NEW YORK STATE | Office of the Medicaid Inspector General

2021 ANNUAL REPORT

Kathy Hochul
Governor

Frank T. Walsh, Jr.
Acting Medicaid Inspector General

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Message from the Acting Medicaid Inspector General

It is once again my pleasure to provide the Office of the Medicaid Inspector General's (OMIG) 2021 Annual Report, which details the results of the agency's efforts to prevent and detect fraud, waste, and abuse in the State's Medicaid program and to recover improperly expended funds. Beyond its commitment to root out fraud and retain precious taxpayer dollars for health care, this report also recognizes the important contributions of OMIG in supporting the provider community and promoting access to efficient, high-quality patient care for Medicaid beneficiaries throughout the State.

COVID-19 continued to present significant challenges across New York and throughout the health care provider community in 2021. The availability of vaccines, increased access to testing, and widespread adoption of day-to-day mitigation strategies bolstered New York's ability to manage the evolving pandemic. Given the ongoing response to the pandemic, OMIG continued to adjust its operations to perform its essential program integrity functions while avoiding imposing unnecessary burdens on health care providers, which helped ensure their ability to deliver much-needed services. OMIG was able to return to the Medicaid program nearly $3.2 billion in combined recoveries and cost savings in 2021.

Going forward, to meet its program integrity mission and contribute to the State's high-quality health care delivery system, OMIG will continue to develop and implement new initiatives, enhance its processes and procedures, work collaboratively with the provider community and stakeholders, and conduct robust outreach and educational activities to inform practitioners, associations, Medicaid beneficiaries, and the public at large.

Sincerely,

Frank T. Walsh, Jr.
Acting Medicaid Inspector General

General Overview

History and Authority

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

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

Mission Statement

The mission of OMIG is to enhance the integrity of the 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.

Annual Reporting

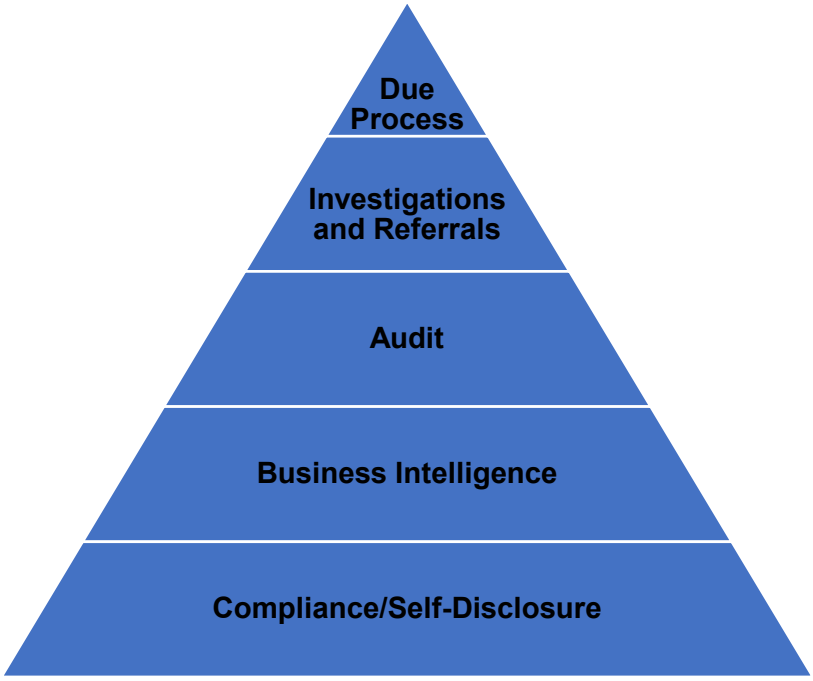
As required by New York State Public Health Law (PBH) §35(1), OMIG must annually submit a report summarizing the activities of the agency for the prior calendar year. This Annual Report includes information about audits, investigations, and administrative actions, initiated and completed by OMIG, as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

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

Function

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

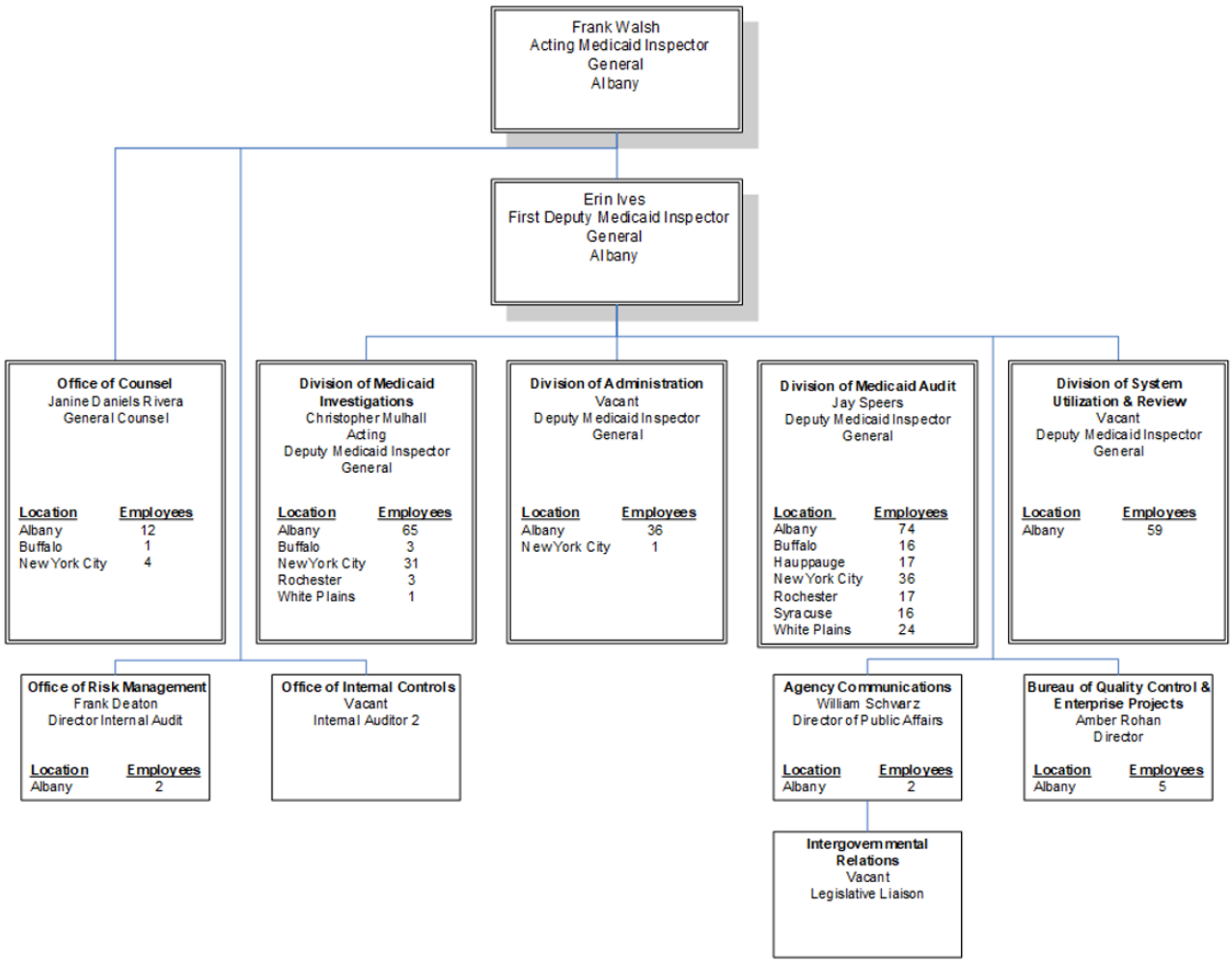
- Understand, promote, and advise on Medicaid policies and procedures that advance program integrity objectives.
- Closely coordinate with New York State Department of Health (DOH) and other state agencies involved in the Medicaid program to identify their priorities and objectives and develop enforcement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



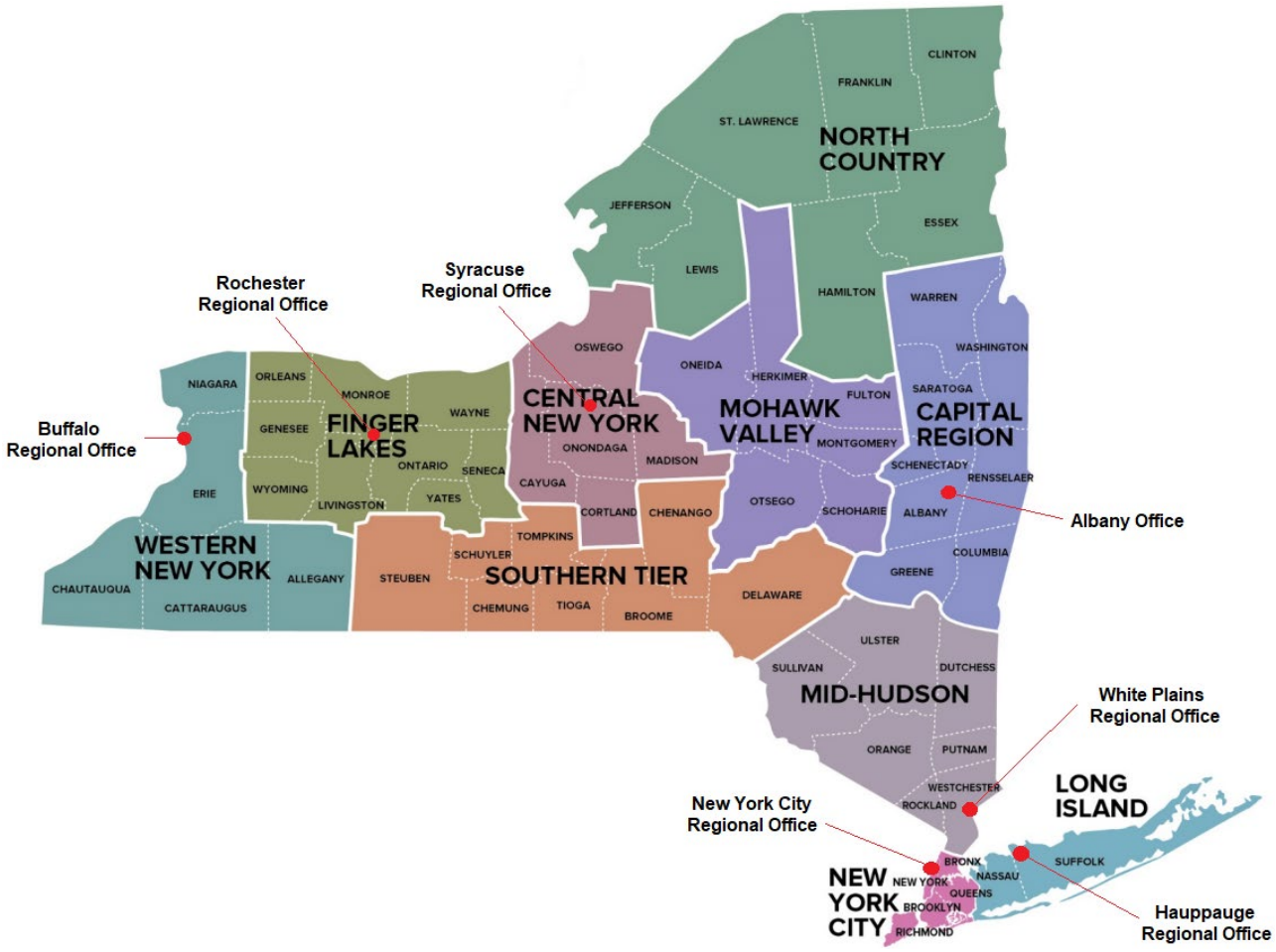
- Educate and collaborate with Medicaid providers and payers, including Managed Care Organizations (MCO), to improve their understanding and compliance with current Medicaid requirements.
- Monitor, identify and evaluate aberrant fiscal or programmatic trends and prioritize those that merit investigation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

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

Executive Organization Chart



Regional Office Locations and Staffing



OMIG has 427 staff working on Medicaid program integrity functions. These positions include auditors, investigators, nurses, data analysts, pharmacists, other clinical/medical professionals, program administrators/managers, and persons providing legal, technological, and clerical support. OMIG has seven offices across the state, with the number of staff present in each region broken down below:

- Albany 257
- New York City 72
- White Plains 25
- Buffalo 20
- Rochester 20
- Hauppauge 17
- Syracuse 16

2021 Agency Highlights

Continued Impact of COVID-19 Pandemic

The challenges for New York's health care delivery system continued in 2021 with its ongoing response to the progression of the COVID-19 pandemic, as the impact of new variants emerged. The public health emergency (PHE) program considerations and waivers put in place at both the Federal and State levels, also continued to ensure that the health care industry had the resources and capacity to respond to the evolving nature of the COVID-19 pandemic. Additionally, Congressional legislation passed during the PHE restricted the disenrollment of Medicaid recipients to ensure continuity of care. These restrictions impacted recoveries in retro disenrollment and multiple Client Identification Numbers (CIN). In support of these policy objectives OMIG continued its collaboration with the health care industry to avoid any actions that would unnecessarily impact the delivery of health care services or the availability of resources.

With the broader availability of COVID-19 vaccines and adherence to public health mitigation strategies, New York was able to re-calibrate restrictions and return to a greater sense of normalcy.

OMIG began to transition from a mostly remote posture in 2020 to progressively returning to field operations during 2021, mindful of environmental impacts to health care providers and lessons learned during the pandemic. In response to PHE limitations, OMIG accommodated remote working and temporarily paused several project types across various divisions due to potential impacts on health care provider service delivery or resources. In 2021, OMIG was able to re-initiate virtually all paused projects and resume field work.

With open communication and commitment to program oversight, OMIG was able to finalize many projects across the State throughout 2021 and keep pace with prior year results.

Regulatory Development

Throughout the course of 2021, OMIG continued to develop and work towards finalizing draft regulations, which when implemented, will support enacted legislation (Chapter 56 of the Laws of 2020, Part QQ) and modernize regulations governing provider and MCO activities designed to detect and prevent fraud, waste, and abuse. Specifically, the draft regulations will clarify New York State's mandatory compliance program requirements for Medicaid providers and provide additional direction regarding the establishment and implementation of such programs. In addition, they will establish standards for the investigation and prevention of fraud, waste, and abuse within the Medicaid program for participating MCOs. Finally, the regulations will fully implement, consistent with federal law, the requirement that a provider report, return and explain Medicaid overpayments, and the procedures for self-disclosing such payments to OMIG.

Financial Hardship

On July 6, 2021, OMIG implemented an enhanced financial hardship process, which affords providers the opportunity to apply for relief in the event an OMIG audit may pose a financial hardship to the organization. Providers that have received a Final Audit Report and wish to apply for financial hardship consideration may contact OMIG's Bureau of Collections Management who will send the provider a Financial Hardship Application. Upon receipt, OMIG will review the application and decide an appropriate re-payment plan. In 2021, 38 hardship applications were received, and financial relief was granted in each instance.

Payment Error Rate Measurement Project

The Centers for Medicare & Medicaid Services (CMS) measures improper payments in the Medicaid and State Child Health Insurance programs under the Payment Error Rate Measurement (PERM) program. New York State is required to participate in this program once every three years and assists CMS in all three components of their review: Eligibility Review, Data Processing, and Medical Review. OMIG was responsible for assisting with the Medical Review component. CMS pulled a sample of 600 claims for the Medical Review portion of their review, which included 492 claims that required the gathering of medical records to support the claims. CMS requests the medical records from the provider and after a period of 75 days with no response from the provider they determine that claim to be in error. In this review CMS was unable to obtain medical records for 200 claims. As a best practice, OMIG contacts the providers and requests the medical records for the identified claims CMS had marked as an error. Due to these efforts, OMIG subsequently received the missing records for all 200 claims, and as a result New York State's error rate was found to be only 1.63%, which was well below the national average of 13.9%. For the past two PERM cycles, New York State has been well below the national average, due to the collaboration between OMIG and the provider community.

Education / Compliance / Self-Disclosure

Education

OMIG provides an extensive range of provider outreach and education through informational webinars, guidance materials, presentations, and onsite meetings - to associations, provider groups, and other stakeholders across the state. To this end, in 2021, OMIG delivered presentations on topics including the audit review process, compliance, and agency priorities and key focus areas. Additionally, OMIG's website has been enhanced to improve transparency and better serve the provider community and the public, including increasing the lookback period from two to five years for Final Audit Report postings. The Agency also maintains an email listserv with more than 5,100 subscribers from across the health care delivery system.

OMIG will continue its ongoing communication efforts with the provider and stakeholder communities utilizing all appropriate vehicles, including presentations, the DOH *Medicaid Update*, public website updates, and the agency's listserv.

Compliance Certifications Transition

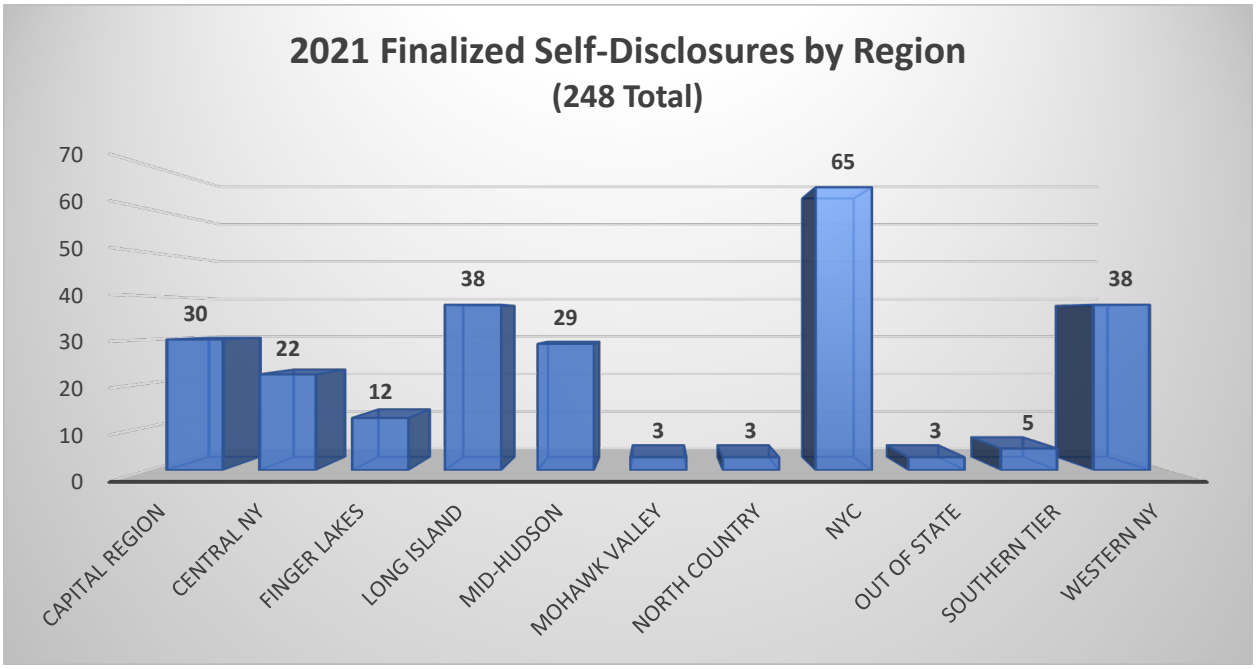
Pursuant to Social Services Law (SOS) § 363-d, providers are required to certify to the DOH upon enrollment in the Medicaid program that they are satisfactorily meeting its requirements. To minimize the administrative burden on the health care provider community by avoiding duplicative certification requirements, OMIG adopted the pre-existing "Certification Statement for Provider Billing Medicaid" in 2020 as a means of documenting annual compliance certification. This change has reduced the number of inquiries received from providers about the certification process and has reduced time needed for providers to comply with the compliance program certification obligation. In 2021, the Bureau of Compliance (BOC) responded to 66 telephone calls and 375 emails from the provider community.

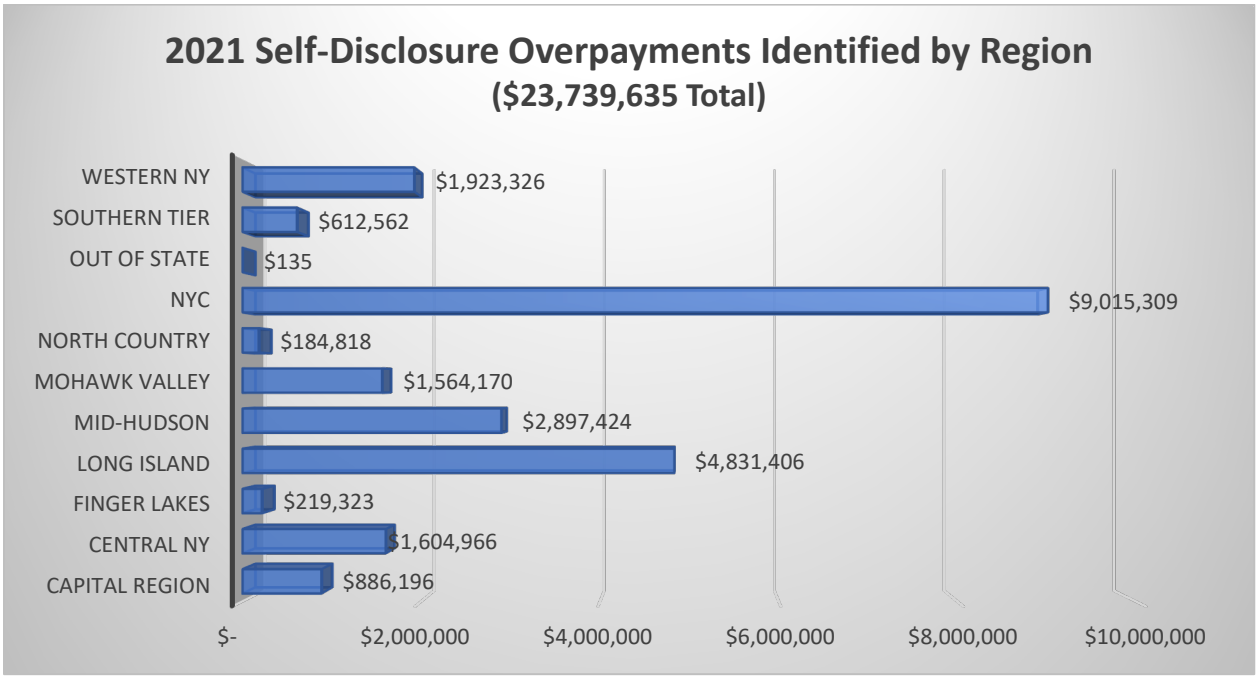
Corporate Integrity Agreements

Corporate Integrity Agreements are monitoring agreements with Medicaid providers who have been determined to have engaged in one or more unacceptable practices that would otherwise warrant exclusion as a provider in New York's Medicaid program. These agreements are for a five-year term and involve a heightened level of monitoring by OMIG. A large part of the monitoring of providers is conducted by an Independent Review Organization (IRO), including on-site visits to the provider's facilities in order to report on the provider's progress and activities associated with the CIA. The IRO is engaged by the provider, at the provider's expense, and with OMIG's approval. Additionally, the agreement establishes additional requirements for a provider beyond the typical reporting required of all Medicaid providers. All providers under a Corporate Integrity Agreement during 2021 operated nursing homes. Due to the restrictions imposed on access to nursing homes during the pandemic, the IROs were not able to make on-site visits. BOC made adjustments in the process so that the IROs could accomplish their reviews and report remotely, and allowed additional time to meet these requirements so that the providers could focus on the needs of the residents due to

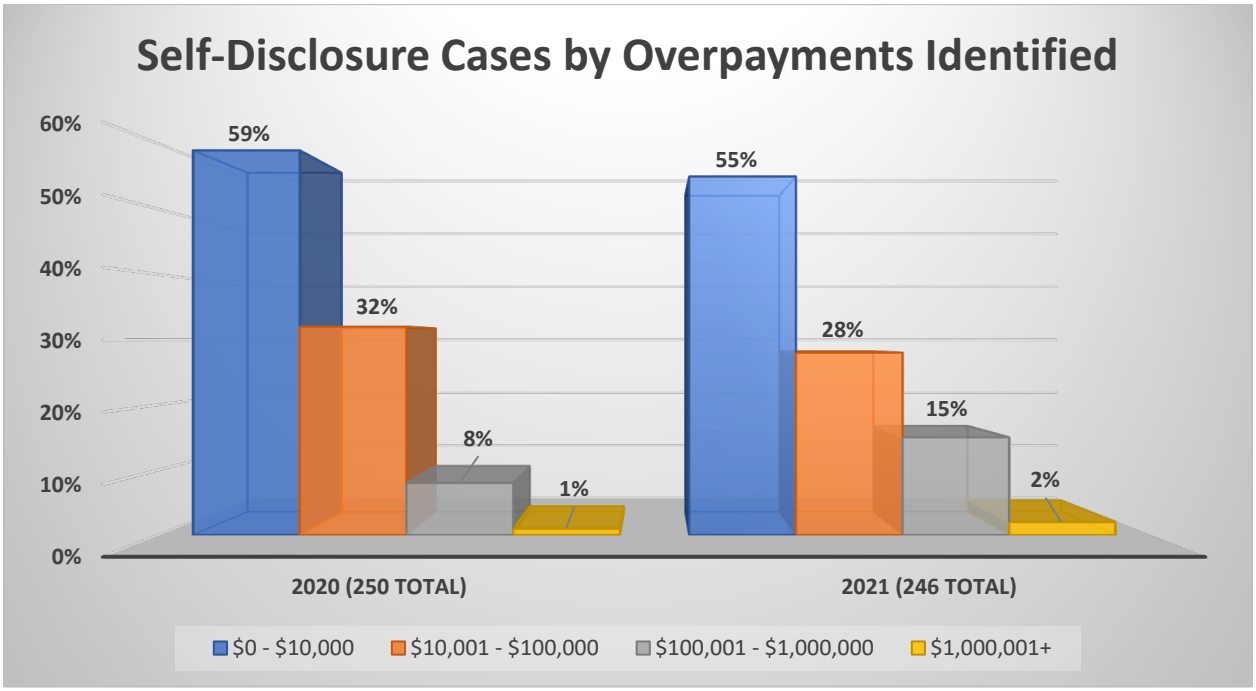
conditions caused by the pandemic. These process modifications allowed OMIG to receive all required reports in advance of the conclusion of the Corporate Integrity Agreements, which all expired in March and April of 2021.

Self-Disclosure

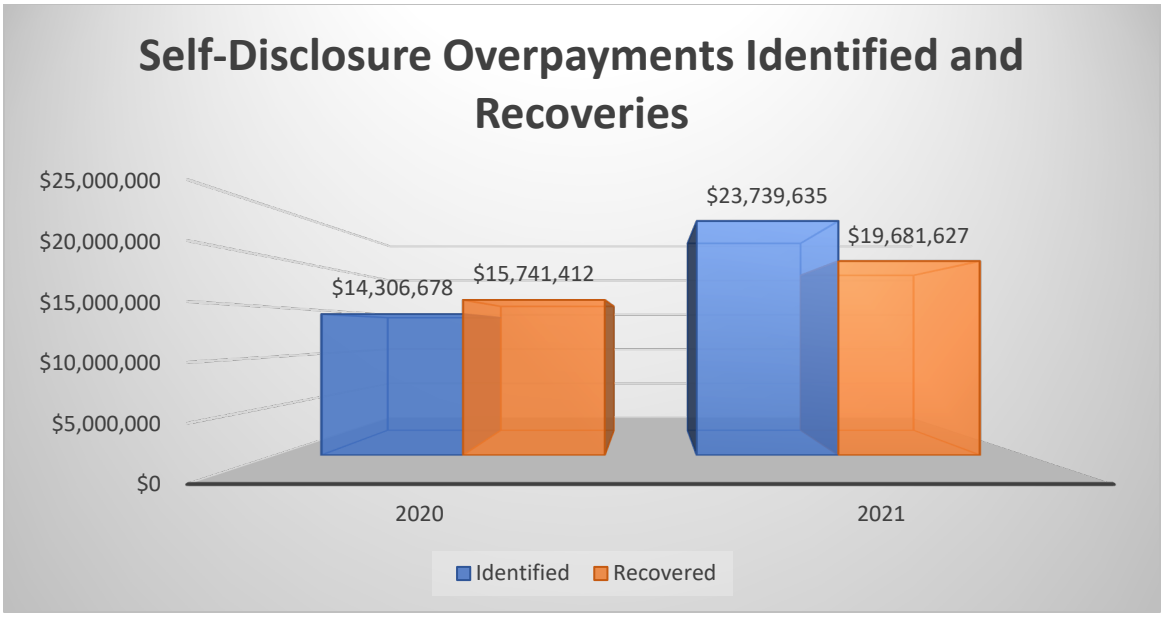




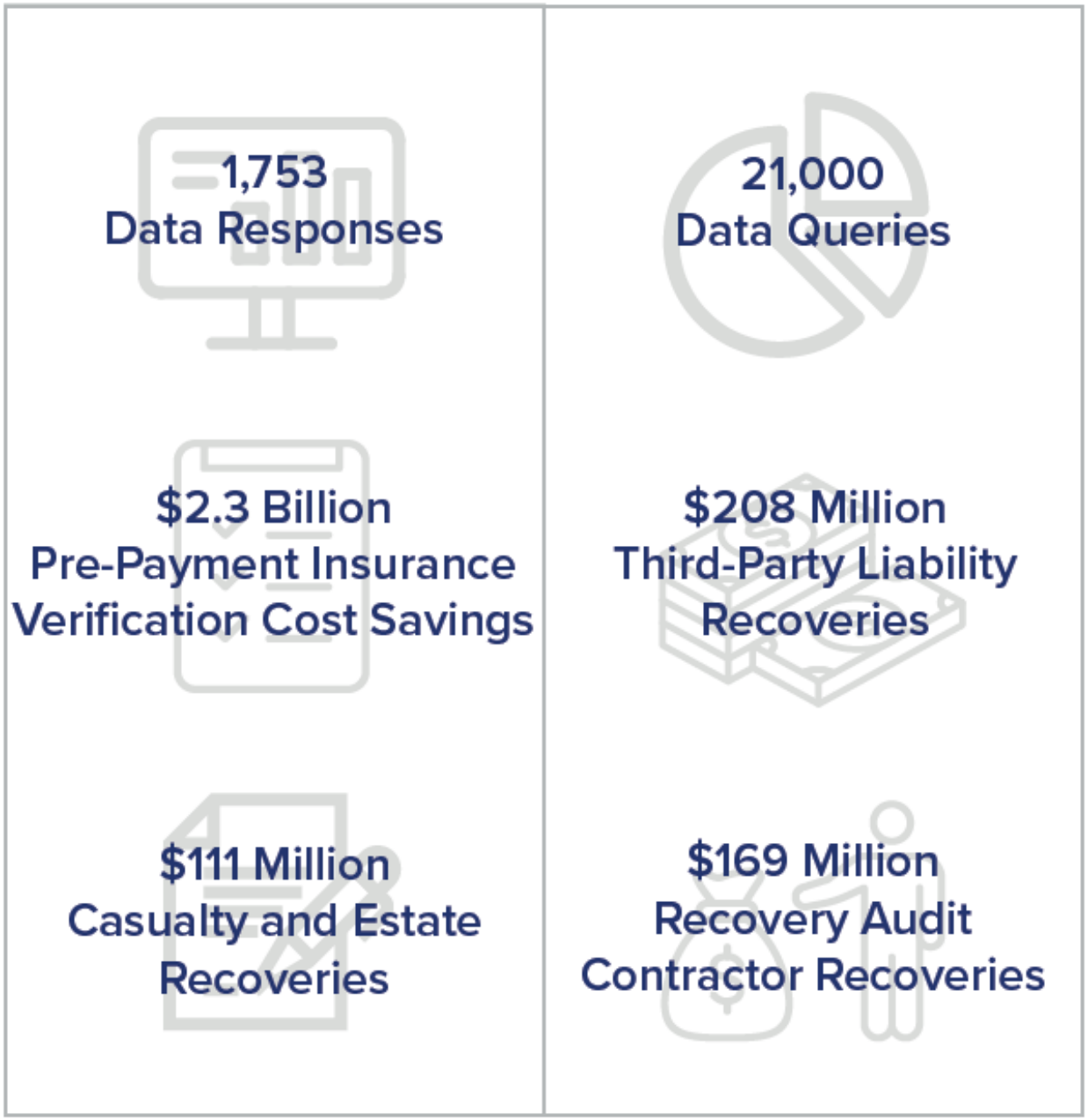
OMIG's self-disclosure program gives providers an easy-to-use method to meet their federal and state requirements to disclose Medicaid overpayments they have received. It is the mechanism for Medicaid enrolled providers and other entities to comply with the mandatory requirements to report, return, and explain Medicaid overpayments. OMIG's approach is designed to encourage providers to investigate and report matters involving possible fraud, waste, abuse, or inappropriate payment of funds which affect the state's Medicaid program that they identify through self-review, compliance programs, or internal controls. Identification and self-disclosure of Medicaid overpayments should be an element of an effective compliance program. Providers can also self-disclose as a result of internal or external audits, Medicaid guidance, or policy updates. Medicaid overpayments of any value identified by the provider are required to be self-disclosed to OMIG. Historically, more than half of the self-disclosures that OMIG receives are less than $10,000.



In 2021, OMIG processed 246 self-disclosure submissions with over $23 million in Medicaid identified overpayments, which is an increase of more than $9 million from 2020.


Self-Disclosure Overpayments Identified and Recoveries
$25,000,000
$20,000,000
$15,000,000
$10,000,000
$5,000,000
$0
$14,306,678
$15,741,412
$23,739,635
$19,681,627
2020
2021
Identified
Recovered

Business Intelligence and Third-Party Liability



Data Mining and Technological Support

New York State York State Medicaid is a data-intensive and complex program of multiple information systems including eMedNY, the Medicaid Management Information System, and the Medicaid Data Warehouse (MDW), a central data repository of all Medicaid paid and denied claims. Utilizing technology is essential to effective program integrity oversight of the services provided to more than 7 million recipients by more than 200,000 enrolled providers. The OMIG Division of System Utilization and Review (DSUR) staff members specialize in applying technological solutions to support agency initiatives. DSUR staff employ knowledge and expertise of Medicaid data and systems to develop complex data analytics and to systemically prevent and detect improper billing practices.

Many agency initiatives depend on data driven analytics. DSUR staff utilize the MDW and many related program applications to conduct various analytical tasks which support management decisions, audits, investigations, and hearings. The data analysis encompasses a wide range of provider types and program areas and supports OMIG and other state agency operations. DSUR staff provide technical oversight, support, and training to the agency's audit and investigative staff, which include the extraction and evaluation of varied datasets to identify patterns and guide agency initiatives. Additionally, staff share expertise in computer programming and documentation, system analysis, data analysis, program research and information gathering, and presentation.

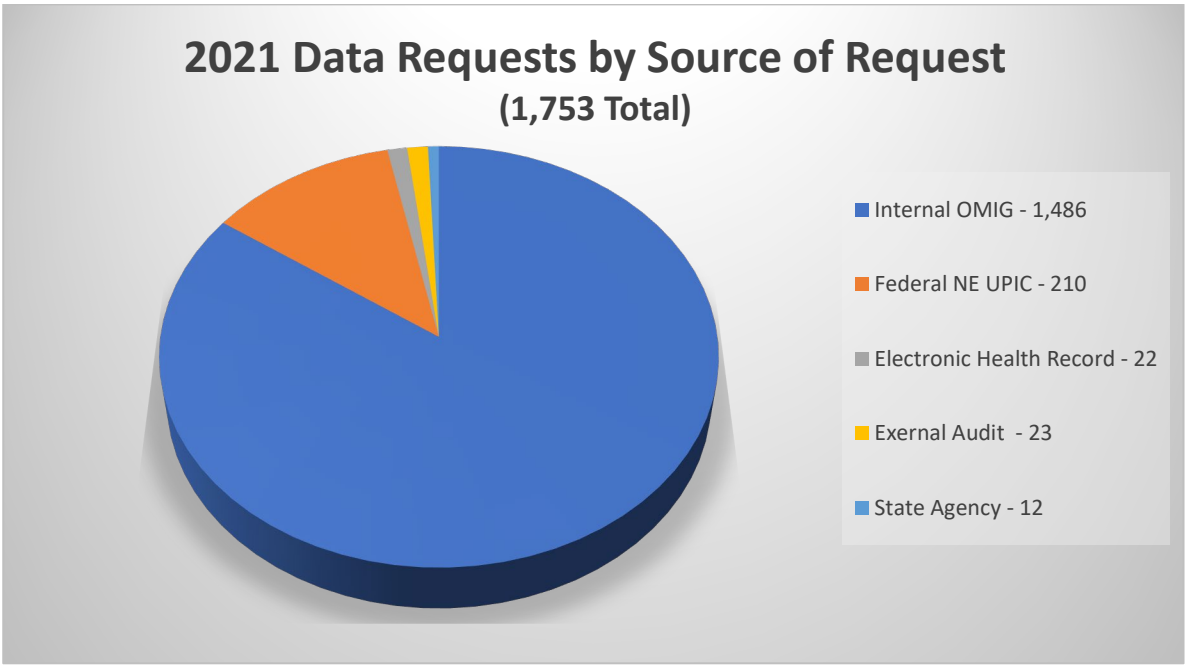
In 2021, DSUR produced Medicaid fee-for-service (FFS) and MC data extraction and analytics comprising over 21,000 queries of the MDW, in support of 1,508 internal and 245 external data requests. Data requests fluctuate due to the ebb and flow of the audit process, projects initiated, and external requests.

Audit projects supported by data analytics include:

- FFS Nursing Home and Inpatient Hospital Crossover Payment
- Review of Capitation Payments when New York State Paid FFS Long-Term Care Services During the Capitation Period
- Incompatible Services
- Health Home
- Assisted Living Program (ALP)
- Diagnostic and Treatment Center
- Hospice with Included Services Billed Separately for a Duplicate Payment
- Hospice for Dual Eligibles
- Pharmacy for Prescriptions Greater Than 30 Days Being Filled
- Deceased Recipients
- Enhanced Nursing Home Rate Code
- Multiple CIN
- Managed Long-Term Care (MLTC) Eligibility and Care Management
- Medicaid Managed Care Operating Report (MMCOR) Reviews
- Federally Qualified Healthcare Centers (FQHC) Crossover

Investigation activities supported by data analytics:

- Transportation PPR and Investigations
- MCO Referrals
- Dental Reviews
- Recipient Investigations
- Pharmacy Projects



Third-Party Liability

Under federal law, Medicaid is the payor of last resort, paying for covered services only after payment from all other liable third-party sources has been maximized. However, third-party insurance coverage is not always known at the time of service and providers may not bill all responsible third-party insurers prior to billing Medicaid. OMIG enforces this requirement by using Gainwell, its third-party liability contractor. Gainwell identifies and confirms third-party insurance coverage and other payment sources and pursues recovery of Medicaid overpayments for FFS claims and MC encounters paid by Medicaid for which other payers are liable.

Upon identifying third-party insurance, Gainwell initiates provider and Medicaid MC reviews that direct providers to bill liable third-party insurance carriers for services erroneously paid by Medicaid. These reviews generated more than $207 million in recoveries in 2021, a 51% increase over the prior year level of $137 million. This growth is largely reflective of the continuation of projects that were initially paused in response to the pandemic.

Pre-payment Insurance Verification (PPIV) Services:

PPIV includes identifying insurance coverage other than Medicaid for medical, dental, pharmacy, and vision. Gainwell verifies insurance segments and updates the Medicaid claim processing system by either adding or end-dating insurance coverage information, thereby causing claims submitted to Medicaid to be edited and denied in instances when other payers are liable. In 2021, more than $2.2 billion in inappropriate Medicaid payments were systematically averted by edits implemented for insurance coverage identified by PPIV.

Casualty and Estates Recoveries

Casualty and Estates (C&E) funds are recovered on behalf of OMIG from Medicaid recipients in cases involving the award of a personal injury settlement and/or from their estates. When a Medicaid recipient passes away, the estate and any assets owned by the recipient are subject to recovery for any Medicaid expenses associated with services provided prior to the recipient's death. When a Medicaid recipient receives a settlement because of a personal injury, and Medicaid paid for the treatment of those injuries, any amounts paid by Medicaid are subject to recovery out of the settlement funds. C&E recoveries in 2021 remained relatively steady as recovery activities and in-person court appearances resumed prudently. These activities resulted in recovering more than $111 million.

Medicaid Recovery Audit Contractor

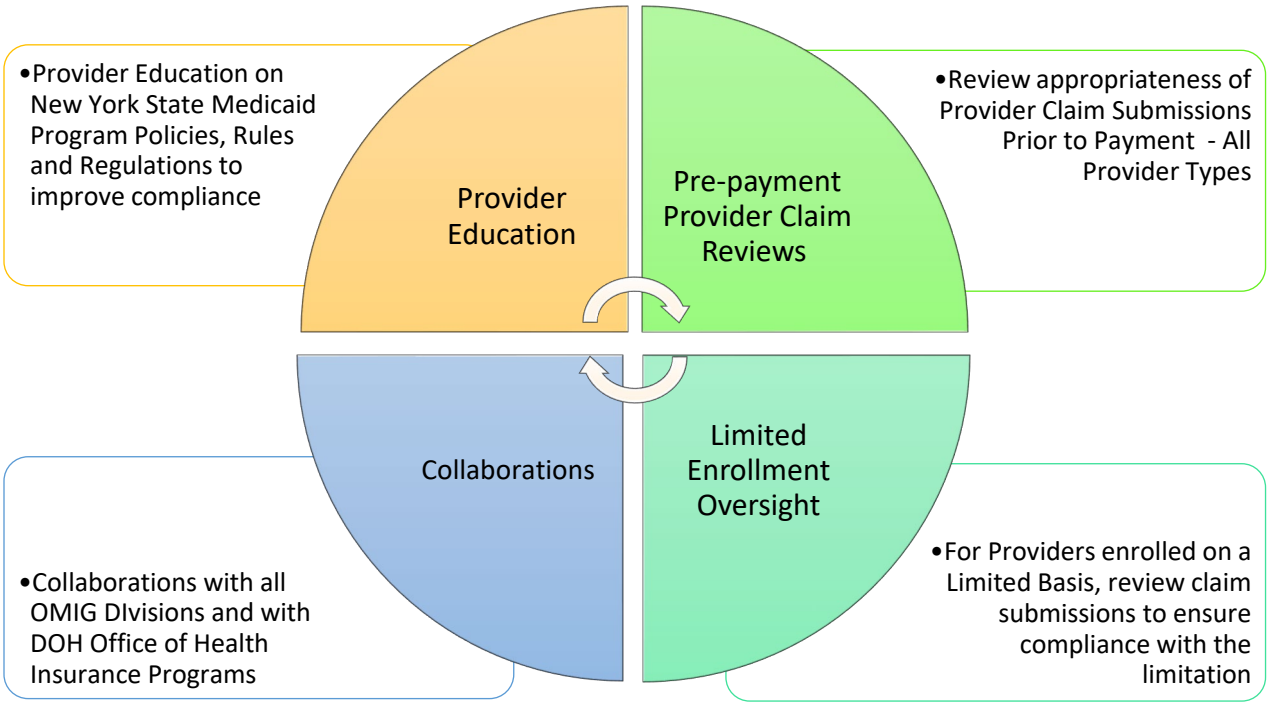
Pursuant to a federal requirement under the Affordable Care Act (ACA), OMIG continued its engagement with the Recovery Audit Contractor (RAC) to supplement the agency's Medicaid program integrity efforts. The RAC's mission is to reduce improper payments through the efficient detection and collection of overpayments; to report suspected fraudulent and/or criminal activities; and implement actions that will prevent future improper payments. Utilizing data mining to identify improper payments and working with providers to recover identified overpayments. The State contracted with Gainwell to perform this function. These projects resulted in recoveries of more than $169 million, which is an increase of more than $86 million from 2020. The increase is due to 2021 being the first full year that the RAC was able to send out reviews for the Code 11 project. In this project, OMIG has the right to recover capitation payments for a Medicaid MC recipient where DOH has determined that the recipient was simultaneously enrolled for comprehensive health care coverage through any government health insurance program.

OMIG continues to facilitate the exchange of Medicare data with CMS' Unified Program Integrity Contractor (UPIC) to enhance the RAC's ability to identify potential overpayments that would likely not be detected by reviewing Medicaid claims data alone. OMIG is heavily reliant upon and utilizes various Medicaid information technology systems to perform oversight of the Medicaid program, confirm the

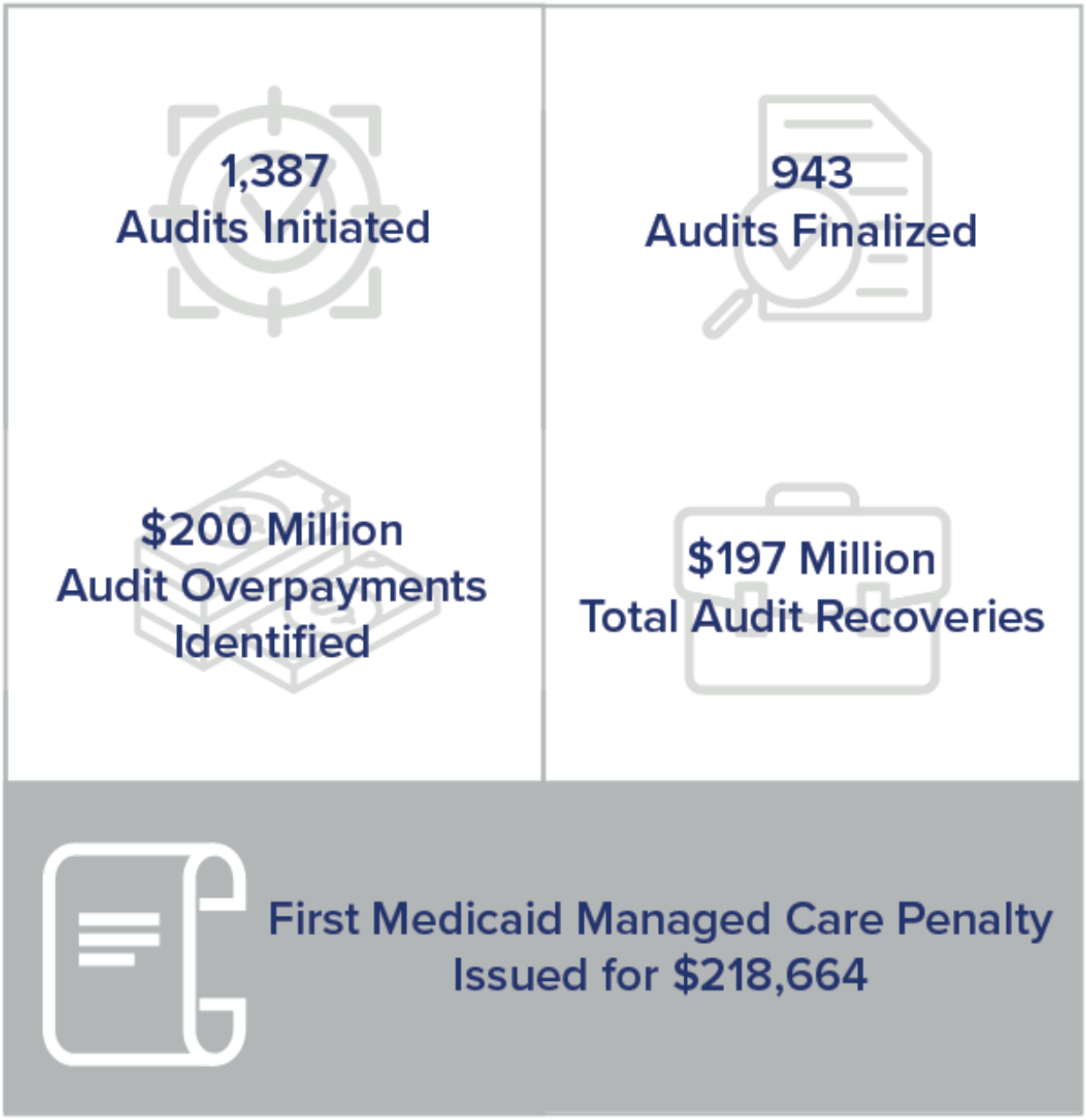
appropriateness of provider payments and provide timely, accurate, and defensible data and analysis to support Medicaid program integrity initiatives throughout the agency.

Pre-payment Review

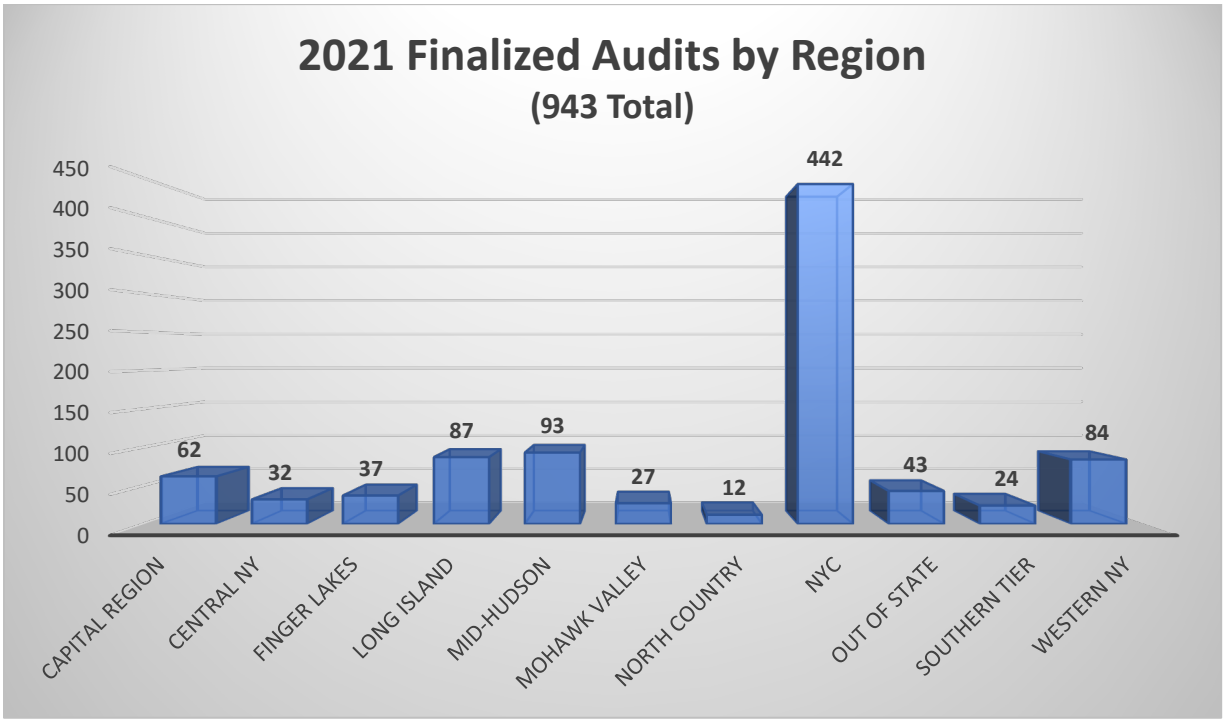
The PPR team consists of dental and health professionals and auditors who review claims for appropriateness prior to payment, ensuring Medicaid funds are paid appropriately. Edit criteria is applied on eMedNY to pend targeted claims for review prior to payment. The pend edit is a tool utilized in collaboration with other divisions and agencies to enhance program oversight and to educate providers to improve compliance with Medicaid billing rules. The chart below depicts the many ways PPRs can be used as a program integrity tool.

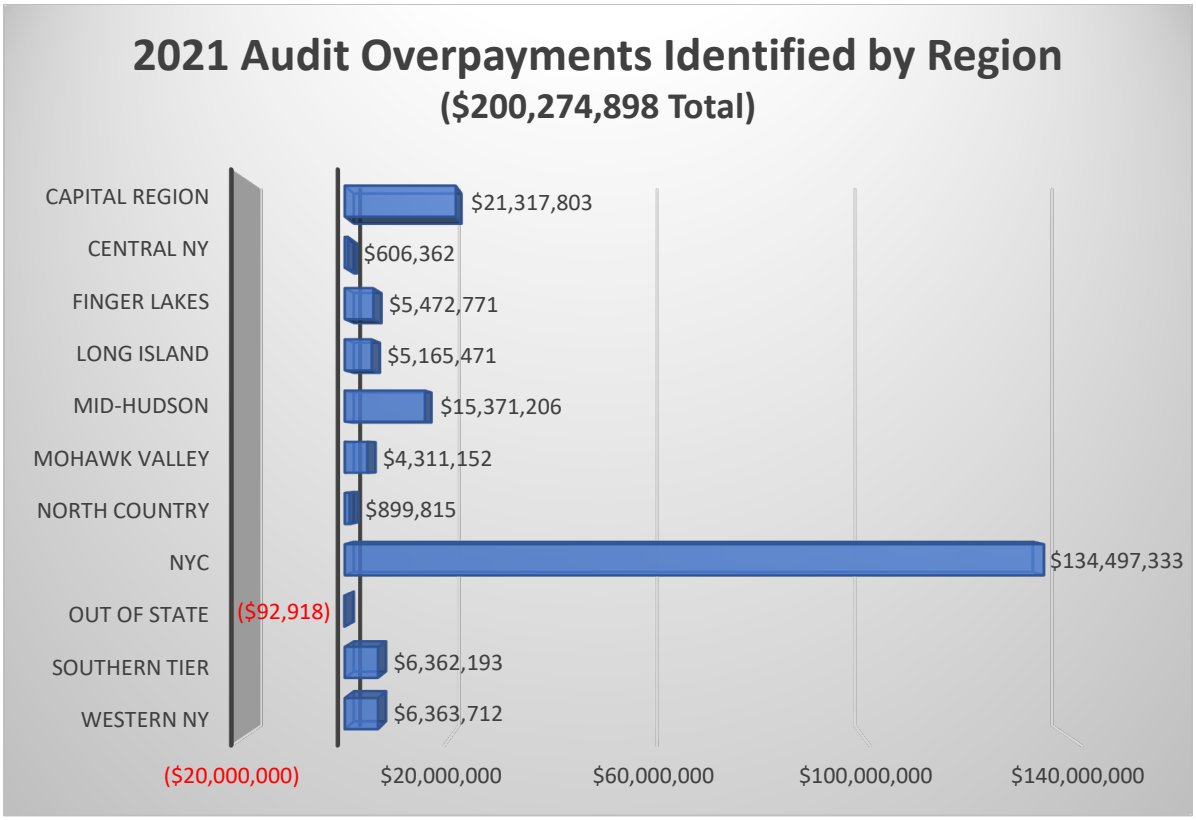


Medicaid Audits



OMIG conducts audits of Medicaid expenditures across all provider and payer types, including MCOs, hospitals, clinics, nursing homes, home health, assisted living, and medical practitioners. The purpose of these audits is to assess provider compliance with Medicaid program integrity statutes, as well as regulations and guidance issued by DOH or other relevant State agencies. Where appropriate, OMIG publishes protocols created in conjunction with the relevant State agencies and the provider community. Audits are performed to ensure that Medicaid recipients have appropriate access to quality medical services, that services are documented and billed appropriately, and that those receiving program funds adhere to the program requirements which ensures that Medicaid recipients receive services at least equal to those who have private health insurance. Audits are conducted in a manner which fosters communication with providers to successfully resolve disputes over potential findings. Providers are encouraged to submit documentation to support the appropriateness of claim payment. OMIG reviews all submitted documentation and determines the appropriateness of the claim based on the information provided. Where providers are found to be out of compliance with Medicaid requirements, OMIG identifies and recovers associated Medicaid overpayments. In 2021, OMIG finalized 943 audits identifying overpayments of over $200 million.





Managed Care Audits

New - Medicaid Managed Care Operating Report

MMCOR reviews are conducted to validate the costs reported in the submission of MC cost reports by MCOs. These reviews ensure that pertinent costs and data reported on MMCORs submitted to DOH is accurate, complete, and allowable. OMIG performs these reviews of both Mainstream Managed Care (MMC) and MLTC plans' cost reports. SOS §364-j(38) was enacted in 2020 allowing OMIG to impose a penalty of twice the amount of any misstatement in the cost report. For the first time, in 2021, OMIG finalized one review with a penalty of more than $218,000, which was recovered in full.

New - Enhanced Nursing Home Rate Code Project

Historically, when a MMC enrollee was permanently placed in a nursing home, the enrollee became ineligible for MMC. These rules were updated so that MMC enrollees permanently placed in a nursing home could remain in MMC. An enhanced capitated rate was developed for those enrollees due to the additional costs associated with nursing home placement. The Managed Care/Family Health Plus/HIV Special Needs/Health and Recovery Plan Model Contract (Model Contract) outlines the procedures for a member's placement in a nursing home and the Plan's obligation to pay the nursing home. OMIG has conducted reviews of other enhanced or supplemental payments in the past, such as the Supplemental Maternity and Newborn

Capitation Payments, or 'kick' payments, and used that experience to develop this review.

OMIG worked with DOH to develop a project to identify questionable enhanced capitated payments. To accomplish this, staff reached out to General Dynamics Information Technology (GDIT) to identify instances where a plan billed for the traditional rate but was paid the enhanced rate, and the payment had not been properly adjusted to the traditional rate. In addition, staff reviewed encounter data and enrollee eligibility information to identify instances where the system did not show evidence of a member having been placed in a nursing home, the nursing home having been paid, or the member meeting the eligibility requirements for nursing home placement. In 2021, OMIG finalized 15 audits identifying overpayments of more than $1.2 million. Audits in this area generated recoveries of more than $800,000.

Deceased Enrollees

OMIG has the responsibility of recovering premiums paid to MCOs for enrollees listed on the monthly roster who are later determined to be deceased. This is accomplished by matching data provided by the DOH's Bureau of Vital Statistics and the New York City Bureau of Vital Statistics against the monthly capitation payments paid to MCOs for months after the MC enrollee's month of death. In addition, OMIG staff identify capitation payments paid after Medicaid claims data indicates death occurred and/or after the date of death listed in the member's demographic data. This second level review is an important control activity that identifies monthly payments that were not previously identified as part of the first level enrollment reviews conducted by local social service districts (LDSS), the New York City Human Resources Administration (NYC HRA) or the New York State of Health (NYSoH), usually due to the timing of when date of death data is available. In 2021, OMIG finalized 50 audits identifying overpayments of more than $24.9 million in capitation payments paid after an enrollee's date of death. Audits in this area recovered more than $24.8 million.

Family Planning Chargeback

Federal Medicaid law states that a Medicaid recipient's access to family planning services cannot be restricted. Medicaid MC enrollees can go to any Medicaid provider for family planning services, without a referral or prior authorization. If family planning services are included in the MCO benefit package, the Model Contract outlines a process by which these FFS family planning claims are identified and "charged back" to the MCO. Under this provision, if an enrollee seeks family planning services from a provider outside the MCO network, the provider is compensated by Medicaid and the MCO agrees to reimburse Medicaid for the payments made to the non-network provider. OMIG works with DOH to develop the criteria to identify these family planning services and reconcile with the MCO those claims subject to the chargeback.

OMIG staff use a custom report to identify claims subject to the chargeback and conduct an extensive reconciliation process allowing the MCOs the ability to review and

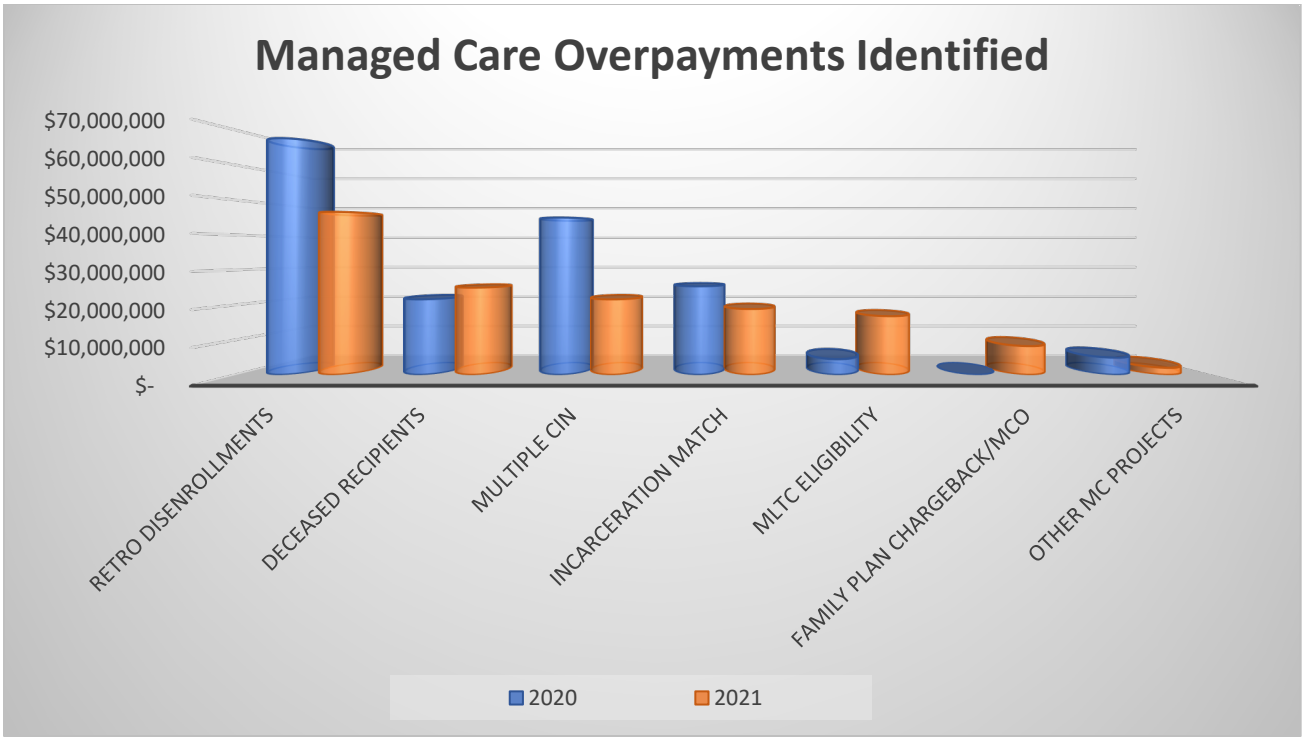
dispute the findings while still preserving the privacy of the Medicaid enrollees pursuing family planning services. In 2021, OMIG finalized 17 audits identifying overpayments of more than $8 million in FFS family planning services that were charged back to the Plan. Audits in this area recovered more than $4.7 million.

Incarcerated Enrollees

Incarcerated Medicaid recipients are eligible for "inpatient-only" Medicaid coverage, and any capitation payments paid for complete months of incarceration are subject to recovery. OMIG staff receive data from DOH and county jails identifying Medicaid recipients incarcerated in both state prisons and county jails. Due to delays in reporting periods of incarceration to local districts, Medicaid eligibility is not always updated in a timely fashion, resulting in inappropriate capitation payments paid to the MCOs. OMIG continues to conduct these second-level reviews, following up on the first-level review conducted by the local district, to recover inappropriately paid capitation payments for incarcerated Medicaid MC enrollees. In 2021, OMIG finalized 23 audits identifying overpayments of more than $18.8 million in inappropriate capitation payments paid for Medicaid MC enrollees incarcerated for the entire payment month. Audits in this area recovered more than $22.1 million.

Managed Long-Term Care

The MLTC Partial Capitation program allows for Medicaid enrollees requiring a significant level of care to receive services in their home and community rather than in a nursing home setting. OMIG's reviews ensure enrolled recipients are eligible for the program, and that care management is being provided by the MLTC plans in accordance with assessments and care plans specific to the enrollees. The MLTC plan is responsible for the care management of their enrollees, to ensure the care has been determined to be medically necessary and it has been received by their enrollees. In 2021, OMIG finalized six audits identifying overpayments of more than $16.7 million. Audits in this area recovered more than $17.9 million.



Provider Audits

Federally Qualified Healthcare Centers Fee-For-Service/Managed Care Crossover

FQHCs are eligible for Medicaid payments – either through MC or FFS – to cover their costs of providing a comprehensive package of health care services, consistent with federal requirements. OMIG finalized audits of FQHCs which identified instances where the providers received both a Medicaid FFS shortfall payment (indicating payment for the threshold visit was paid by an MCO and a FFS all-inclusive payment for the same individual recipient on the same date of service. In 2021, OMIG finalized 11 audits identifying overpayments and recoveries of more than $1.2 million.

Assisted Living Program

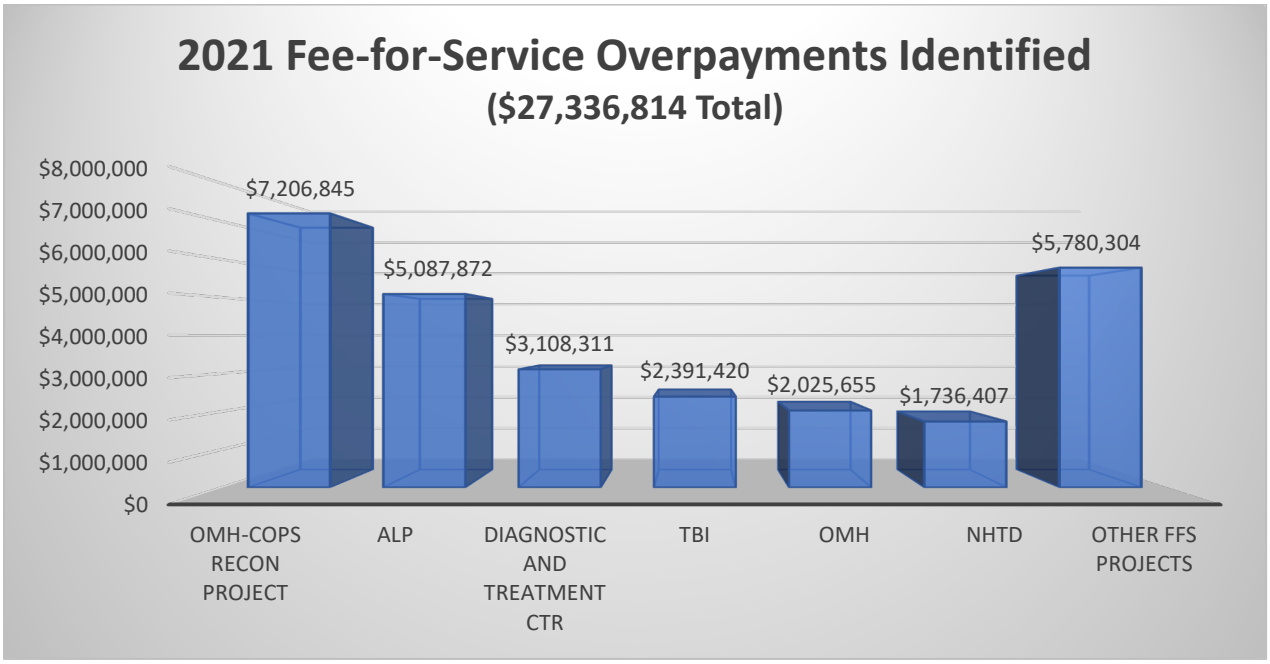
OMIG is conducting audits of ALP providers to address deficiencies identified as part of an audit conducted by the U.S. Department of Health and Human Services, Office of the Inspector General (HHS-OIG). HHS-OIG audit findings included missing medical evaluations, interim assessments, plans of care, and service documentation. OMIG auditors assess whether patients are receiving the proper medical visit and levels of care via a review of the required documents and the services being rendered in support of the claims selected for review. In 2021, OMIG finalized eight audits identifying overpayments of more than $5 million. Audits in this area recovered more than $4.1 million.

Nursing Home Transition and Diversion

The Nursing Home Transition and Diversion (NHTD) waiver program is a home and community-based program that helps New York's Medicaid eligible seniors and people with physical disabilities receive comprehensive services they need while they live in a community-based setting, rather than in a nursing home, congregate care setting, or other institution. This program uses Medicaid funding to provide supports and services, such as independent living skills training and wellness counseling. These home-based services require specially trained aides to render specific services.

OMIG works with DOH to ensure program integrity and patient safety issues are addressed as part of the audit process. Due to the type of services being provided, OMIG directs specific attention toward personnel requirements, such as whether an aide has received the necessary training to perform their duties and if they are up to date with mandatory health screenings and medical requirements. Focusing on these areas ensures proper treatments are rendered in a safe environment.

In 2021, OMIG finalized one audit that identified overpayments of more than $1.7 million. Of the eight findings, the top three were that NHTD service training was not completed; that partial service hours were billed incorrectly; and for no documentation of service. Audits in this area recovered more than $240,000.

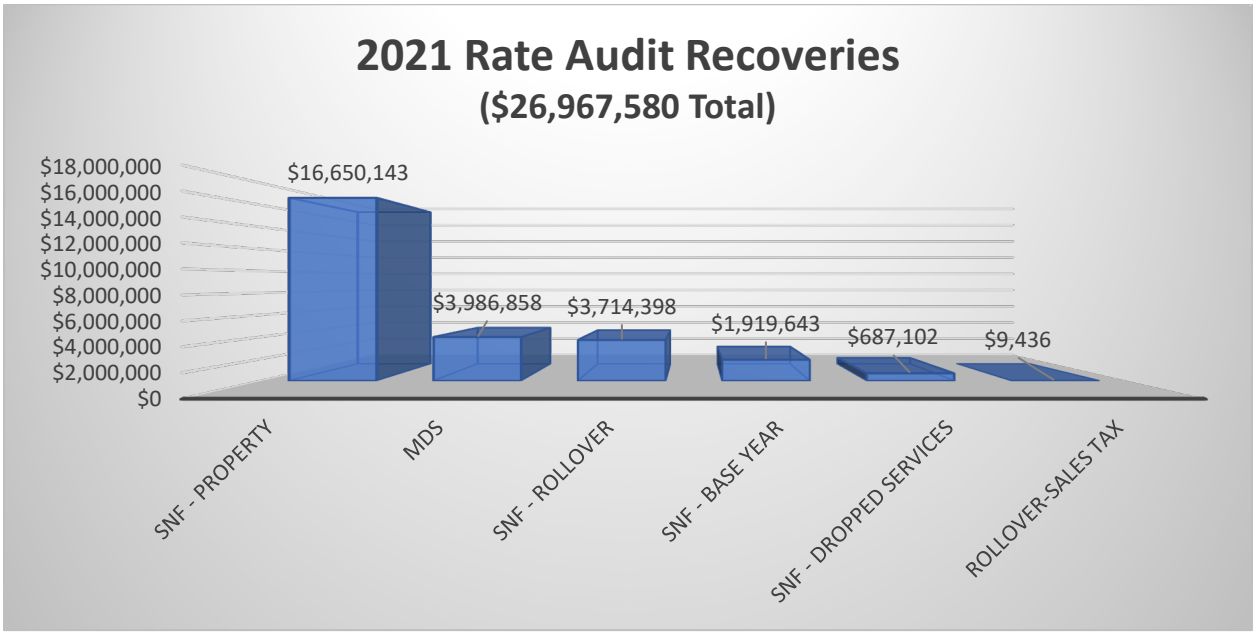


Rate-Based Providers

Audits of rate-based providers, such as nursing homes, are conducted to enhance program integrity by ensuring only accurate and allowable costs are reported and reimbursed. Costs that are misstated by a provider may artificially inflate the rate paid to that provider. Since most Residential Health Care Facilities' costs are fixed and a

related portion of the rate is calculated on a regional basis, OMIG conducts property component audits of individual providers to verify reported capital costs are accurate, allowable, and substantiated. Property audits analyze and confirm or adjust the capital costs reimbursed in the property component of the rate.

Examples of disallowances include equipment rental expenses and mortgage interest costs. The equipment rental expense was disallowed because the provider the was unable to produce documentation to substantiate reported rental expenses. The provider receiving Medicaid payments is required to provide adequate cost information based on financial and statistical records that can be verified on audit. The mortgage interest finding identified a mortgage that had been paid off by the provider's parent company; however, the provider continued to receive reimbursement for mortgage interest and property insurance. As a result of the audit, the provider's rate was adjusted so that the state was no longer reimbursing the provider for these unallowable costs both retroactively and prospectively.



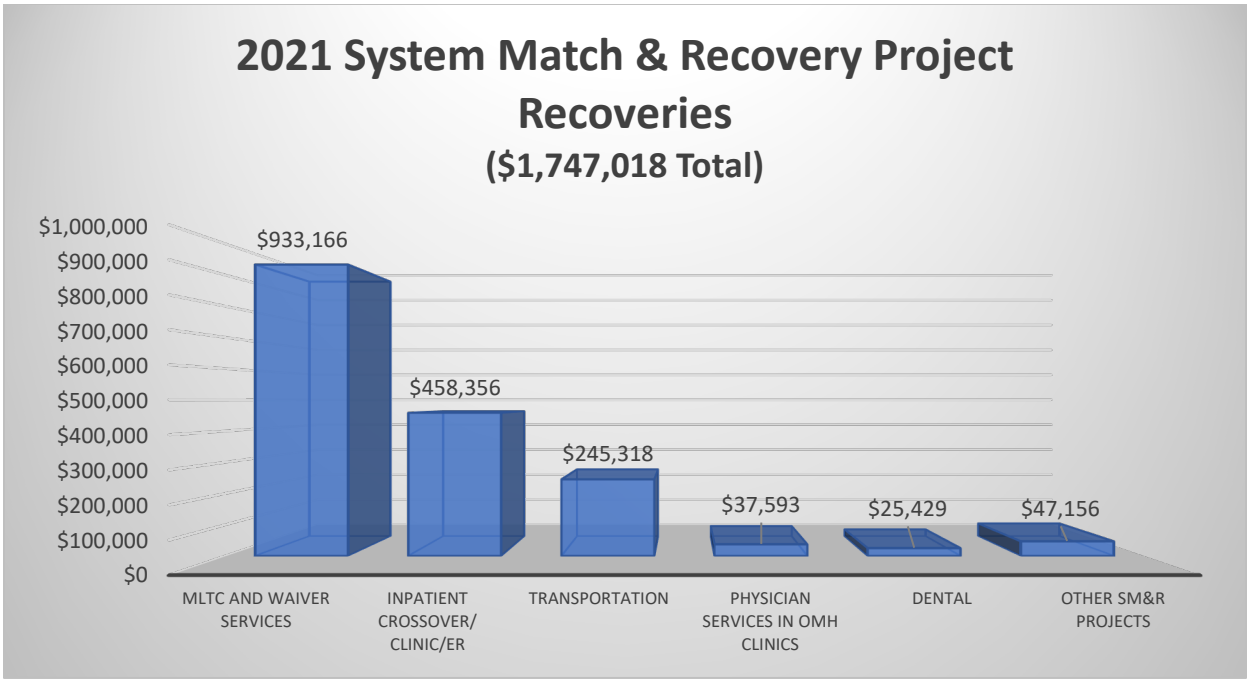
County Demonstration

The Medicaid Fraud, Waste, and Abuse County Demonstration was implemented in 2006 and is a partnership between OMIG, New York State counties, and NYC to detect Medicaid provider fraud, waste and abuse and recoup any identified overpayments. Participating counties can recoup 40 percent of the non-federal share of the recovery amount, net the state-funded share of their administrative audit costs. Under the County Demonstration Program, the counties, with OMIG oversight and training, perform audits of pharmacy, transportation, durable medical equipment and assisted living program providers. In 2021, 11 audits were finalized, identifying overpayments of more than $24.4 million. Audits in this area recovered more than $1.8 million.

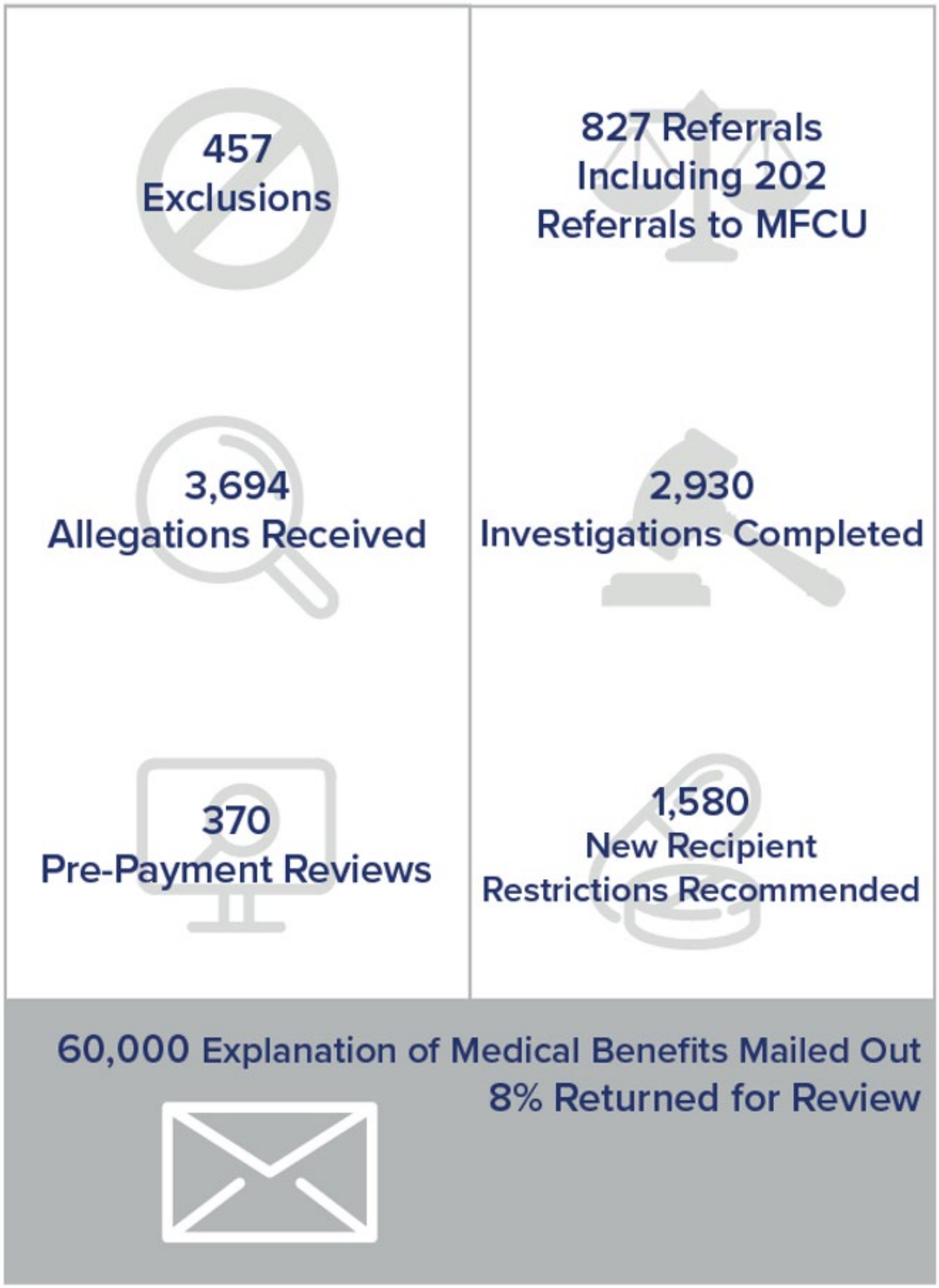
System Match and Recovery Projects

System Match and Recovery Audits are conducted to identify uncommon and potentially inappropriate provider claiming patterns. During the audit process, OMIG educates providers to improve their compliance with Medicaid billing rules to reduce future claim errors. Data analysis of paid claim data sets is performed to identify noncompliance with Medicaid claiming rules or aberrant billing patterns which warrant further review. This analytical approach allows OMIG to conduct a comprehensive audit across many providers at once.

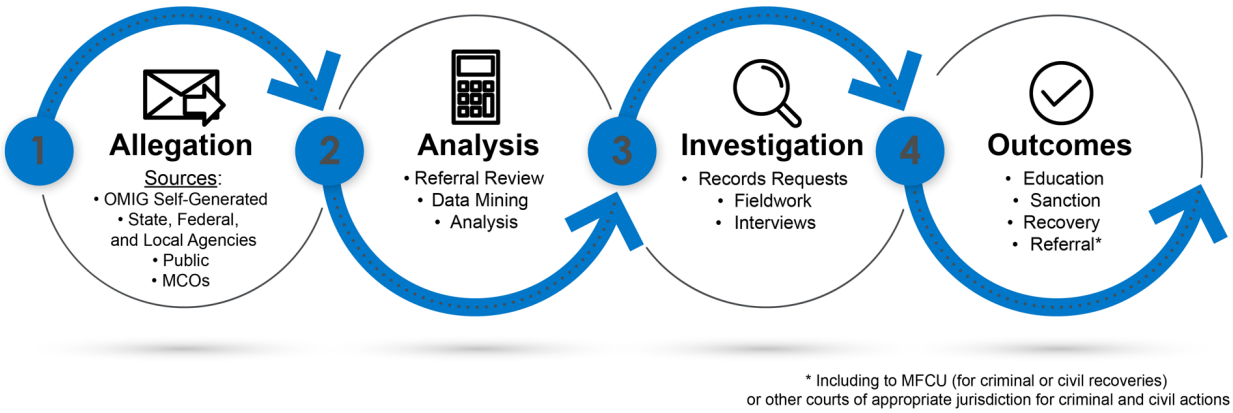
In 2021, OMIG finalized 102 audits identifying overpayments of more than $1.1 million. These audits were performed in multiple project areas including, but not limited to, MLTC and waiver services, inpatient crossover/clinic/ER, dental, and deceased recipients. Audits in this area recovered more than $1.7 million.



Division of Medicaid Investigations

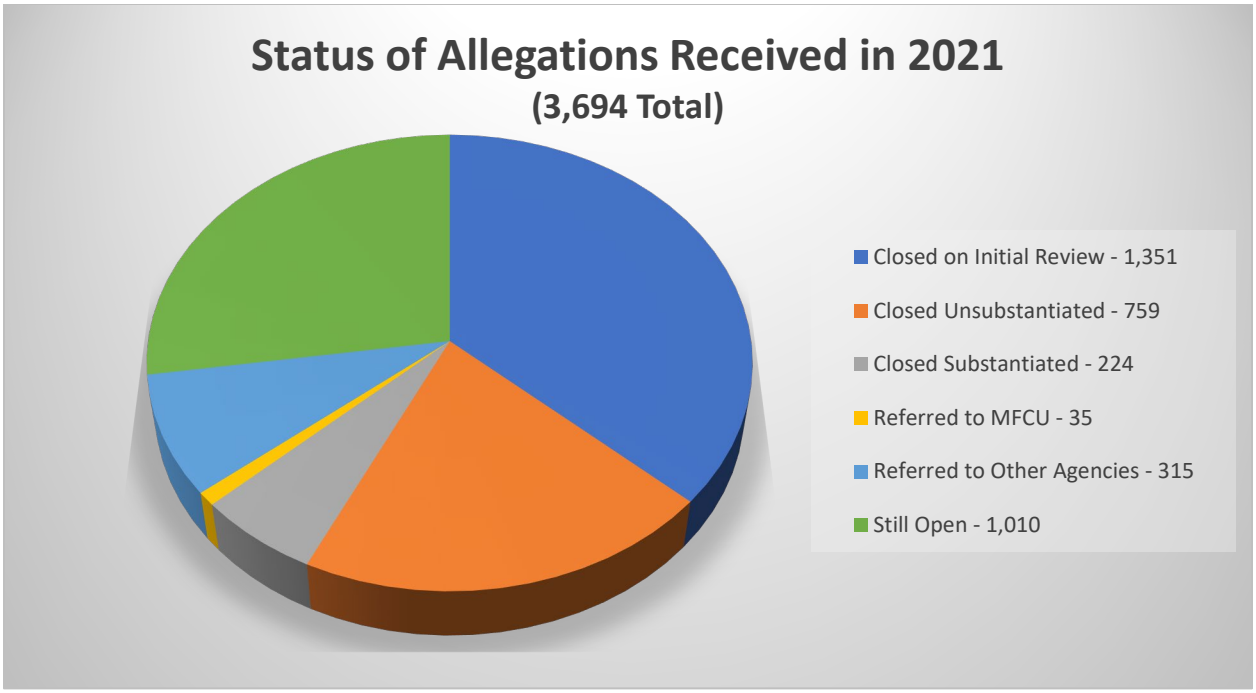


OMIG reviews all allegations of fraud, waste, or abuse it receives within the Medicaid program. These allegations are received from a variety of sources including federal, state, and local law enforcement and governmental agencies, health care plans and providers, Medicaid recipients, and the general public. In 2021, OMIG received 3,694 allegations of fraud, waste, or abuse.



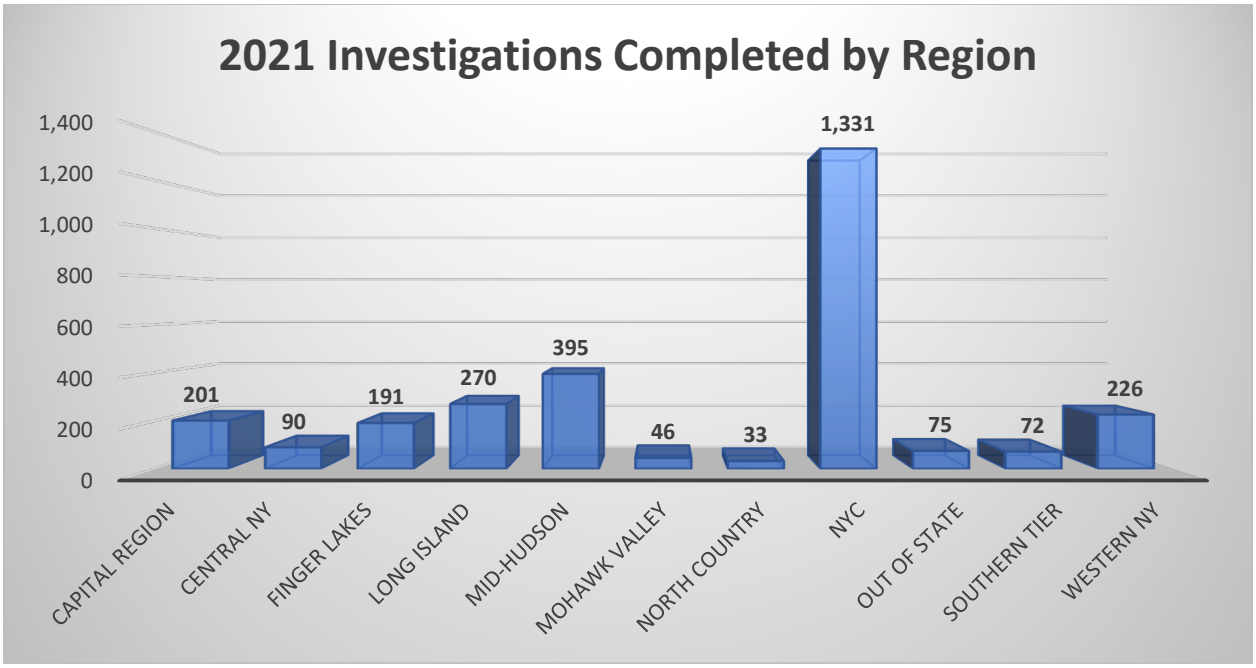
Allegations can involve enrolled and non-enrolled providers (e.g., home health aides, consumer directed personal assistance program), health care related organizations, and recipients that are interacting with the Medicaid program. Allegations are analyzed utilizing a variety of methods, including but not limited to data mining, undercover operations, analysis of returned Explanation of Medical Benefits (EOMB) letters, and interviews of complainants and subjects. Investigations can lead to referrals, recoveries, administrative actions, and/or sanctions.

Allegations are fully analyzed by OMIG staff to identify if there is sufficient evidence requiring a more thorough investigation, which may warrant OMIG action or referral to another enforcement entity, as necessary. OMIG is required to refer all credible allegations of fraud to the MFCU. As detailed in the table below, nearly one-third of all allegations received in 2021 (1,351) were closed due to insufficient information to advance the case. Nearly 50 percent were advanced within OMIG for further review and for appropriate activities to be taken, which can include provider education, excluding providers from participating in New York State Medicaid, referrals, or recoveries. Nine percent (350) of these allegations were referred to MFCU or to other enforcement agencies. Of note, more than 29 percent of allegations are self-generated by subject matter experts within OMIG.



OMIG Increases Completed Investigations and Referrals in 2021

OMIG processed 31% more allegations in 2021 compared to 2020. In 2021, there was a 132% increase in referrals to MFCU, as well as a 105% increase in referrals to other partner agencies including regulatory, licensing, and law enforcement agencies. OMIG investigators conducted investigations using a hybrid of remote tools such as desk credential verification reviews (CVRs), electronic provider outreach and communication, and data analytics, as well as increasing their presence in the field.



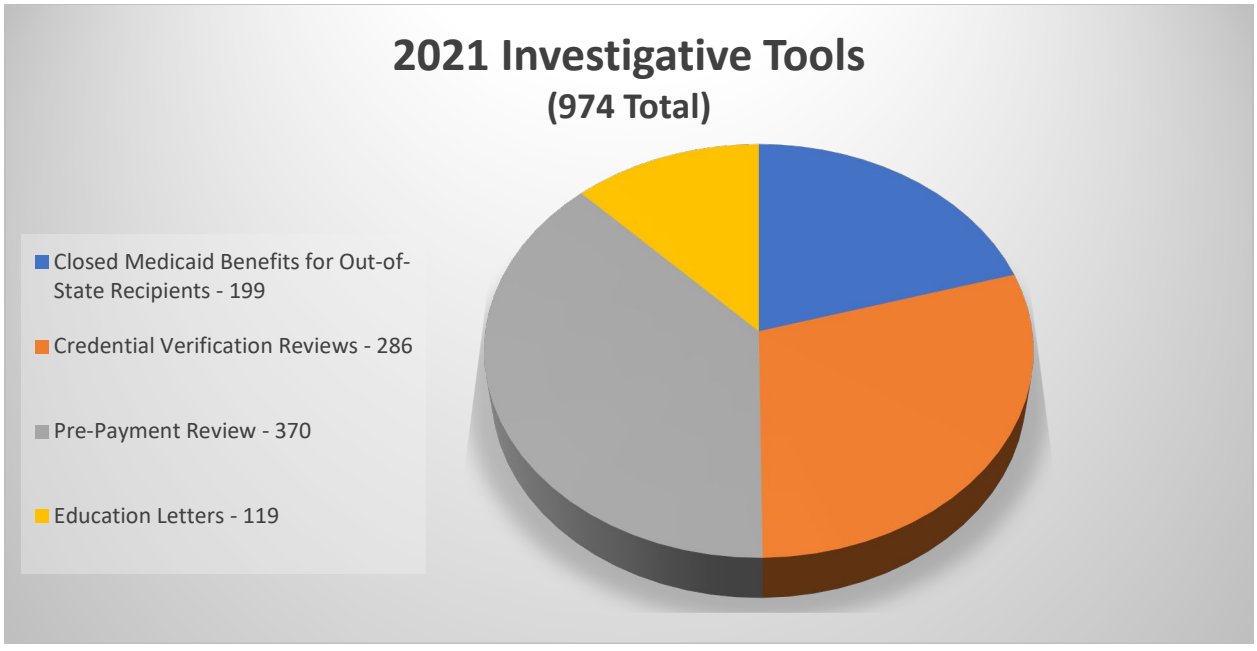
Managed Care Referrals Enhancements

MCOs, as agents of the State Medicaid program, are contractually required to conduct oversight of their provider networks to ensure compliance with Medicaid program and reimbursement requirements. MCOs conduct this oversight using their SIU or compliance officers that are tasked with identifying, evaluating, and referring instances of fraud, waste, and abuse to OMIG. OMIG assesses all referrals received from MCOs for compliance with the reporting requirements outlined in the MC contracts. These referrals are reviewed for accuracy and completeness, and the assessment results are evaluated as part of the Managed Care Program Integrity Reviews of the MCOs.

In reviewing MCO referrals, OMIG identifies those necessitating further investigation, cases that have statewide relevance or overlap existing activities and merit review, and cases that are best addressed at the MCO level. At the conclusion of these reviews, OMIG notifies the MCO of its determination in connection with the referral and provides clearance for the MCO to recover identified overpayments where appropriate.

OMIG also streamlined its internal triage process, and now more expeditiously communicates determinations to MCOs regarding whether OMIG is accepting the referral or returning it for the MCO to take action. In 2021, OMIG processed 900 referrals involving 1,422 unique subjects (individuals, providers, etc.), supporting OMIG's ability to pursue fraud, waste, and abuse based upon these referrals.

Investigative Tools:



OMIG Increases Cost Savings Attributed to Out-of-State Recipients

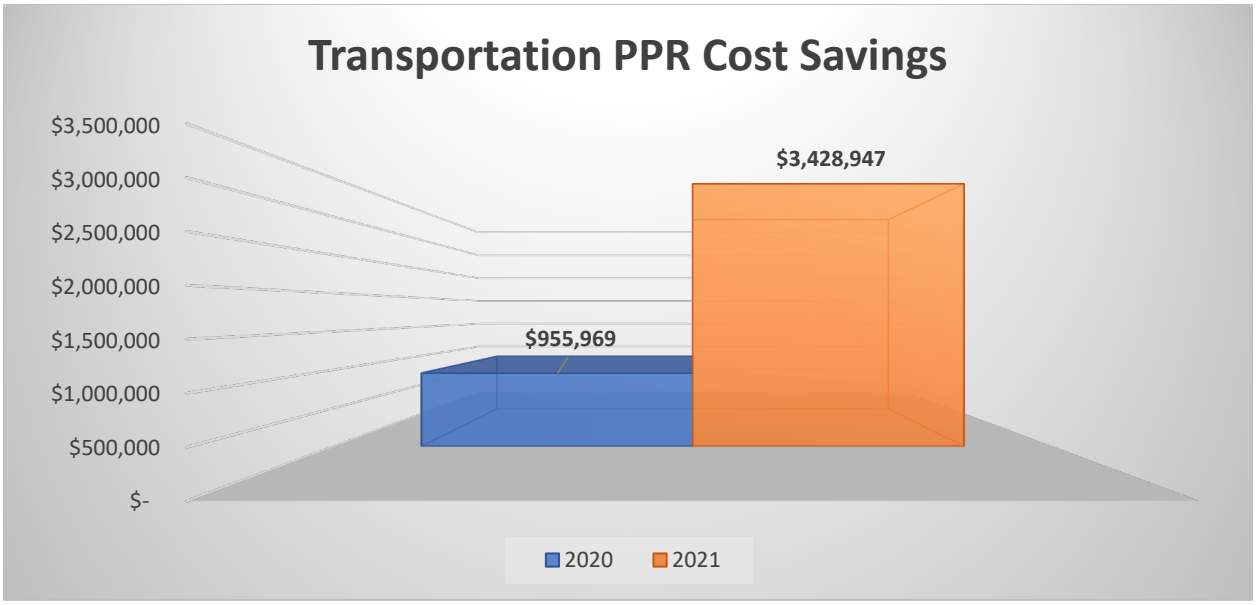
During the PHE, federal law prohibited the closing of a recipient's Medicaid benefit except in a limited number of circumstances, including if the recipient was residing out of state and enrolled in New York State Medicaid. In 2021 OMIG expanded its efforts to identify recipients that were receiving New York State Medicaid benefits while residing in another state. OMIG used multiple data systems and investigative tools to pursue recipients fraudulently using New York State addresses to qualify for benefits and forwarded these finding to the DOH with a recommendation to close the Medicaid benefit. These new processes substantially increased cost savings for the New York State Medicaid program in 2021 resulting in cost savings of approximately $1.3 million compared to cost savings of $149,850 in 2020.

Credential Verification Reviews

OMIG investigation staff routinely conduct on-site CVRs to gather information needed to assess compliance with program requirements and guidelines. The CVR process allows investigators to obtain information on provider and staff credentials, the physical attributes of the place of business, record keeping protocols, and procedures for Medicaid claiming. In 2021, OMIG resumed on-site CVRs while continuing to conduct them remotely when appropriate. OMIG completed 286 CVRs in 2021.

Pre-payment Reviews

A pre-payment review is a method used by OMIG to pend claims submitted by providers, prior to payment to verify a provider's compliance with Medicaid programmatic or payment guidelines. When an investigation uncovers information indicating a provider may not be compliant with Medicaid rules or regulations, a pre-payment review may be requested to prevent improper payments from being issued to the provider. This has become an effective tool in managing provider compliance, particularly for smaller providers or new entrants to the Medicaid program. For example, in 2021, OMIG completed 373 pre-payment reviews of transportation providers' claims, resulting in more than $3.4 million in cost savings to the program due to the denial of those claims that that were not compliant with Medicaid program requirements.



Education Letters

OMIG issues education letters to providers when appropriate based on investigative findings. The letters include applicable New York State Medicaid program regulations, laws, rules, and policies necessary for the provider to comply with the New York State program. The letters remind the provider of their obligations as a Medicaid provider, and also provides a contact name for them to call with any questions.

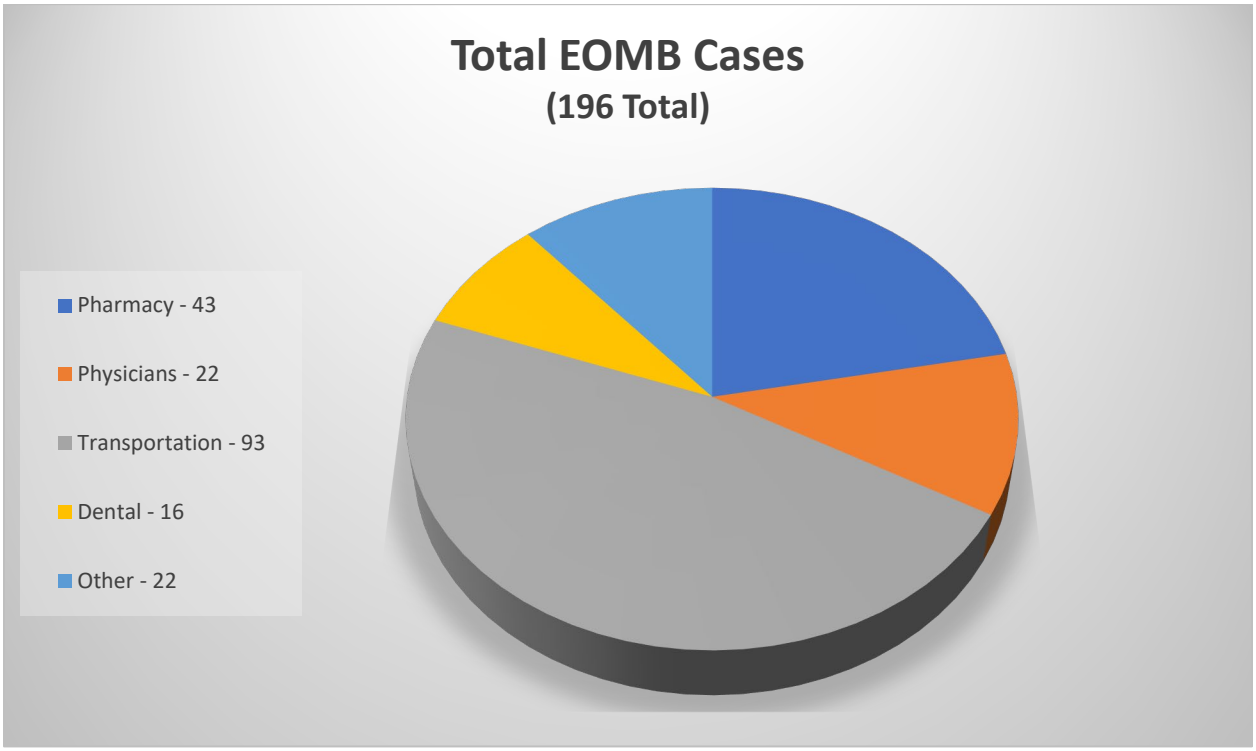
Explanation of Medical Benefits

EOMBs (commonly known as Explanation of Benefits or EOBs) are used to communicate with recipients about the care they are receiving from New York State Medicaid providers, and to ensure that they are receiving the services New York State Medicaid is paying for based on claims submitted by their providers. EOMBs both fulfill a federal mandate to inform recipients regarding the services they receive and serve as a valuable tool to communicate with recipients regarding instances of fraud, waste and abuse identified through internal data analytics. OMIG uses data analytics to identify possible subjects and generates EOMBs to communicate with recipients who have obtained services from providers who appear as outliers by the number and types of claims they are submitting. Data analytics is also performed to target specific fraud schemes.

In 2021, OMIG generated 60,000 EOMBs across multiple provider categories. Of the 4,813 EOMBs returned by recipients to OMIG, 746 recipients reported not receiving services, or had concerns with the services billed. These allegations led to OMIG initiating or supporting 196 investigations.

During 2021, OMIG's EOMB projects included:

- Transportation claims with no corresponding medical claims
- Providers with higher-than-average telehealth claims
- Pharmacies billing high-cost medications
- Home health claims during holidays and school breaks
- EOMBs to support ongoing investigations



Improved Process for Excluding Providers with Out-of-State Convictions

In 2021, OMIG expanded the scope and frequency of its reviews of available websites of prosecutorial agencies, to identify New York State health care providers that have either been charged with or convicted of a crime related to health care in other states. This new process expedites the identification of providers not previously detected until the licensing board, or another PI agency took an action. The websites used by OMIG include justice.gov, the federal prosecutors in New York State, the federal prosecutors in contiguous states, and the district attorney offices in Albany, Syracuse, Rochester, and Buffalo.

Transportation

Transportation has been one of the fastest growing Medicaid service categories, both from a provider enrollment and cost perspective. Most providers are small, regionally specific operations with limited knowledge or connection to the New York State

Medicaid program or the needs of its recipients. Consequently, both DOH and OMIG have identified it as an area for enhanced oversight.

❖ ***Case Files: Transportation***

- On February 9, 2021, OMIG testified before the Monroe County grand jury in Rochester, assisting MFCU in the prosecution of Murtada Ebrahim for hiding his ownership of an affiliate transportation company while he was excluded from the New York State Medicaid program. On March 2, 2021, the grand jury determined to indict Mr. Ebrahim on charges of Grand Larceny, Health Care Fraud and Offering a False Instrument for Filing. Previously, Mr. Ebrahim was excluded on August 4, 2008, when charged with crimes related to the submission of false claims to New York State Medicaid that led to sentencing of 2-6 years of incarceration and restitution of $971,268.

- On May 25, 2021, Lissette Joza pleaded guilty to Grand Larceny and Money Laundering for acting as a driver for Purple Heart Transportation in a scheme to bill New York State Medicaid for transportation services that were never provided. OMIG's investigation of Purple Heart Transportation was initiated after OMIG's fraud hotline received a complaint from a Medicaid recipient alleging they lost their Medicaid card and that a transportation provider was billing Medicaid using their information. OMIG performed analysis of the recipient's claims data, which showed that Purple Heart Transportation was the billing provider, and then sent EOMBs to recipients with claims billed by Purple Heart Transportation. Twenty-one recipients returned EOMBs with allegations of non-receipt of transportation services. Additional recipients contacted OMIG's fraud hotline with allegations that specific recipients were getting paid monthly for giving their information to Purple Heart Transportation so they could bill Medicaid. OMIG investigators contacted the EOMB recipients, validated the EOMBs received, and referred the subject to MFCU. Three defendants have pleaded guilty in this case and are awaiting sentencing.

- OMIG collaborated with the U.S. Department of Homeland Security and HHS-OIG in an investigation of KJ Transportation C Services Inc., for a scheme involving millions of dollars of fraudulent claims related to transportation services. OMIG contributed to this investigation by obtaining records from DOH and assisting with claims data analysis.

  Defendants include the owner, the manager, drivers, and recruiters of the Medicaid enrollees, who paid the recipients to schedule fraudulent trips, paid unlawful kickbacks, fraudulently scheduled trips that never took place, and were paid up to hundreds of thousands of dollars in exchange for this work. Five defendants are pending sentencing.

Pharmacy

OMIG pharmacy consultants assisted with agency-wide program integrity activities in a variety of areas including, pre-payment clinical review, pharmacy audit, pharmacy investigations, county demonstration projects, and pharmacy enrollment reviews. During 2021, OMIG centralized its pharmacy consultant services and expanded their support of program integrity across the agency.

OMIG and DOH Pharmacy Policy Collaboration

OMIG's pharmacy consultants work collaboratively with DOH pharmacy policy staff to assist OMIG investigators with interpretation of Medicaid pharmacy policy and to also identify areas where pharmacy policy could be strengthened. For example, an OMIG investigator identified that the Medicaid pharmacy policy did not align with current industry standards for returning unfurnished prescriptions back to stock. At the time of the investigation, the Medicaid pharmacy policy manual indicated that a pharmacy had 60 days to reverse a claim if the prescription was not delivered. This conflicted with current investigative standard procedures that were established using the industry standard of 2 to 3 weeks and prior DOH pharmacy policy guidance issued in the *Medicaid Update*, that stated a pharmacy had 14 days to reverse the claim if the prescription was not picked up. This collaboration resulted in a revision to the New York State Medicaid Pharmacy Policy Manual to align with the 14-day limit outlined in the *Medicaid Update*. The manual was updated on December 22, 2021.

❖ *Case Files: Pharmacy*

- On March 17, 2021, pharmacist Robert Sabet was indicted by a grand jury on charges of conspiracy to commit health care fraud, kickbacks, and use of the proceeds for personal gain in an amount over $10,000. The HHS-OIG served an arrest warrant for Sabet at his home in Brooklyn following the execution of search warrants at the pharmacies Bobbyrock, Inc., d/b/a Brooklyn Chemists, and Luckycare Inc. on January 15, 2021.

  OMIG's involvement with the case began when the Assistant U.S. Attorney (AUSA) was working on a different case in collaboration with OMIG involving New Moon Pharmacy, and an OMIG investigator identified the former Supervising Pharmacist, Sabet, as a high dispenser of drugs for his own pharmacy, Bobbyrock, Inc. OMIG already had an open case on Bobbyrock, Inc. after the pharmacy was identified through data analytics as having a high refill rate for Nascobal, an expensive nasal spray. OMIG sent EOMBs to recipients identified as having multiple refills of Nascobal, and numerous EOMBs were returned with allegations from recipients that they had never received the refills, and in some cases any of the drugs listed on the EOMBs. OMIG staff also conducted additional data and clinical analysis of Bobbyrock claims data. OMIG and HHS-OIG worked together conducting multiple interviews with the EOMB recipients and determined that this pharmacy had been dispensing drugs without

medical necessity and without request from the recipients. The investigation found that Sabet was using similar billing patterns at his second pharmacy, Lucky Care.

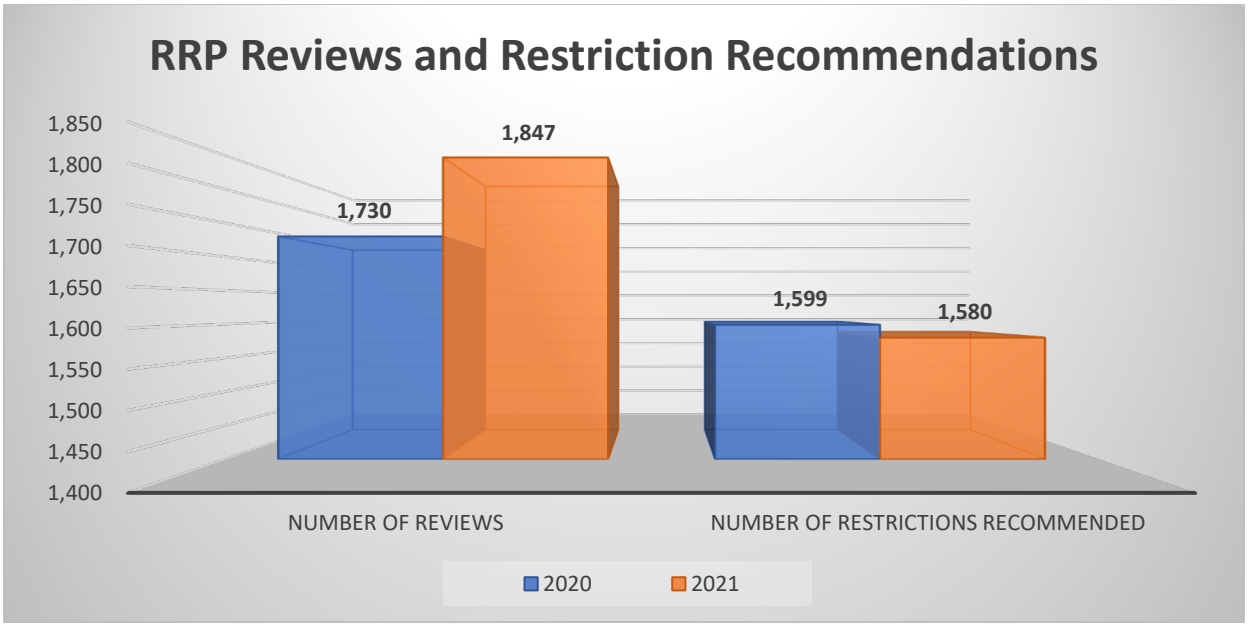
❖ ***Case Files: Collaboration with State and Federal Agencies***

- In September 2019, the Suffolk County District Attorney's Office contacted OMIG regarding an active case they were working with Homeland Security, the IRS, and the U.S. Department of State investigating a scheme involving Turkish nationals entering the country in response to Facebook ads, in order to give birth to their children in the United States. The Turkish nationals allegedly paid $7,500 in exchange for airfare, the address of a Suffolk County home to list as a residence, transport to and from the airport and passport office, and enrollment in New York State Medicaid prior to entering the country. The investigation also found that for filing the Medicaid applications, cash was paid to at least two enrolled facilitators working for several MCOs. The agencies combined investigative efforts to confirm the scope of the scheme, and to date, six individuals have been sentenced and ordered to pay restitution.

Recipient Restriction Program

OMIG's Recipient Restriction Program (RRP) restricts recipients to an assigned physician, or other service provider, after determining that the recipient has engaged in behaviors that are detrimental to either themselves or the Medicaid program. This restriction is based on the outcome of a thorough analysis of services billed and rendered and is conducted by OMIG's State Medical Review Team consisting of health care professionals.

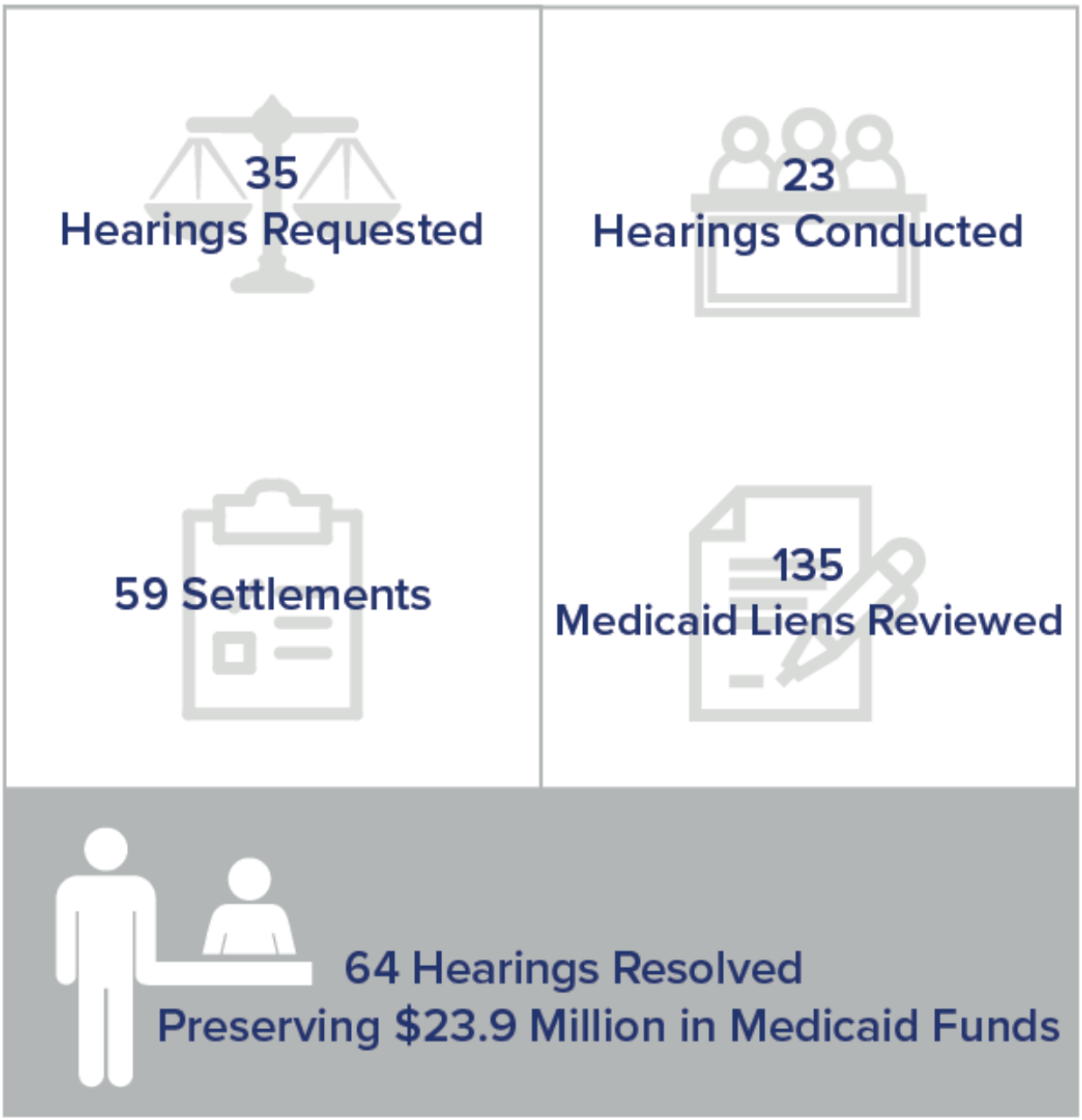
RRP increased its involvement and coordination with MCOs in 2021 to expedite reporting procedures ensuring recipients were getting the proper care they required. Part of the coordination involved changing timelines, which allowed OMIG to enter restrictions in eMedNY and more efficiently track recipients restricted by MCOs.



❖ ***Case Files: Recipient Investigations***

- A joint investigation between OMIG and Schuyler County LDSS resulted in the arrest of two recipients from Watkins Glen, after finding that they allegedly failed to report income to the LDSS and NYSoH, while actively receiving public assistance and Medicaid. On October 21, 2021, the Schuyler County Sheriff's Office arrested the couple for fraudulently receiving more than $130,000 in public assistance over a span of six years. Both were arraigned by a village of Montour Falls judge, released on their own recognizance, and will appear in court for the charges at a later date. The portion of the fraud related to Medicaid totaled $97,490.

Due Process Protections



Audits, investigations, and reviews conducted by OMIG are governed by laws and regulations which afford persons and providers subject to such actions ample due process protections. These include the right to respond to an OMIG draft audit report or proposed action, and the opportunity to appeal OMIG final determinations. OMIG's Office of Counsel supports the mission of OMIG by providing legal advice and counsel regarding OMIG's legal responsibilities, defending the agency in court litigation, representing the agency in administrative hearings, and other administrative appeals.

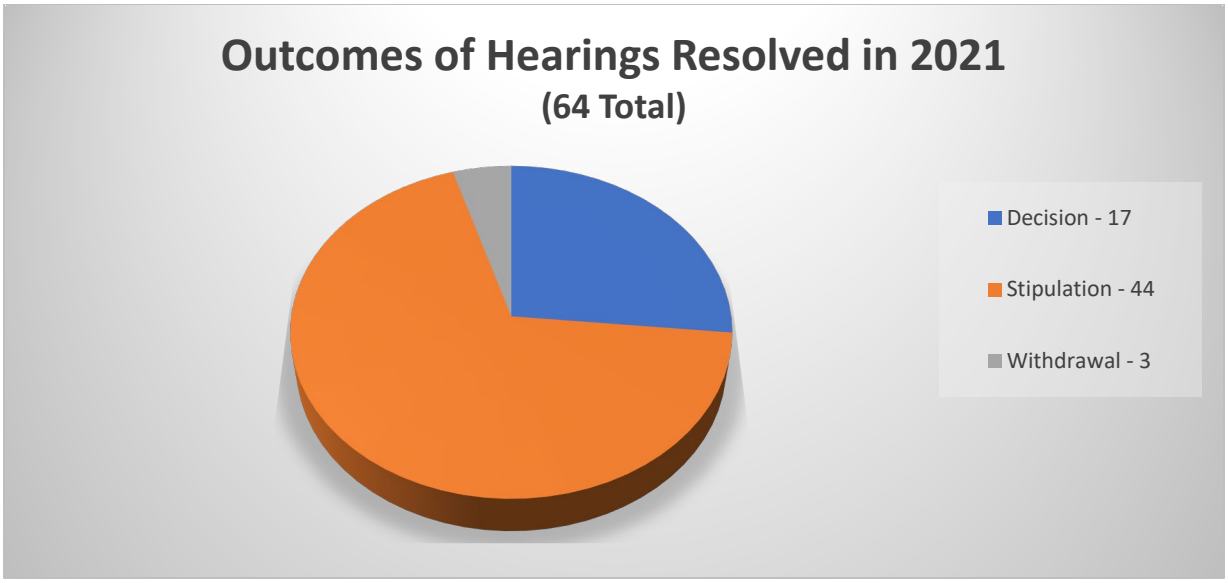
Administrative Hearings

Providers who have received a Final Audit Report, or a Notice of Agency Action (collectively referred to as the "final determination") are entitled to challenge that final determination in an administrative hearing. Such hearings are conducted by DOH Administrative Law Judges (ALJ) in the Bureau of Adjudications and defended by OMIG attorneys.

Hearings must be requested within 60 days, after the provider's receipt of the final determination. All requests for hearing are assigned to an attorney who is responsible for defending OMIG's findings, the identified Medicaid overpayments, and/or sanctions for unacceptable practices. Some requests are withdrawn by the provider while others are settled to the satisfaction of OMIG and the provider without the need for a hearing. OMIG's attorney manages the progress of the case by communicating with the provider or their representative to either facilitate the hearing process, or to reach a fair and mutually agreeable resolution for both parties.

In 2021, 35 new requests for hearing were received, and of those, 13 were voluntarily withdrawn by the provider, either by letter or through a stipulation of settlement. A total of 64 hearing cases were resolved by the completion of hearings, withdrawal, or settled - with most of the cases being resolved without proceeding to a full hearing before an ALJ. Also, in most of the cases that went forward to a full hearing, the ALJ's decision affirmed OMIG's audit findings. These decisions can be found at: www.health.ny.gov/health_care/medicaid/decisions/.

As in 2020, hearings throughout 2021 continued to be conducted remotely rather than in person because of the ongoing COVID-19 pandemic. Despite the ongoing challenges of conducting hearings in the remote environment, OC was able to defend agency actions efficiently while affording providers the ability to exercise their due process rights. This graph illustrates the total number of hearings resolved in 2021 and their outcomes.



Stipulations of Settlement

OMIG attorneys negotiate and facilitate settlements between the agency and providers. Stipulations of settlement may result from a provider agreeing to resolve an audit following an exit conference or issuance of a draft audit report, to resolve a request for hearing, or to resolve a self-disclosure. Stipulations of settlement are formal written documents executed by the provider and OMIG. The stipulations define the terms of settlement, including but not limited to, the review period in question, the overpayment amount owed, and the repayment terms. In 2021, OC finalized 59 stipulations, of which 44 stipulations were in lieu of proceeding to an administrative hearing, and 15 stipulations were for pre-final determinations and self-disclosure cases.

External Audits

OMIG's External Audit Unit (EAU), working with DOH, coordinates and manages audits of the Medicaid program conducted by outside audit and oversight agencies, such as the Office of the State Comptroller (OSC), HHS-OIG, and CMS. The following chart is a summary of OSC reports, HHS-OIG reports, CMS reviews, and independent audits received during 2021. In 2021, EAU received a total of 42 audit reports/reviews containing millions of claims and MC encounters. Addressing these audits requires the coordinated efforts of OMIG staff from all divisions across the agency. Staff are involved in all stages of the audit process, including responding to requests during fieldwork, attending meetings, performing data analysis, answering follow-up questions, and preparing responses to all reports received. Additionally, OMIG performs any necessary audit, investigative or recovery actions to address recommendations outlined by the external audit agencies.

OSC

- OSC performs audits pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law. Examples of audit areas include:
  - Supplemental Maternity Capitation Payments to MCOs
  - Medicaid Payments for Misclassified Patient Discharges
  - MC Premiums for Recipients with Multiple CINs
  - OPRA Services for Providers No Longer Participating in Medicaid

HHS-OIG

- As a recipient of U.S. Department of Health and Human Services (HHS) grant funds, the State agency is subject to Office of Inspector General (OIG) audits and other reviews. Examples of audit areas include:
  - MC beneficiaries assigned more than one identification number
  - Health Home Program Services
  - Assisted Living Program

New York State Financial Statement Audits

- Pursuant to the requirements of Chapter 405 of the Laws of 1999, the Office of the State Comptroller engages a certified public accounting firm to perform an independent audit of the State of New York's financial statements as prepared by the State Comptroller. In 2021, KPMG performed the audit of the State's financial statements for the year ended March 31, 2021.

Appendix

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

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

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

Data Tables

2021 Initiated Audits by Region					
Audit Department	**Downstate**	**Upstate**	**Upstate Western**	**Out of State**	**Total**
County Demonstration Program	3	0	5	0	8
Managed Care	312	88	109	0	509
Provider	475	169	149	77	870
Total Audits	**790**	**257**	**263**	**77**	**1,387**

2021 Finalized Audits by Region					
Audit Department	**Downstate**	**Upstate**	**Upstate Western**	**Out of State**	**Total**
County Demonstration Program	9	0	2	0	11
Managed Care	237	68	90	0	395
Provider	283	110	102	42	537
Total Audits	**529**	**178**	**194**	**42**	**943**

2021 Overpayments Identified by Region					
Audit Department	**Downstate**	**Upstate**	**Upstate Western**	**Out of State**	**Total**
County Demonstration Program	$24,460,781	$0	$22,546	$0	$24,483,327
Managed Care	99,740,582	28,163,954	10,961,839	0	138,866,374
Provider	15,461,442	11,924,723	9,633,185	(94,153)	36,925,197
Total Audits	**$139,662,804**	**$40,088,677**	**$20,617,570**	**($94,153)**	**$200,274,898**

2021 Penalties by Region					
Audit Department	**Downstate**	**Upstate**	**Upstate Western**	**Out of State**	**Total**
County Demonstration Program	$0	$0	$0	$0	$0
Managed Care	0	0	218,664	0	218,664
Provider	0	0	0	0	0
Total Audits	**$0**	**$0**	**$218,664**	**$0**	**$218,664**

2021 Overpayments Recovered by Region					
Audit Department	**Downstate**	**Upstate**	**Upstate Western**	**Out of State**	**Total**
County Demonstration Program	$1,669,755	$128,731	$6,218	$0	$1,804,704
Managed Care	98,798,236	29,606,361	11,083,722	0	139,488,319
Provider	37,101,819	12,138,087	6,945,709	24,119	56,209,734
Total Audits	**$137,569,810**	**$41,873,178**	**$18,035,648**	**$24,119**	**$197,502,756**

Audit Summations	
Audit Department	**Amount**
County Demonstration Program	4
Managed Care	3
Provider	504
Total Summations	**511**

2021 Self-Disclosures by Region					
Activity	**Downstate**	**Upstate**	**Upstate Western**	**Out of State**	**Total**
Initiated	115	67	91	4	277
Finalized	101	60	82	3	246
Overpayments Identified	$13,846,715	$3,819,495	$6,073,290	$135	$23,739,635
Recoveries	$11,157,788	$3,452,185	$5,071,519	$135	$19,681,627

Summary of Investigations by Source of Allegation and Region								
	Downstate		Upstate		Out of State		Totals	
Initial Source	Opened	Completed	Opened	Completed	Opened	Completed	Opened	Completed
Anonymous	123	140	57	78	1	1	181	219
District Attorney	0	6	0	0	0	0	0	6
Enrolled Recipient	21	45	20	25	1	1	42	71
Federal Agencies	24	113	5	11	0	7	29	131
General Public	132	195	78	96	2	2	212	293
Law Enforcement	1	3	5	3	0	0	6	6
LDSS	8	9	20	28	0	0	28	37
MCOs	194	201	45	69	13	17	252	287
MLTC Plans	91	131	19	62	0	0	110	193
MCO Subcontractor	0	0	1	1	0	0	1	1
Non-Enrolled Provider	1	0	0	0	0	0	1	0
Non-Enrolled Recipient	0	4	0	0	0	0	0	4
OMIG	460	606	715	723	12	14	1,187	1,343
Other State Agencies	94	98	129	122	63	33	286	253
Provider	40	50	31	36	0	0	71	86
Total	**1,189**	**1,601**	**1,125**	**1,254**	**92**	**75**	**2,406**	**2,930**

Referrals to MFCU	
Provider Type	**Amount**
Capitation Provider	2
Clinical Social Worker (CSW)	1
Consumer Directed Aide	6
Dental Groups	6
Dentist	16
Diagnostic and Treatment Center	2
Home Health Agency	11
Home Health Aide	1
Laboratory	1
Long-Term Care Facility	1
Medical Appliance Dealer	1
Multi-Type	3
Non-Enrolled Provider	15
Nurse	4
Owner	1
Personal Care Aide	3
Pharmacy	10
Physician	17
Physicians Group	3
Social Adult Day Care	8
Recipient	15
Therapist	1
Transportation	74
Total	**202**

Referrals to Other Agencies	
Agency	**Amount**
AG - Not MFCU	6
Law Enforcement Agency	36
LDSS	54
MAS-Medical Answering Service	12
New York City Department of Health	20
NYC HRA Bureau of Client Fraud Investigations	39
New York State Bureau of Narcotic Enforcement	2
New York State Department of Health	345
New York State Department of Justice	11
New York State DOH Office of Professional Medical Conduct	6
New York State Education Department – Not Professional Discipline	6
New York State Education Department – Office of Professional Discipline	33
New York State Inspector General	1
New York State Justice Center	4
New York State Office of Addiction Services and Supports (OASAS)	1
New York State Office of Children and Family Services (OCFS)	1
New York State Office of Health Insurance Programs (OHIP)	1
New York State Office of the Welfare Inspector General	2
OHIP-Managed Care	2
Out of State	1
US Health and Human Services (HHS-OIG)	42
Total	**625**

Exclusions	
Reasons for Exclusions	**Number of Actions**
18 NYCRR 504.1(d)(1) – Affiliations	88
18 NYCRR 515.2 – Unacceptable Practice	1
18 NYCRR 515.7(b) – Indictments	84
18 NYCRR 515.7(c) – Convictions	111
18 NYCRR 515.7(e) – Professional Misconduct	77
18 NYCRR 515.8 – Mandatory Exclusion	96
Total	**457**

2021 Third-Party Liability and RAC Recoveries	
Activity Area	**Amount**
Casualty & Estate	$111,123,465
Third-Party Liability	207,655,738
Recovery Audit Contractor	169,362,672
Home Health Care Medicare Maximization Project	7,265,264
Self-Disclosed Third-Party Health Insurance	975,100
Total	**$496,382,239**

2021 Recoveries	
Activity Area	**Amount**
Third-Party Liability	$207,655,738
Recovery Audit Contractor	169,362,672
Managed Care	139,488,319
Casualty & Estate	111,123,465
Provider	56,209,734
Self-Disclosure	19,681,627
Home Health Care Medicare Maximization Project	7,265,264
County Demonstration Program	1,804,704
Self-Disclosed Third-Party Health Insurance	975,100
Investigation Financial Activities	156,187
Total	**$713,722,810**

2021 Cost Savings Activities	
Activity Area	**Amount**
Dental Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	$318,303
Enrollment and Reinstatement Denials	55,049,569
Exclusions/Terminations – Internal	1,666
Exclusions/Terminations – External	5,217,689
Medical Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	5,624,422
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	8,922,848
Pre-Payment Insurance Verification Commercial	1,920,922,099
Pre-Payment Insurance Verification Medicare	359,511,061
Recipient Medicaid MC Benefits - Case Closures for False Information	1,298,671
Recipient Restriction	96,192,330
Total	**$2,453,058,658**

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To report Medicaid fraud, waste, or abuse call the toll-free Fraud Hotline:
(877) 87-FRAUD / 877-873-7283