the obligation to repay the federal government its proportionate share within 60 days of discovery. This protocol must be consistent with governing statutes and regulations. The process works as follows:

Repayment

The provider has 20 days from the date of the final report/notice to either make payment in full or to notify OMIG of its request to enter into a repayment agreement. Providers failing to either make payment in full or make repayment arrangements will be subject to a 50-percent withhold of their future Medicaid payments. No interest will be charged if the repayment is completed within 90 days from the date of the final report. Repayment periods exceeding 90 days from the date of the final report are subject to interest.

When the provider's proposed repayment term exceeds two years and/or the weekly withhold rate would be less than 15 percent of the provider's annual Medicaid billings, OMIG requires financial information from the provider to establish the terms of the repayment agreement. If additional information is requested, OMIG will establish a 15-percent withhold of the provider's Medicaid billings, and the provider will have a 30-day period in which to submit the requested financial information. OMIG must receive the financial information within 30 days of the

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request, or a 50-percent withhold will be imposed. OMIG will adjust the rate of recovery, or require immediate payment in full, if the unpaid balance is not repaid as agreed.

Any money due to the provider from the department may be used as an offset against any overpayments.

Notice

OMIG provides notice to the provider five days after withholding any funds.

ASSESSMENT OF INTEREST PROTOCOL

In accordance with 18 NYCRR § 518.4, the protocol for assessment of interest on overpayments relies on the following procedure:

Interest Assessment

OMIG uses two periods for interest assessment:

- (a) from the date of overpayment to the date of notice of audit findings (pre-final interest); and
- (b) from the date of notice of audit findings to the date of repayment (post-final interest).

(a) From the date of overpayment to the date of the notice of audit findings (pre-final interest), the following interest policy is applicable for each audit/program area:

Managed Care Audits

Pre-final interest will be assessed beginning on the date of the overpayment through the date of the draft report/notice if the insurer causes an action that creates an overpayment (e.g., billing a monthly capitation payment prior to a newborn's date/month of birth). The rate of interest will be the prime rate, and the calculation will adjust with any change to the prime rate over the period for which interest is calculated. The final interest amount owed for overpayments identified in the final report/notice will be calculated from the date of the overpayment to the date of the draft report/notice.

If the insurer is not at fault for the overpayment, e.g., billing for a capitation payment for an incarcerated enrollee, no pre-final interest will be assessed.

Fee-for-Service Audits

Pre-final interest will not be assessed when statistical sampling/projection of findings is used to calculate an overpayment.

When sampling/projection has not occurred and the audit process consists of a claim-by-claim review, pre-final interest will be assessed on any overpayment identified, beginning on the date of the overpayment through the date of the draft report/notice. The final interest amount owed for the overpayments identified in the final report/notice will be calculated from the date of the overpayment to the date of the draft report/notice.

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Rate Audits

Pre-final interest will not be assessed. In accordance with 18 NYCRR 518.4, interest is not assessed for inpatient facilities established under Article 28 of the Public Health Law with respect to cost report audits for any period prior to issuance of a notice of determination, nor for a period of at least 90 days after such notice is issued.

(b) From the date of notice of audit findings to the date of repayment (post-final interest), the following interest policy is applicable for each audit/program area:

Managed Care Audits, Fee-for-Service Audits, Rate Audits

If full repayment is made within 90 days of the date of the final report/notice, no interest will be assessed. If full repayment is not made within 90 days of the date of the final report/notice, recoveries of amounts due are subject to interest charges at the prime rate plus two percentage points beginning on day 91. Such interest will be collected by DOH's Fiscal Management Group (FMG) once OMIG refers the case/collection. Medicaid checks issued to the provider will be reduced by the designated withhold percentage or fixed weekly amount until the liability has been repaid. The interest shall be posted and accumulated on a weekly basis, and collection of the interest assessed shall begin after the principal amount owed has been fully repaid. Interest shall be collected in the same manner and at the same rate of Medicaid check reduction as the related negative liability.

ACCOUNTS RECEIVABLE INITIATIVES

BCM will continue to work to improve OMIG accounts receivable process and will seek to complete the following initiatives during the 2010-11 work plan period:

- For providers who are not actively billing Medicaid and therefore not liquidating amounts owing via the Medicaid withhold recovery method, OMIG will investigate affiliated providers and establish withholds on their Medicaid billings, as appropriate.
- Refer accounts that are 180 days delinquent to the Attorney General's office for further collection action.
- Refer accounts that are 180 days delinquent to New York State's Department of Taxation and Finance and/or the Office of State Comptroller to facilitate collection.
- OMIG will establish procedures to collect outstanding balances from providers participating in the Medicare program. The Center for Medicare and Medicaid Services (CMS) Federal Claims Collection Act Section 1885 of title XVIII and Social Security Act 42 CFR (§405.375) provides for the withhold of payments for these providers to satisfy uncollected Medicaid accounts receivable.

OFFICE OF COUNSEL (OC)

The Office of Counsel (OC) to the Office of the Medicaid Inspector General promotes OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

In addition to providing day-to-day internal legal advice and support to OMIG, the OC coordinates OMIG's role in the prevention, detection and investigation of Medicaid fraud and abuse internally, and with other outside agencies. The OC is also responsible for developing new

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and modifying existing regulations relating to OMIG's activities, including but not limited to, the recovery of improperly expended medical assistance (Medicaid) funds. Further, the OC provides general legal services to OMIG, including advice and support regarding OMIG's programs and operations, and representation at administrative hearings and in litigation matters relating to Medicaid fraud and abuse. One of the major responsibilities vested within the OC is assessing agency risk and ensuring that fairness exists at all levels of agency process. The OC assists OMIG in pursuing its statutory mandate when appropriate evidence exists to support agency actions.

Over the past year, the OC has seen a dramatic increase in its workload. A large emphasis has been placed on increasing communication with all of the respective OMIG divisions.

For FFY 2011, the OC will expand the scope of legal assistance and advice needed to support the needs of the other OMIG divisions. This includes increasing its overall staff size and regional office presence to ensure that there is ample access to OC staff. Specific activities include more collaboration internally among the various OMIG divisions and externally with sister agencies. . Negotiations are currently underway with the Department of Taxation and Finance, as well as the New York State Office of the Welfare Inspector General, regarding the exchange of information relating to excluded providers and individuals, and third-party liability issues. The OC is also negotiating intergovernmental task force agreements that allow OMIG staff to join forces with other state and federal entities to prevent, detect and identify Medicaid fraud and abuse.

The OC is currently working with the Medicaid integrity contractors (MIC), contracted through the CMS to negotiate joint operating agreements (JOAs) for both the Audit MIC (IPRO) and Review MIC (Thomson Reuters) so that OMIG can collaborate and assist with the federal Medicaid Integrity Program.

As part of OMIG's ongoing efforts to foster provider compliance, the OC will continue to work with executive staff in the overall effort to develop compliance program guidance specific to particular types of providers. This includes assisting in the review of corporate integrity agreements, the Division of Medicaid Audit and working with the federal government on provider self-disclosures. Lastly, any initiatives of the Medicaid Inspector General and/or the other Deputy Medicaid Inspectors General that call for legal advice, support and/or assistance will become the priority of OC staff.

In addition, the OC will continue its efforts in the following focus areas, which represents some of its more traditional work:

Administrative Decision-Making

The OC will continue to review appeals of notices of immediate agency action submitted by individuals and providers that are excluded from participation in the Medicaid program pursuant to 18 NYCRR § 515.7. Such reviews result in final determinations of the agency that affirm, reverse or modify in whole or in part the determination to exclude.

Bureau Support

The OC will continue to provide legal advice and support to all divisions, bureaus and offices within OMIG on new and existing initiatives. The OC's major initiatives for FFY 2011 include, but are not limited to:

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- working with and providing assistance as necessary to the Office of Legislative and Intergovernmental Affairs in reviewing and drafting state legislation;
- Reviewing and analyzing the impact of new federal healthcare reform legislation;
- providing assistance to the Human Resource Management Group in the area of labor relations and management-related issues;
- working with the Collections Management Group to restructure and strengthen OMIG's policies and procedures associated with collection initiatives, including bankruptcy-related issues and the referral of cases for civil recoveries;
- assisting the Bureau of Budget and Financial Management with the contract review process; and
- developing training materials and sessions for OMIG staff on a variety of topics, such as: the administrative hearing process, how to testify at administrative hearings, service of process and subpoenas, and Medicaid policy implication reports.

Creation and Revisions of Regulations

The OC continues to work closely with the Governor's Office of Regulatory Reform (GORR) to revise current regulations and promulgate new regulations to accomplish OMIG's statutory mission. OMIG published a regulatory agenda in the *New York State Register* on January 13, 2010, which included OMIG's plan to review, revise and amend Title 18 NYCRR Parts 515, 518, and 519. Current rulemakings under development in the OC include amendments to 18 NYCRR § 518, § 519 and § 540.6 regarding provider hearing rights in relation to third-party liability recoupment and a technical amendment to 18 NYCRR § 518.7, which has been proposed as a consensus rule. The OC continues to work with OMIG staff on initiatives to develop, implement and amend regulations relating to such areas as Medicaid program integrity, quality of care and other policy-related issues.

Hearings and Litigation

The OC will continue to represent OMIG in administrative hearings in which individuals and/or organizational providers appeal sanction and/or overpayment determinations issued by way of a notice of final agency action or final audit report. The OC's involvement in this area primarily involves representing the interests of OMIG as reflected in the final determination at the administrative hearing. This includes preparing witnesses to testify in the proceeding, making opening statements before the administrative law judge to summarize what the case will show and what evidence will be presented, cross-examining appellants and their witnesses, making timely objections during the administrative hearing, gathering, reviewing and submitting into evidence all of the necessary and supporting documentation that supports the final determination, preparing a closing brief, and creating a record for the administrative law judge that both explains and supports the action taken.

The OC will continue to provide legal support to the Office of the Attorney General in its representation of OMIG in judicial proceedings. Within the last year, OC attorneys have appeared in court along with the assistant attorney general assigned to the case. The OC will continue to provide such assistance, in addition to assisting in providing research and preparation of documents submitted to the courts.

In the case of administrative hearings and litigation, assistance by the OC may also involve the negotiation of settlements, and the review of the final determination prior to issuance, to ensure consistency and compliance with governing rules and regulations.

All of the OCs work and efforts are in support of the Medicaid Inspector General's goal to make New York State the national leader in Medicaid program integrity.

CONCLUSION

As a public integrity agency, the Office of the Medicaid Inspector General is dedicated to preserving and protecting the Medicaid program for those in need, and to safeguard the state's taxpayers from fraud and abuse of Medicaid.

OMIG's approach for FFY 2011 stresses mandatory compliance programs for providers who bill or receive more than \$500,000 annually from the Medicaid program. Through this effort, New York State will see reductions in improper Medicaid payments on the front end—before they take place—rather than making it necessary to recoup such money after it has been paid.

OMIG will work to educate providers on compliance issues during 2011 through outreach efforts, including Webinars and other communications efforts. We will focus on governance and its relationship to the function of compliance, stressing the importance of the role of boards of directors in monitoring the day-to-day operations of the providers whom they serve. OMIG will recover overpayments through provider disclosures and actions against providers who fail to make disclosures.

OMIG's areas of concentration for FY2011 include:

- Pharmacy, device and prescription drug issues
- Home health and personal care issues
- Evaluation and review
- Employee training and professional standards
- Outreach to beneficiaries and beneficiary advocacy organizations

Additionally, OMIG will rely on its newly-convened audit advisory committee to help the agency facilitate candid discussions on audit processes and systems.

The federal Affordable Care Act imposes significant obligations on both providers and states in order to assure quality affordable healthcare. We will work with providers to ensure that they are aware of and meet their obligations under both that statute and New York's mandatory compliance program. We remain committed to continuous performance improvement, both internally and externally, and to full disclosure and transparency.

This plan represents an ambitious—yet accomplishable—set of goals for FFY 2011. With the commitment of a group of dedicated public servants statewide, OMIG plans to work with all of its constituents to meet or exceed the expectations found in this document.

EXHIBIT I: PART 521 COMPLIANCE REGULATION

A new Part 521, entitled “Provider Compliance Programs,” is added to Title 18 of the Codes, Rules and Regulations of the State of New York to read as follows:

**PART 521
PROVIDER COMPLIANCE PROGRAMS**

§521.1 General requirements and scope.

To be eligible to receive medical assistance payments for care, services, or supplies, or to be eligible to submit claims for care, services, or supplies for or on behalf of another person, the following persons shall adopt and implement effective compliance programs:

- (a) persons subject to the provisions of articles twenty-eight or thirty-six of the public health law;
- (b) persons subject to the provisions of articles sixteen or thirty-one of the mental hygiene law; or
- (c) other persons, providers or affiliates who provide care, services or supplies under the medical assistance program or persons who submit claims for care, services, or supplies for or on behalf of another person for which the medical assistance program is or should be reasonably expected by a provider to be a substantial portion of their business operations.

§521.2 Definitions.

For purposes of this Part, the definitions contained in Parts 504 and 515 of this Title shall apply. In addition, the following terms, as used in this Part, shall have the following meanings:

- (a) “Required provider” means a provider meeting any of the criteria listed in subpart 521.1 of this Part.

(b) “Substantial portion” of business operations means any of the following:

- (1) when a person, provider or affiliate claims or orders, or has claimed or has ordered, or should be reasonably expected to claim or order at least five hundred thousand dollars (\$500,000) in any consecutive twelve-month period from the medical assistance program;
- (2) when a person, provider or affiliate receives or has received, or should be reasonably expected to receive at least five hundred thousand dollars (\$500,000) in any consecutive twelve-month period directly or indirectly from the medical assistance program; or
- (3) when a person, provider or affiliate who submits or has submitted claims for care, services, or supplies to the medical assistance program on behalf of another person or persons in the aggregate of at least five hundred thousand dollars (\$500,000) in any consecutive twelve-month period.

§521.3 Compliance Program Required Provider Duties.

(a) Every required provider shall adopt and implement an effective compliance program. The compliance program may be a component of more comprehensive compliance activities by the required provider so long as the requirements of this Part are met. Required providers’ compliance programs shall be applicable to:

- (1) billings;
- (2) payments;
- (3) medical necessity and quality of care;
- (4) governance;

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- (5) mandatory reporting;
- (6) credentialing; and
- (7) other risk areas that are or should with due diligence be identified by the provider.

(b) Upon applying for enrollment in the medical assistance program, and during the month of December each year thereafter, a required provider shall certify to the department, using a form provided by the Office of the Medicaid Inspector General on its Web site, that a compliance program meeting the requirements of this Part is in place. The Office of the Medicaid Inspector General will make available on its website compliance program guidelines for certain types of required providers.

(c) A required provider's compliance program shall include the following elements:

- (1) written policies and procedures that describe compliance expectations as embodied in a code of conduct or code of ethics, implement the operation of the compliance program, provide guidance to employees and others on dealing with potential compliance issues, identify how to communicate compliance issues to appropriate compliance personnel and describe how potential compliance problems are investigated and resolved;
- (2) designate an employee vested with responsibility for the day-to-day operation of the compliance program; such employee's duties may solely relate to compliance or may be combined with other duties so long as compliance responsibilities are satisfactorily carried out; such employee shall

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report directly to the entity's chief executive or other senior administrator designated by the chief executive and shall periodically report directly to the governing body on the activities of the compliance program;

(3) training and education of all affected employees and persons associated with the provider, including executives and governing body members, on compliance issues, expectations and the compliance program operation; such training shall occur periodically and shall be made a part of the orientation for a new employee, appointee or associate, executive and governing body member;

(4) communication lines to the responsible compliance position, as described in paragraph (2) of this subdivision, that are accessible to all employees, persons associated with the provider, executives and governing body members, to allow compliance issues to be reported; such communication lines shall include a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified;

(5) disciplinary policies to encourage good faith participation in the compliance program by all affected individuals, including policies that articulate expectations for reporting compliance issues and assist in their resolution and outline sanctions for:

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- (i) failing to report suspected problems;
- (ii) participating in non-compliant behavior; or
- (iii) encouraging, directing, facilitating or permitting either actively or passively non-compliant behavior;

such disciplinary policies shall be fairly and firmly enforced;

(6) a system for routine identification of compliance risk areas specific to the provider type, for self-evaluation of such risk areas, including but not limited to internal audits and as appropriate external audits, and for evaluation of potential or actual non-compliance as a result of such self-evaluations and audits, credentialing of providers and persons associated with providers, mandatory reporting, governance, and quality of care of medical assistance program beneficiaries;

(7) a system for responding to compliance issues as they are raised; for investigating potential compliance problems; responding to compliance problems as identified in the course of self-evaluations and audits; correcting such problems promptly and thoroughly and implementing procedures, policies and systems as necessary to reduce the potential for recurrence; identifying and reporting compliance issues to the department or the office of Medicaid inspector general; and refunding overpayments;

(8) a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including but not limited to

reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials as provided in sections seven hundred forty and seven hundred forty-one of the labor law.

521.4 Determination of Adequacy of Compliance Program.

(a) The commissioner of health and the Medicaid inspector general shall have the authority to determine at any time if a provider has a compliance program that is effective and appropriate to its characteristics and satisfactorily meets the requirements of this Part.

(b) A provider whose compliance program that is accepted by the federal department of health and human services office of inspector general and remains in compliance with the standards promulgated by such office shall be deemed in compliance with the provisions of this Part, so long as such plans adequately address medical assistance program risk areas and compliance issues.

(c) In the event that the commissioner of health or the Medicaid inspector general finds that the required provider does not have a satisfactory program, the provider may be subject to any sanctions or penalties permitted by federal or state laws and regulations, including revocation of the provider's agreement to participate in the medical assistance program.

Appendix A

Glossary of Abbreviations

ADHC	Adult Day Health Care
ALP	Assisted Living Programs
APG	Ambulatory Patient Group
AQC	Office of Audit and Quality Control
BLTCR	Bureau of Long Term Care Reimbursement
BMA	Bureau of Medicaid Audit
CDPAP	Consumer-Directed Personal Assistance Program
CDT	Continuing Day Treatment
CHAP	Community Health Assessment Process
CHHA	Certified Home Health Agency
CIA	Corporate Integrity Agreement
CIN	Client Identification Number
CMA	Center for Medicaid Advocacy
CMS	Center for Medicare and Medicaid Services
COPS	Comprehensive Outpatient Programs Services
CQC	Commission on Quality of Care
CSC	Computer Science Corporation
CSP	Community Support Programs
CY	County Year
D&TC	Diagnostic and Treatment Center
DDSO	Developmental Disabilities Services Office
DLIA	Division of Legal and Intergovernmental Affairs
DMA	Division of Medicaid Audit
DME	Durable Medical Equipment
DMI	Division of Medicaid Investigations
DOH	Department of Health
DRA	Deficit Reduction Act
DRG	Diagnosis-Related Group
DSH	Disproportionate Hospital Share Payments
DTBA	Division of Technology & Business Automation
EAR	Enrollment Audit Review
ERISA	Employee Retirement Income Security Act
FFS	Fee For Service
FFY	Federal Fiscal Year
FQHC	Federally Qualified Health Center
FWA	Fraud, Waste and Abuse
GME	Graduate Medical Education
HCBS	Home and Community-Based Services
HCIA	Health Care Integration Agencies
HHA	Home Health Agency
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HMS	Health Management Systems
IMD	Institutions for Mental Disease
IRO	Independent Review Organizations
JOA	Joint Operating Agreement

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LDSS	Local District of Social Services
LFY	Local Fiscal Year
LTHHCP	Long-Term Home Health Care Program
MCO	Managed Care Organization
MFCU	Medicaid Fraud Control Unit
MICSA	Medicaid Insurance Community Service Agency
MLTC	Managed Long Term Care Organizations
MMIS	Medicaid Management Information Systems
MOU	Memorandum of Understanding
MUT	Medicaid Utilization Threshold Program Unit
NMMDAC	New York Medicare Medicaid Data Analysis Center
NYCRR	New York Code of Rules and Regulations
OASAS	Office of Alcoholism and Substance Abuse Services
OC	Office of Counsel
OCFS	Office of Children and Family Services
OHIP	Office of Health Insurance Programs
OIG	Office of Inspector General
OMH	Office of Mental Health
OMIG	Office of the Medicaid Inspector General
OC	Office of Counsel
OPWDD	Office of People with Developmental Disabilities
OTDA	Office of Temporary Disability Assistance
PBM	Pharmacy Benefit Managers
PCA	Personal Care Aide
PERM	Payment Error Rate Measurement
PHL	Public Health Law
PMPH	Prepaid Mental Health Plan
PPS	Prospective Payment System
RHCF	Residential Health Care Facility
RHHI	Regional Home Health Intermediary
SFY	State Fiscal Year
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TBI	Traumatic Brain Injury
TOA	Threshold Override Application
TPA	Third-Party Administrators
WSP	Waiver Service Providers

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APPENDIX B

PROVIDER
ELECTRONIC/PAPER TRANSMITTER IDENTIFICATION NUMBER (ETIN)
APPLICATION

This ETIN application form is to be used only by enrolled providers. It is not to be used by service bureaus or billing agencies submitting transactions (claims) on behalf of an enrolled NYS Medicaid provider. Service Bureaus/Billing Agencies must complete a Service Bureau/Billing Agency ETIN Application, located at www.emedny.org.

To apply for an Electronic/Paper Transmitter Identification Number (ETIN), which is required to send and receive New York State Medicaid data electronically or on paper, please complete the items below and forward, along with a Certification Statement to:

Computer Sciences Corporation
Attn: Provider Enrollment Support
P.O. Box 4614
Rensselaer, NY 12144-8614

*** PLEASE NOTE: You must submit at least one notarized Certification Statement with this application before an ETIN can be issued. If you are adding a Provider ID number to an existing ETIN, send ONLY the Certification Statement. If this is for your annual recertification, you do not need to send this form; please print pages 3 and 4.**

1. PROVIDER NAME: _____

2. PROVIDER ADDRESS: _____
(Street)

(City) (State) (ZIP Code + 4)

()- _____ ()- _____
(Telephone Number) (Extension) (FAX Number)

3. ADMINISTRATOR'S NAME: _____

4. CONTACT PERSON'S NAME: _____

5. CONTACT TELEPHONE NUMBER: _____

6. 10-DIGIT NATIONAL PROVIDER ID (NPI)
(REQUIRED, UNLESS NPI EXEMPT): _____

7. MMIS PROVIDER NUMBER(S) (REQUIRED IF NPI EXEMPT): _____

AUTHORIZED SIGNATURE:

(NAME PRINTED) (SIGNATURE)

(TITLE) (DATE)

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(1) ETIN _____ (2) BILLING SERVICE NAME (IF APPLICABLE) _____

eMedNY/MEDICAID MANAGEMENT INFORMATION SYSTEM

CERTIFICATION STATEMENT FOR PROVIDER BILLING MEDICAID

(3) As of (date) _____, all claims submitted electronically or on paper to the State's Medicaid fiscal agent, for services or supplies furnished

(4) by (provider name) _____

(5) (8-digit Medicaid Provider Number -- REQUIRED) []

(6) (10-digit National Provider ID (NPI) -- REQUIRED unless exempted from NPI) []

will be subject to the following certification.

I am (or the business entity named in this form of which I am a partner, officer, or director is) a qualified provider enrolled with and authorized to participate in the New York State Medical Assistance Program and in the profession or specialties, if any, required in connection with this claim; the persons providing services, care and supplies have the necessary licensing, certification, training and experience to perform the claimed services; I have reviewed these claims; I (or the entity) have furnished or caused to be furnished the care, services, and supplies itemized and done so in accordance with applicable federal and state laws and regulations; I have read the eMedNY Provider Manual and all revisions thereto; all claims are made in full compliance with the pertinent provisions of the Manual and revisions; all claims for care, services and supplies provided at the order of another professional have to the best of my knowledge been ordered by that professional in bona fide compliance with the procedures set forth in the manual and revisions. All care, services and supplies for which claim is made are medically necessary for the treatment of the named recipient, the amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any other source other than the Medical Assistance Program; payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid; ALL STATEMENTS, DATA AND INFORMATION TRANSMITTED ARE TRUE, ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE; NO MATERIAL FACT HAS BEEN OMITTED; I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL, STATE AND LOCAL PUBLIC FUNDS AND THAT I MAY BE FINED AND/OR PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS FOR ANY VIOLATION OF THE TERMS OF THIS CERTIFICATION, INCLUDING BUT NOT LIMITED TO FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT; taxes from which the State is exempt are excluded; all records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medical Assistance Program will be kept for a period of six years from the date of payment, and such records and information regarding these claims and payment therefor shall be promptly furnished upon request to the local Department of Social Services, the State Department of Health, the Office of the Medicaid Inspector General, the State Medicaid Fraud Control Unit or the Secretary of the Department of Health and Human Services; there has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion; I agree (or the entity agrees) to comply with the requirement of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to (1) make administrative corrections to claims submitted under this agreement to enable its automated processing, subject to reversal by the provider, and (2) accept the claim under this agreement as original evidence of care, services and supplies furnished.

In submitting claims under this agreement I understand and agree that I (or the entity) shall be subject to and bound by all rules, regulations, policies, standards, fee codes and procedures of the New York State Department of Health and the Office of the Medicaid Inspector General as set forth in statute or title 18 of the Official Compilation of Codes, Rules and Regulation of New York State and other publications of the Department, including eMedNY Provider Manuals and other official bulletins of the Department. I understand and agree that I (or the entity) shall be subject to and shall accept, subject to due process of the law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or my entity's) past, present or future status in the Medicaid program and/or imposing any duly considered sanction or penalty.

I UNDERSTAND THAT MY SIGNATURE HEREON THE ABOVE CERTIFICATION WILL APPLY TO ALL CLAIMS SUBMITTED ELECTRONICALLY OR ON PAPER, USING MY (OR THE ENTITY'S) NPI OR MEDICAID PROVIDER IDENTIFICATION NUMBER. THIS CERTIFICATION REMAINS IN EFFECT AND APPLIES TO ALL CLAIMS UNTIL SUPERSEDED BY ANOTHER PROPERLY EXECUTED CERTIFICATION STATEMENT.

PLEASE DO NOT STAPLE OR WRITE IN BAR CODE AREA

(7) (Signature) _____ (8) (Date) _____

(9) (Print Name and Title) _____

(10) (Telephone #) _____ (11) (eMail, if available) _____

STATE OF _____ (12)
COUNTY OF _____

On this _____ day of _____, 20____, before me personally came _____ to me know and known to me to the individual described in and who executed the foregoing instrument, and (s)he acknowledge to me that (s)he executed the same.

(SEAL)

NOTARY PUBLIC

PR15200-R1117 (Rev. 6/20/2008)



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CERTIFICATION STATEMENT INSTRUCTIONS

A Certification Statement must be completed:

1. When you are applying for an Electronic/Paper Transmitter Identification Number (ETIN) for the electronic or paper submission of New York Medicaid data. At least one Certification Statement must accompany the ETIN Application Form. If you have multiple providers that you want linked to the new ETIN, you must complete and notarize a Certification Statement for each provider that is to be linked to the new ETIN, and send the Certification Statement(s) along with the ETIN Application Form.
2. When you are adding a provider ID number to an existing ETIN, you must complete and notarize a Certification Statement for the provider ID to be added, and indicate the ETIN in the top left corner of the form.

In both instances above, if you want the provider/ETIN combination to receive remittances electronically, you must also complete an Electronic Remittance Request form for the provider(s) and ETIN you are certifying. You must do this each time you link a new provider to your ETIN. Failure to do so will result in a paper, rather than electronic, remittance for that provider/ETIN combination.

NOTE: YOU MUST BE ENROLLED IN EITHER EMEDNY EXCHANGE OR FTP PRIOR TO REQUESTING ELECTRONIC REMITTANCE. ALL DOCUMENTS PERTAINING TO ELECTRONIC REMITTANCE CAN BE FOUND AT WWW.EMEDNY.ORG OR BY CALLING THE EMEDNY CALL CENTER AT: 1-800-343-9000.

Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement. You will be asked to update your Certification Statement on an annual basis.

The numbered fields on the Certification Statement correspond with the explanations given below:

- Field 1:** ETIN (Electronic/Paper Transmitter Identification Number) If you are using this form to obtain an ETIN, leave this field blank. If you wish to add a provider ID number to an existing ETIN, please indicate the ETIN in the top left corner of the form.
- Field 2:** BILLING SERVICE NAME If applicable, enter the name of the billing service that the provider is enrolled with. If you are not using a billing service, leave this field blank.
- Field 3:** DATE Enter the date the Certification Statement is submitted to the fiscal agent.
- Field 4:** PROVIDER NAME Enter the name of the provider whose signature is being notarized.
- Field 5:** 8-Digit Medicaid Provider ID Number Until NPI implementation by NYSDOH, the Provider's Medicaid Number must be entered in this field.
- Field 6:** 10-Digit National Provider Identifier (NPI) Enter the NPI, unless exempted from NPI.
- Field 7:** SIGNATURE Enter the signature of the individual indicated in Field 4. This must be an original signature.
- Field 8:** DATE Enter the date the Certification Statement was signed and notarized.
- Field 9:** NAME AND TITLE Print the name and the title of the person whose signature appears in Field 7.
- Field 10:** TELEPHONE # Enter the telephone number of the person whose signature appears in Field 7.
- Field 11:** EMAIL ADDRESS (If Available) If available, enter the email address of the person whose signature appears in Field 7.
- Field 12:** NOTARY PUBLIC To be completed and signed by the Notary Public. The fiscal agent cannot accept Certification Statements that are not notarized. In addition to the notary signature, NYSDOH requires a notary seal or stamp on this document.

Please mail original (FAX copies are not acceptable) completed Certification Statements to:

Computer Sciences Corporation
ATTN: Enrollment Support
PO Box 4614
Rensselaer, NY 12144-8614

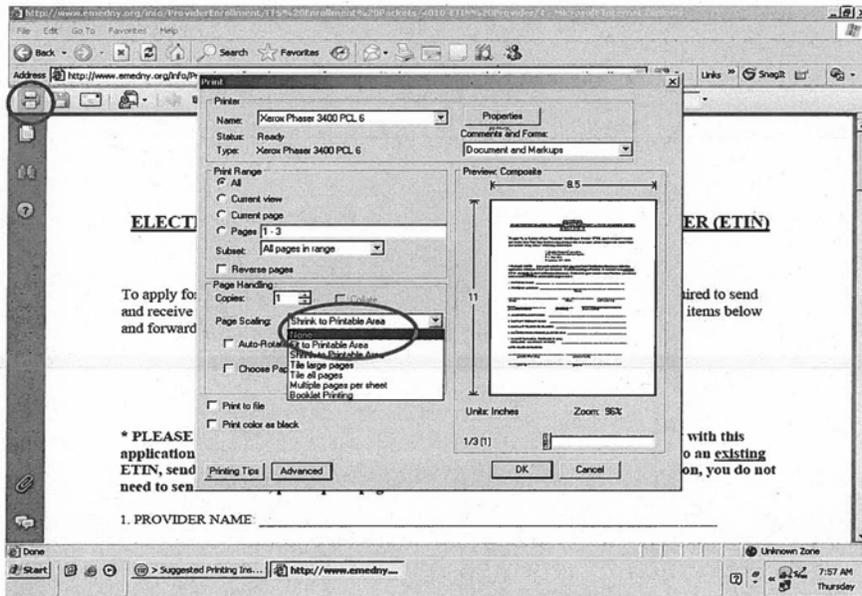
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Printing Instructions

It is important to use the following printing instructions so that the submitted form processes accurately.

Select Print Button from upper left hand corner of screen.

In the print box under Page Scaling, change the defaulted option from 'Shrink to Printable Area' to 'None' as shown:



(Rev. 6/20/2008)