NEW YORK STATE | Office of the Medicaid Inspector General

2023 Annual Report

Kathy Hochul
Governor

Frank T. Walsh, Jr.
Acting Medicaid Inspector General

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Table of Contents

Message from the Acting Medicaid Inspector General	Page 4
General Overview	Page 6
Executive Organization Chart	Page 9
Regional Office Locations	Page 10
2023 Agency Highlights	Page 11
Provider Engagement / Compliance / Self-Disclosure	Page 16
Business Intelligence and Third-Party Liability	Page 26
Medicaid Audits	Page 32
Medicaid Investigations	Page 47
Office of Counsel	Page 67
External Audits	Page 71
Powers and Duties	Page 72
Frequently Used Acronyms	Page 74
Data Tables	Page 76
Back Cover / Contact Information	Page 84

Message from the Acting Medicaid Inspector General

On behalf of the Office of the Medicaid Inspector General (OMIG), I am proud to present this 2023 Annual Report, which details our collective contributions in enhancing the integrity of New York State's Medicaid program.

Essential to this mission is a close collaboration with health care payors and providers to ensure the appropriate delivery of services and supports to recipients without unfairly burdening stakeholders or threatening access to health care services. Throughout 2023, we redoubled our efforts to engage with and listen to Medicaid stakeholders – representing virtually every sector of the health care community -- and quickly responded to their concerns, and implemented a number of their recommendations.

Key 2023 achievements include:

- Enriching provider communication, education, and transparency. Providing relevant and useful information on program requirements and agency operations, involvement in the development of policies and protocols, and alternatives to avoid provider impacts.
- Promoting provider compliance. Reinstituting provider compliance reviews, facilitating provider preparedness, the successful completion of reviews and understanding of findings.
- Advancing self-disclosure. Educating the provider community on federal requirements, streamlining reporting to minimize administrative burdens, and assisting with the calculation of overpayments.
- Identifying and prosecuting fraud. Referring over 250 cases to the Attorney General’s Medicaid Fraud and Control Unit (MFCU) and other law enforcement agencies.
- Preserving Medicaid resources. Completing nearly 3,000 audits and investigations, resulting in over $4 billion in cost savings and recoveries.
- Utilizing data to develop new tools, improve operations and support the implementation of new initiatives, including technical assistance for providers.

These achievements and collaborative stakeholder relations would not be possible without the awareness, commitment, and dedication of OMIG staff statewide. I am honored to serve with the OMIG team as we continue to build on our successes in protecting the integrity of the New York State's Medicaid program.

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 the OMIG as an independent office. The legislation amended the New York State (NYS) Executive, Public Health, Social Services, Insurance, and Penal laws to create OMIG and institute the reforms needed to effectively fight fraud and abuse in the State's Medicaid program. The statutory changes separated the administrative and program integrity functions of Medicaid, 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 evaluates data, performs audits and reviews of Medicaid services and providers, conducts investigations and works with other federal and state agencies that have regulatory oversight or law enforcement powers.

Mission Statement

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

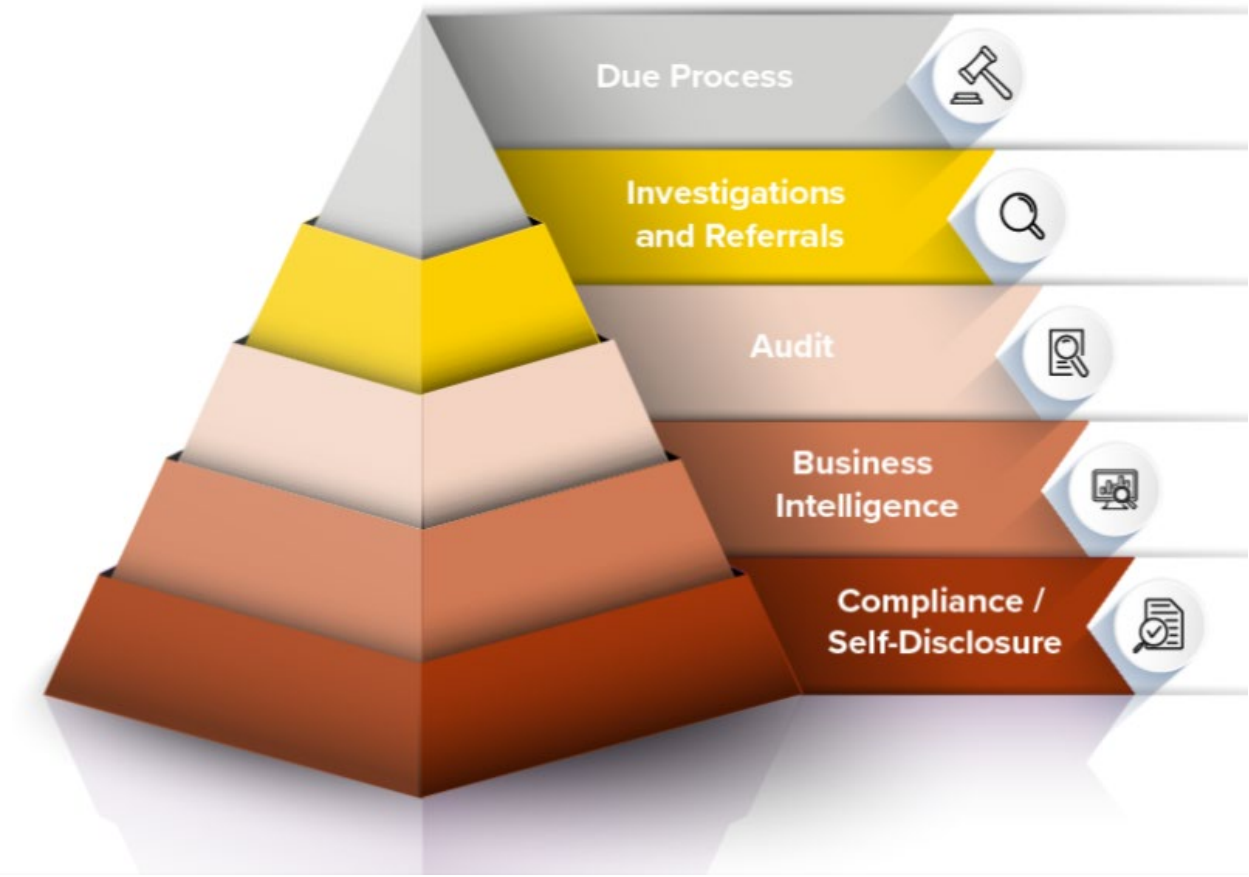
Annual Reporting

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

Amounts reported within this document represent the value of issued final audit reports, self-disclosures, administrative actions, and cost avoidance 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 greater 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. Administrative hearings may not be fully resolved within the same calendar year in which the hearing request is received.

Function



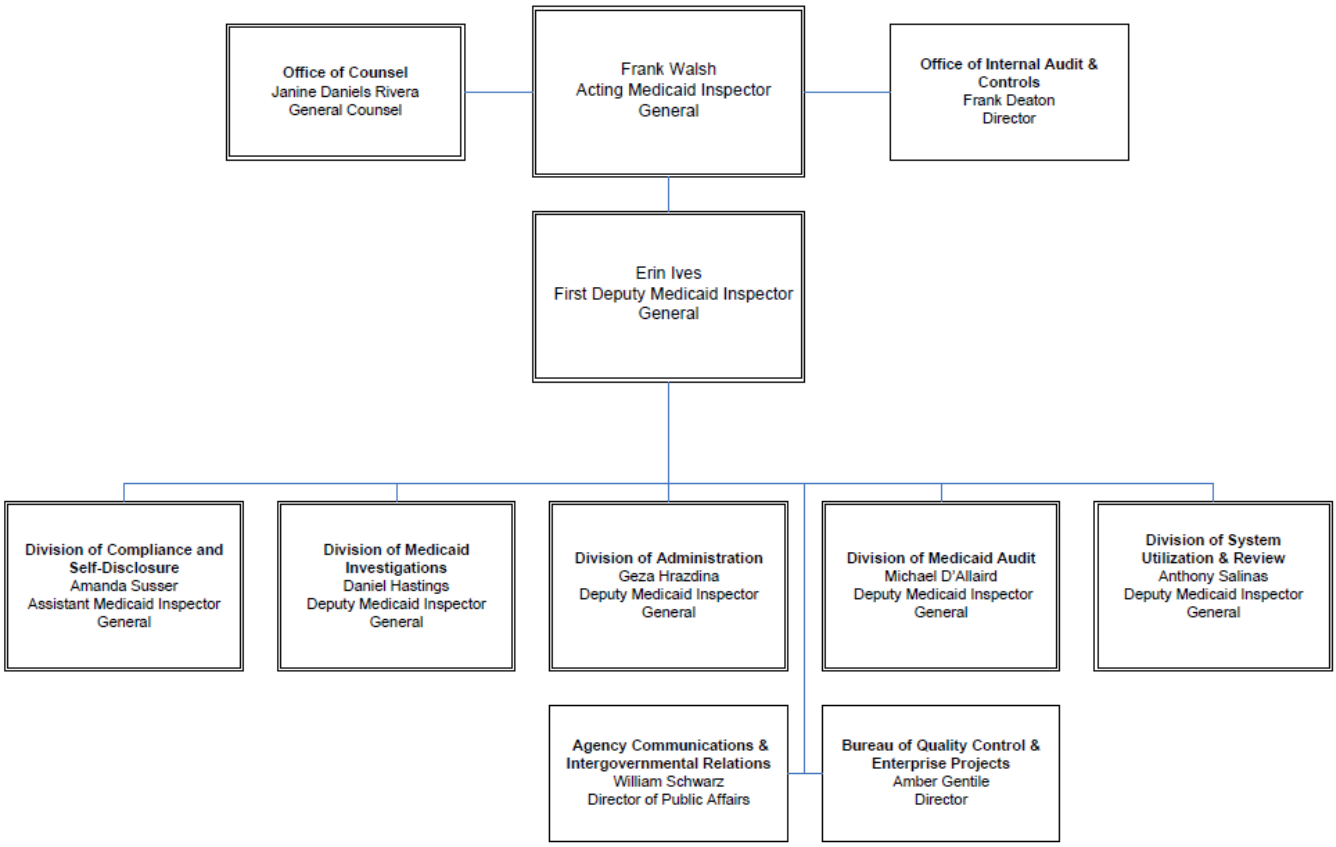
OMIG is an independent agency responsible for the enhancement and promotion of Medicaid program integrity statewide, the protection of efficient and high-quality health care service delivery, and the preservation of resources and support for the continued provision of critical health care services to more than 7.5 million Medicaid recipients.

In realizing these objectives, OMIG actively seeks to:

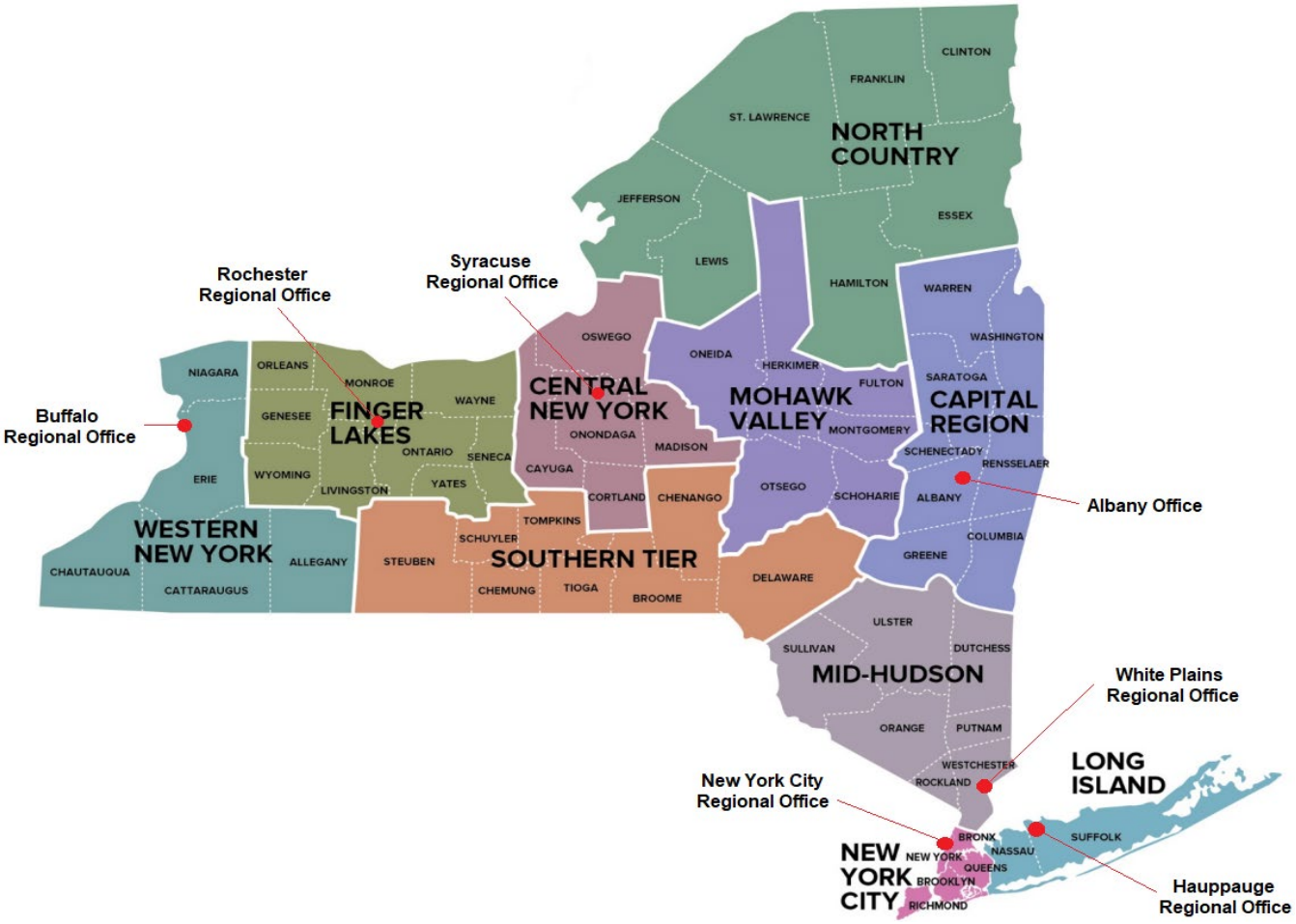
- Understand, promote, and advise on Medicaid policies and procedures that advance program integrity objectives.
- Closely coordinate with NYS Department of Health (DOH) and other state agencies involved in the administration of the Medicaid program to identify their priorities and objectives and develop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

- Educate and collaborate with Medicaid providers and payors, including Managed Care Organizations (MCO), to improve their understanding and compliance with current Medicaid requirements.
- Monitor for, identify and evaluate aberrant fiscal or programmatic trends and prioritize those that merit investigation or audit.
- Partner with and support other Federal, State, and local law enforcement and governmental agencies to identify inappropriate practices and enforce Medicaid rules and requirements.
- Cooperate, comment, and conduct appropriate follow-up actions, including the recovery of identified Medicaid overpayments, resulting from external audits of the NYS Medicaid program.
- Conduct audits in identified areas to assess provider compliance with Medicaid program and reimbursement practices to ensure that Medicaid recipients have access to quality medical services and that services are delivered efficiently. Where appropriate, OMIG publishes audit protocols in advance that are created in conjunction with the relevant state agencies and the provider community.
- Respond to allegations of fraud, waste, and abuse within the Medicaid program, initiate investigations of providers or recipients and take appropriate enforcement actions, including censure, exclusion, recipient restriction, or pre-payment review (PPR). OMIG also coordinates activities with the Special Investigative Units (SIU) of Medicaid managed care (MC) network providers which strengthens program integrity and increases the number of referrals to OMIG.
- Refer credible allegations or identified instances of fraud to the NYS Attorney General's Medicaid Fraud and Control Unit (MFCU) for review, recovery, and potential prosecution. OMIG works closely with MFCU to identify and analyze trends while safeguarding 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



OMIG staff work on Medicaid program integrity functions. These positions include auditors, investigators, nurses, data analysts, pharmacists, other clinical/medical professionals, compliance specialists, program administrators/managers, and persons providing legal, technological, and clerical support, in seven offices across the state.

2023 Agency Highlights

891
Finalized Audits

44
Hearings Resolved

Over $4 Billion in Recoveries and Cost Avoidance

2,022
Completed Investigations

655 Referrals Including 241 Referrals to MFCU

Policy/Process Highlight - Electronic Visit Verification

The 21st Century Cures Act was enacted in December 2016 which covered a wide range of healthcare-related areas including mental health, substance use disorder treatment, and the modernization of the Food and Drug Administration. One notable aspect of the Act was the requirement for Electronic Visit Verification (EVV) for certain home and community-based services. EVV is a technology solution that electronically verifies that a home health visit occurred. It captures key information such as the type of service provided, the individual receiving the service, date and time of service, location of service, and the individual providing the service.

The information provided by the EVV solution will assist in combating fraudulent billing and abuse of the Medicaid program. In addition, it will improve accountability by providing a clear and verifiable record of the services rendered, enhancing the quality of care, and confirm compliance with care plans and bringing cost savings to the state. The program will ensure better patient care and assist in improving overall health outcomes.

In support of this initiative, OMIG has been collaborating with the DOH to identify and assist providers who must comply with the new EVV requirements. At this stage of implementation, the goal is to increase awareness and address barriers to compliance as opposed to enforcement. In 2023, OMIG issued 385 letters to providers, notifying them of potential issues around their EVV data submissions. These issues were primarily related to a lack of EVV data being submitted when appropriate and/or the EVV data not matching actual paid claims.

OMIG has gathered valuable insights from the outreach to providers. First, many providers have expressed challenges in effectively training both new and existing staff to utilize the new EVV system. Additionally, some providers have encountered technical difficulties when attempting to submit data. In addition, some of the smaller providers have reported significant challenges in making the necessary investments to comply with the new requirements. Lastly, there seems to be some general confusion regarding which claims must be submitted to the aggregator. DOH is actively assisting many of these providers with their technical questions and assisting them in becoming fully compliant.

OMIG is refining a report to obtain an accurate compliance rate for providers billing for EVV mandated procedure and rate codes. This report will be used to indicate which providers are showing a high compliance rate of personal care claims and home health

service claims that are EVV verified, when applicable. This will allow OMIG to identify providers who are not meeting a high threshold.

Financial Hardship Reviews

In executing its mission, OMIG is sensitive to the fiscal condition of the health care provider community and works closely with our partner Medicaid state agencies to maintain uninterrupted access to necessary health care services and supports. Throughout the audit process or other OMIG proceedings, providers have the opportunity to inform the OMIG of the potential financial impact the audit or review may have on their business. To address these instances where they arise, OMIG offers a financial hardship process which affords providers the opportunity to apply for relief in the event an OMIG recovery from an audit or review may pose a financial hardship to the organization.

Providers that have received a final notice 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. The intent of this process is to offer objective and reasonable repayment options for providers that can demonstrate a financial hardship. Providers who have received hardship relief are required to re-apply on an annual basis so OMIG can assess any changes in their fiscal position.

In 2023, 20 hardship applications were reviewed and completed, consisting of 13 renewals and seven initial applications. All properly completed applications reviewed received some form of financial relief.

Healthcare Worker Bonus

Employer Self-Disclosures

As part of the Fiscal Year 2022-23 Budget, Governor Kathy Hochul announced the launch of the Health Care and Mental Hygiene Worker Bonus (HWB) Program, which allocated funds for the payment of recruitment and retention bonuses to certain frontline health care and mental hygiene workers. In July 2022, the DOH launched the HWB Portal for employers to claim these bonuses on behalf of their employees. OMIG staff, in collaboration with DOH, developed processes to support audits, investigations, and reviews of HWB claims and payments, as well as the self-disclosure of employer identified HWB overpayments, and the submission of employee inquiries and allegations of nonpayment, to ensure that these bonuses are appropriately distributed.

OMIG is responsible for the extraction of HWB data from the DOH HWB Portal database for use in HWB self-disclosures, employee allegations, and audits. OMIG is also responsible for tracking HWB recoveries and transmitting reconciliation data to DOH for their use in recalculating employee eligibility and making necessary system enhancements.

Employers who received an overpayment of HWB funds are required to report, return, and explain that overpayment to OMIG's Self-Disclosure Unit within 60 days of identification. OMIG is responsible for the intake and processing of those HWB employer self-disclosures, and published HWB Self-Disclosure forms, guidance, and FAQs in March of 2023 for employer use. Employers are expected to complete and submit the HWB Self-Disclosure submission forms, and any additional supporting documentation. At the conclusion of its review of this documentation, OMIG will provide the employer with a notice outlining what was disclosed and providing instructions on repayment or will direct the employer to pay employees, as applicable.

In 2023, OMIG's Self-Disclosure Unit received 1,115 HWB Self-Disclosure submissions. 855 submissions were finalized, resulting in over $10.8 million in identified overpayments and $7.4 million in recoveries.

Employee Allegations

Although employers are required to claim for eligible employees, there are employees who did not receive a bonus because their employers did not claim them, or because the employers did not release the funds they received to the employees. To address the concerns of these employees, OMIG collaborated with NYS Information Technology Services (ITS) to develop the Employee Allegation Portal, which is a webform that employees can use to submit allegations regarding nonpayment of HWB funds. In July 2023, OMIG, in collaboration with DOH, opened the Employee Allegation Portal on the HWB Website allowing employees who believed they were eligible, but did not receive an HWB payment, to submit allegations of employer non-compliance to OMIG. An HWB Inquiry Hotline and a dedicated mailbox were also created.

OMIG is responsible for the intake and processing of employee-submitted inquiries and allegations. Requests for information are sent to employers based on the analysis of the inquiry and data. OMIG completes a review of the information obtained and determines whether the employer should have submitted a bonus and/or if the employee should have received a bonus.

In 2023, OMIG's Division of Medicaid Investigations (DMI) received a total of 1,036 phone calls related to HWB, 659 emails related to employee inquiries, and a total of 2,309 inquiries submitted through the HWB Employee Allegation portal. These inquiries are under active review to determine the appropriate course of action.

Provider Engagement / Compliance / Self-Disclosure

26 Presentations
5,100 Participants

43 Audit Protocols Posted
Including 1 New and 1 Updated in 2023

Finalized 480 Self-Disclosures
Identifying $10.6 Million in Overpayments

Initiated 73 Compliance Program Reviews

Provider Engagement

In 2022, Governor Kathy Hochul directed the New York State Office of the Medicaid Inspector General (OMIG) to engage the healthcare provider community and other Medicaid stakeholders to solicit input on OMIG's Medicaid program integrity efforts.

Through three healthcare provider engagement forums hosted both in-person and virtually throughout New York State between April and May 2023, OMIG received input from among more than 1,500 participants and 450 organizations, representing a broad spectrum of the health care provider community. Topics covered included audit procedures, self-disclosures of Medicaid overpayments, compliance program requirements, financial hardship policies, communications and reporting, ongoing stakeholder engagement, and more.

Increasing OMIG's outreach and educational efforts was a reoccurring theme, with many voicing a desire to better understand OMIG's revised compliance regulations and guidance, details about the audit process and what providers can do to be prepared, and the scope of the Self-Disclosure Program.

Further, stakeholders expressed a strong desire to participate in future engagement sessions to discuss new and emerging policies and procedures and offer recommendations for enhancements that could benefit all parties. In addition to constructive feedback, several providers also shared positive experiences that they have had with OMIG staff through audit processes and there was a strong interest in further developing partnerships. Moreso, many highlighted that audit processes have improved over the years to be a more collaborative experience.

This input informed several actions OMIG has taken and have in process. First, OMIG looked for new opportunities to educate the provider community. In doing so, OMIG published and made available on the website a comprehensive Compliance Program Guidance that provided a detailed explanation of the elements of our reviews, the scoring and provided real-world examples of the documents that providers can use to demonstrate each element and satisfy program requirements.

Additionally, in direct response to provider requests, in June 2023, OMIG posted a Compliance Self-Assessment Form so that providers can assess strengths and weaknesses of their compliance programs. OMIG also published Frequently Asked Questions (FAQs) on its website about the Compliance Program to clarify questions and address comments related to new regulatory requirements.

OMIG also provided updated Self-Disclosure guidance and FAQs in August 2023 to support the rollout of a new Self-Disclosure process. The program was revised to include a new Abbreviated Process to address provider concerns that allows providers to easily and conveniently disclose overpayments resulting from human or transactional errors. It also included the options for providers to report on a monthly basis. This process was implemented prospectively, applying to all qualifying transactions after its August 22, 2023 announcement.

With transparency being a key priority, OMIG enhanced the detail presented in this Annual Report and has increased the number of instructional webinars, and presentations on the audit process, self-disclosure and compliance to the healthcare provider community and other Medicaid stakeholders. Information regarding updates to processes will be announced via the *Medicaid Update* as well as OMIG's listserv, website, and social media channels.

Lastly, OMIG plans to host future provider engagement sessions to maintain regular, ongoing two-way communication with stakeholders. OMIG also developed a 2024 Work Plan was published to the agency's website. OMIG encourages stakeholders to continue providing input on audit protocols and any emerging concerns as it relates to Medicaid program integrity.

Audit Protocols

Audit protocols are developed for fee-for-service (FFS) categories of service or programs audited by OMIG. The protocols assist the provider community in evaluating compliance with Medicaid requirements. Audit protocols are intended solely as guidance in this effort. In 2023, OMIG posted two protocols, bringing the total to 43 protocols listed on the Audit Protocols website.

- **Early Intervention (Revised Protocol)**

  In March 2023, OMIG finalized the development and use of the revised Early Intervention (EI) protocol for evaluation of services provided from April 6, 2016 through October 18, 2021. This development was marked by a collaborative approach, involving key stakeholders such as representatives from various provider associations and the DOH. The insights and feedback from these stakeholders were instrumental in shaping a protocol that addresses practical challenges faced by providers while maintaining rigorous oversight standards.

OMIG conducted several meetings with these groups to gather input, ensuring that their concerns and suggestions were thoughtfully incorporated into the protocol. The collaboration with DOH was particularly significant, as it helped resolve comments and feedback from provider associations, leading to a more effective and widely accepted protocol. This collaborative effort underscores OMIG's commitment to transparency and partnership with the provider community, ensuring that Medicaid requirements are clearly understood and consistently applied.

- **Health Home (New Protocol)**

  In May 2023, OMIG developed Audit Protocols for Health Homes (Adults) to evaluate services provided from January 9, 2014 through July 1, 2019. This achievement is notable, as these Protocols are the first of their kind for the NYS Health Home Program.

  In order to properly formulate these initial audit protocols, OMIG collaborated with key stakeholders, such as the DOH and relevant provider associations. Information and feedback provided to OMIG throughout this process were carefully considered when developing the audit protocols. This collaboration was particularly important, as it provided OMIG with insights from the Provider community, as well as from a regulatory oversight standpoint.

Compliance

NYS Social Services Law (SOS) requires certain persons or entities participating in the Medicaid program to adopt and implement compliance programs designed to detect and prevent fraud, waste, and abuse in the Medicaid program.

Providers subject to these requirements consist of enrolled NYS Medicaid program providers who are categorized as hospitals, residential health care facilities, home care services agencies, providers of developmental disability services, providers of mental disability services, MCOs, and managed long-term care (MLTC) plans, regardless of the amount claimed or received from the Medicaid program. Beyond these service categories, the definition also includes any enrolled provider that claims or receives $1 million or more directly or indirectly (such as Managed Care network participating providers) from the Medicaid program.

Compliance programs should be reasonably designed, implemented, and enforced so that the program is generally effective in preventing, detecting, and correcting fraud, waste, abuse, and non-compliance with Medicaid program requirements.

Effective December 28, 2022, Title 18 of the New York Codes, Rules and Regulations Part 521 was amended to implement statutory changes adopted in the State Fiscal Year 2020-2021 enacted budget. Changes impacted the requirements for establishing and operating effective compliance programs. OMIG conducts compliance program reviews of required providers that represent all provider types and all payment levels, and assessments are made in accordance with state regulations.

In early 2023, OMIG focused its efforts on outreach and education for the provider community through the publication of guidance materials and FAQs on its website, as well as conducting or attending presentations, webinars, and meetings.

- Publications:
  - Compliance Program Guidance,
  - *New York State Medicaid Update - February 2023 Volume 39 - Number 5,*
  - *New York State Medicaid Update - March 2023 Volume 39 - Number 6,*
  - Compliance Program Review Module,
  - Compliance Program Requirements 2023 Webinar,
  - Self-Assessment Form, and
  - Compliance Program FAQs.

- Presentations that reached more than 2,000 participants:
  - One virtual meeting, and
  - 11 presentations (both virtual and in-person).

Both the Compliance Program Guidance and the presentations offered clarification on new regulatory requirements including information regarding contractors and MCOs, what is an effective compliance program, OMIG's compliance program review process, elements of an effective compliance program, and compliance resources.

More information can be found on OMIG's website at:
https://omig.ny.gov/compliance/compliance

Compliance Program Reviews

OMIG conducts reviews to determine if providers are meeting their compliance program obligations. These reviews encompass a specific time period not to exceed 12 months, and focus on determining if the provider adopted, implemented, and maintained an effective compliance program that satisfied the Medicaid program requirements during the review period. In July 2023, OMIG reinitiated Compliance Program Reviews – that were suspended since 2020 due to the COVID pandemic -- and implemented a new review process issuing 73 notification letters for reviews. All provider types and sizes were included.

OMIG reviews the completed Module and supporting documentation submitted by the provider and may reach out with questions or to request additional documentation as necessary.

Based upon the information submitted by the provider, OMIG evaluates performance for each requirement and assesses an average score for each month of the review period. The overall average score is used to determine whether the provider's compliance program satisfactorily met the requirements for all months of the review period.

Average Score Percentages:

- 60% or more is satisfactory, and
- < 60% is unsatisfactory and may result in a monetary penalty.

Upon completion of a review, OMIG notifies the provider of the results in a written compliance program assessment, which advises the provider whether its compliance program satisfactorily met the requirements and of any recommendations for improvement.

A provider that is not effectively meeting state and federal Medicaid requirements is potentially exposed to increased operational, reputational, service, and audit risks, as well as sanctions and the repayment of identified Medicaid overpayments. The consequences of a compliance program review by OMIG may include:

- Monetary penalties up to $5,000 for each month that a provider fails to adopt, implement, and maintain an effective compliance program. This amount may increase to $10,000 per month if a penalty was previously imposed within the past five years.
- Recoupment of monies paid to the provider during the period in which it did not have a compliance program.

- ❖ Termination of the provider's enrollment in the Medicaid program.
- ❖ Sanctions, up to and including exclusion from participation in the Medicaid program.

The provider should identify and implement corrective actions in all areas identified by OMIG as needing improvement. Implementation of these corrective actions may not be immediately reviewed by OMIG, but failure to implement a requested corrective action could subject the provider to sanctions if they are identified in a future review. Discontinuance letters are issued concluding the review when a review cannot proceed, and no assessment is made (e.g., the provider is no longer in business or there was a change in ownership which precipitated a change in the compliance program during the review period).

Final actions were issued for nine providers in 2023 as follows:

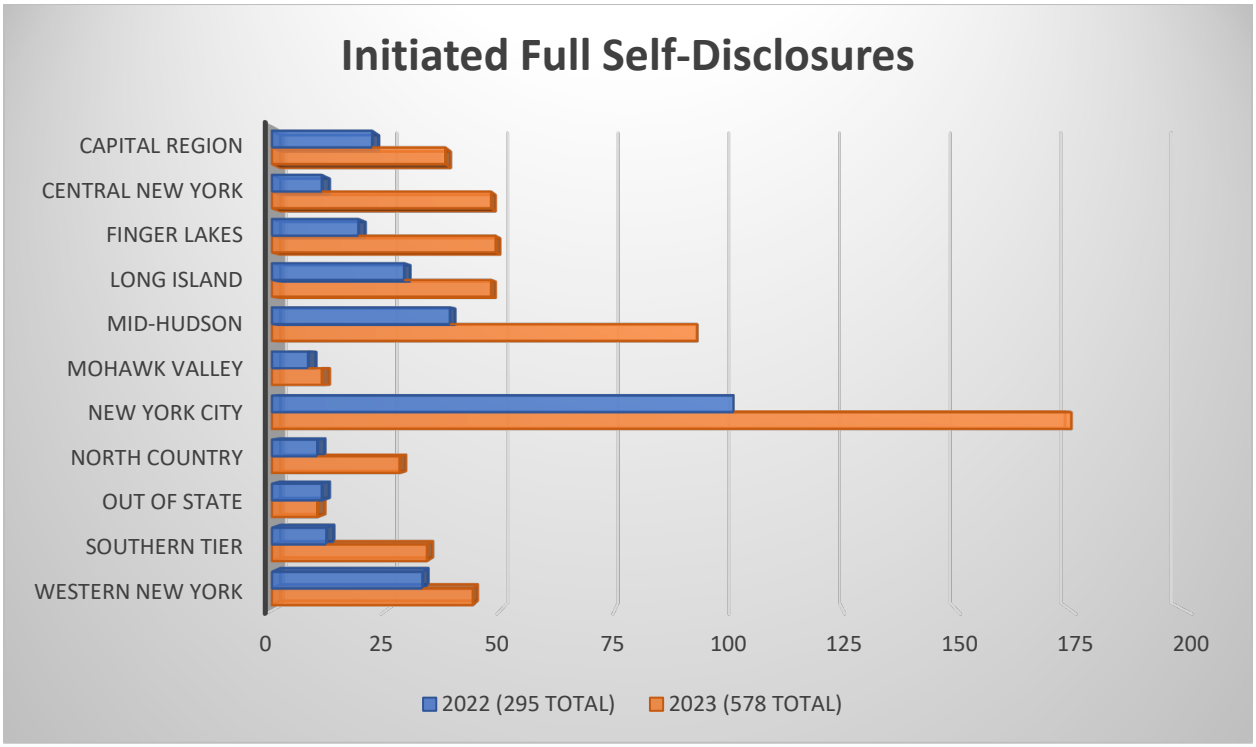
- ❖ Compliance Program Assessments (no sanctions): 7
- ❖ Discontinuance Letters: 2

The remaining reviews are in various stages of the process.

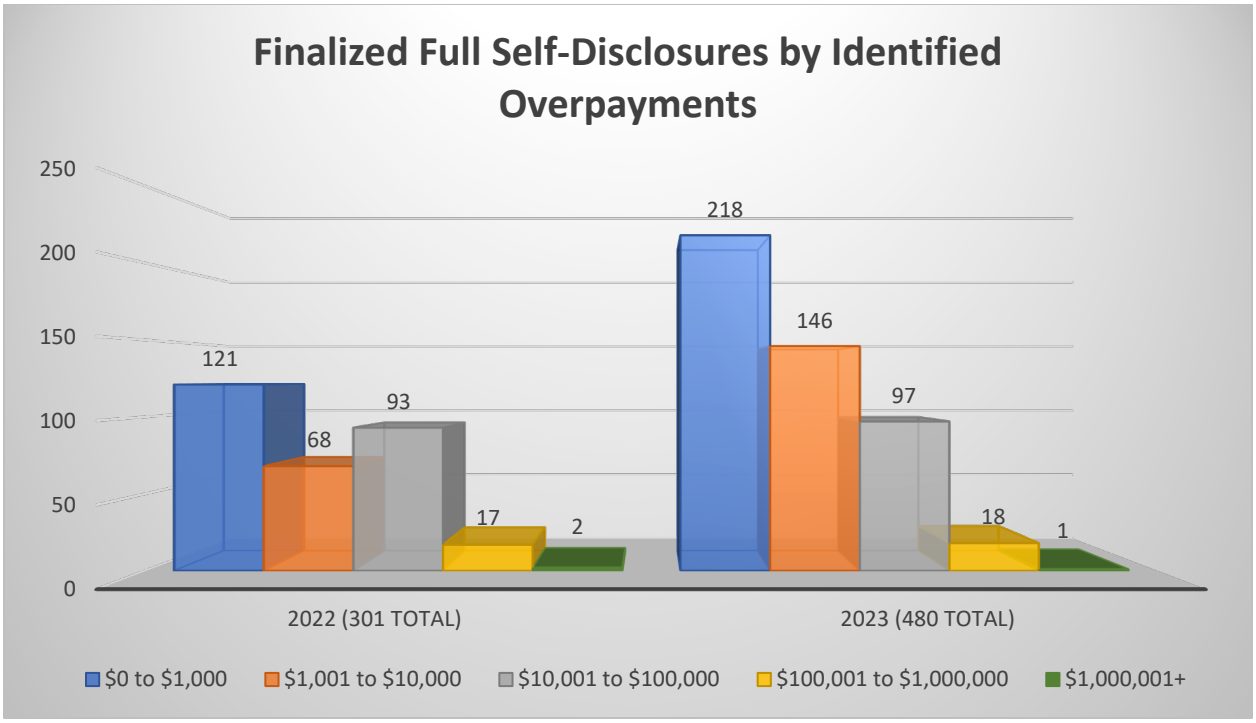
Self-Disclosure

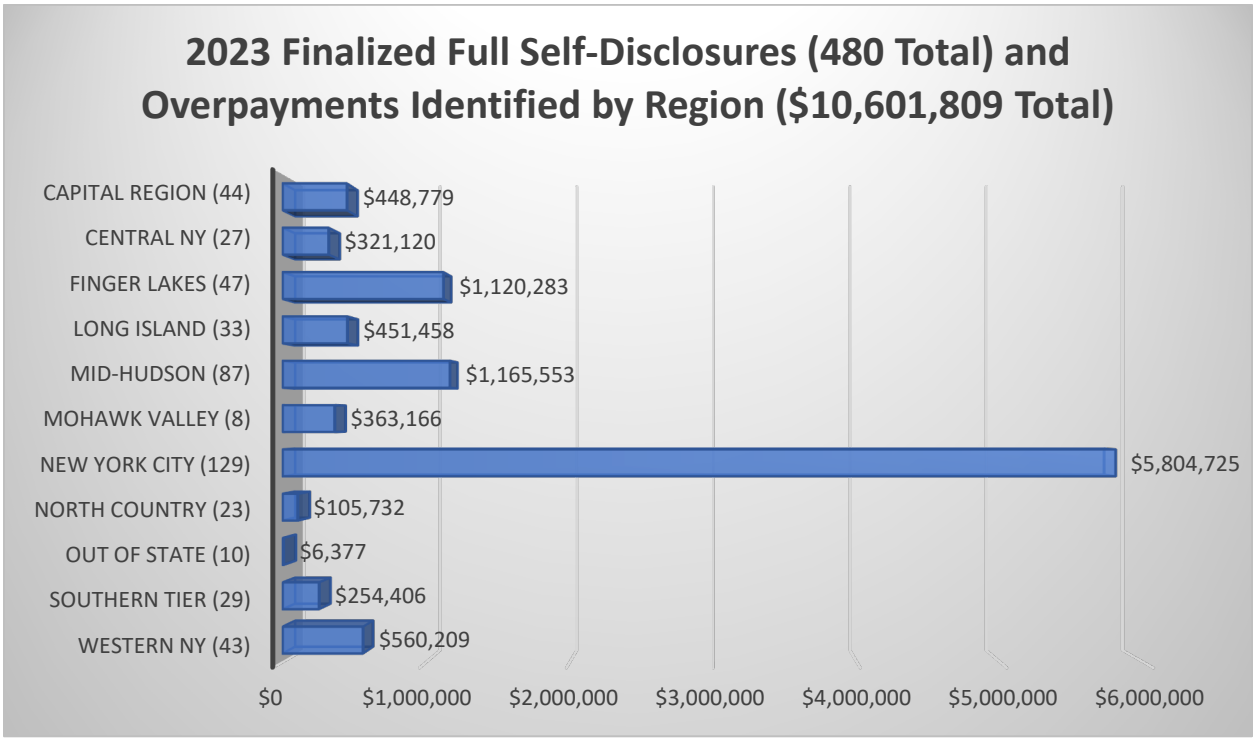
Entities that receive Medicaid funds, or are involved in the receipt of Medicaid funds, are obligated through Federal and State law to self-disclose Medicaid overpayments within 60 days of being identified.

In 2023 OMIG saw a 95% increase in Full Self-Disclosure submissions over calendar year 2022, a direct result of increased engagement with, and education to, the Medicaid community regarding their obligation to report, return and explain self-identified Medicaid overpayments received. These activities included the publishing of updated Self-Disclosure guidance and forms on OMIG's website in January 2023 (Self-Disclosure | Office of the Medicaid Inspector General), a February 2023 *Medicaid Update* publication (New York State *Medicaid Update* - February 2023 Volume 39 - Number 5), and a number of presentations to various provider associations and provider engagement sessions throughout the calendar year.



Although there was a significant increase in submissions, findings remained relatively steady compared to previous years; approximately 76% of Full self-disclosures processed reported overpayments of $10,000 or less.

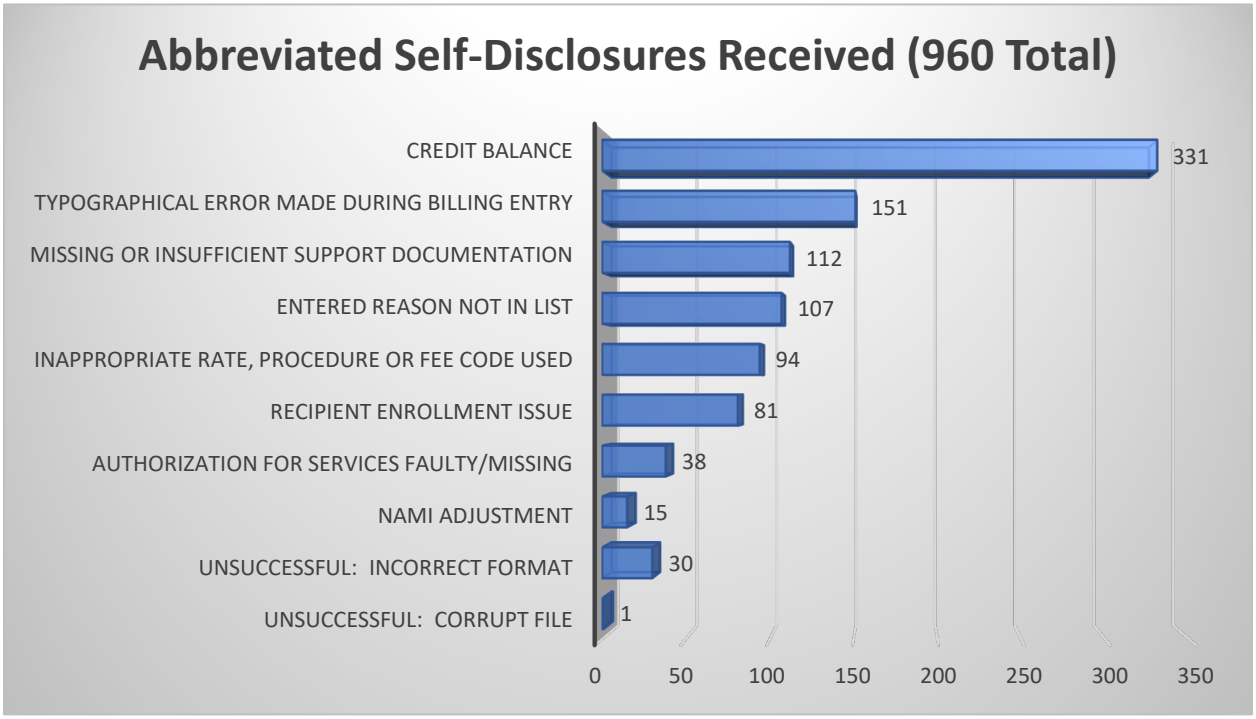




Over the course of 2023 OMIG participated in extensive provider engagement coupled with internal process review. Through those activities OMIG determined that an additional self-disclosure process was needed to provide a streamlined and less burdensome avenue for providers to self-disclose Medicaid overpayments that were

caused by errors determined to be routine or transactional, and where the provider voided or adjusted the overpaid claims to repay Medicaid. To resolve this need, OMIG collaborated with ITS to create a web form that is hosted on OMIG's website allowing providers to submit a report that explains FFS claim adjustments and voids performed in the last 60 days repaying these types of overpayments. In August 2023, OMIG implemented the form as part of the Abbreviated Self-Disclosure process, which is in addition to the existing self-disclosure process, renamed the Full Self-Disclosure process.

From August to December 2023, providers submitted 960 Abbreviated self-disclosures. 97% of submissions were received successfully; errors that prevented successful receipt included the use of external forms instead of OMIG's Abbreviated Statement form and submission of corrupted files.



Business Intelligence and Third-Party Liability

$3.1 Billion Pre-Payment Insurance Verification Cost Avoidance	$224 Million Third-Party Liability Recoveries
$127 Million Casualty and Estate Recoveries	$269 Million Recovery Audit Contractor Recoveries

Business Intelligence

NYS Medicaid is a data-intensive and complex program of multiple information systems including eMedNY - the Medicaid Management Information System (MMIS), and the Medicaid Data Warehouse (MDW) - the central data repository of all Medicaid paid and denied claims. The NYS Medicaid program administers services to more than 7.5 million recipients by more than 200,000 enrolled providers. This resulted in 727 million Medicaid claim or encounter transactions in 2023 alone, consisting of approximately 590 million original claims, 88 million adjustment transactions, and 47 million void transactions. Due to the high volume of data, OMIG is heavily reliant upon technology 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. OMIG staff members employ specialized knowledge of Medicaid data and systems to apply technological solutions and develop complex data analytics to inform and support management decisions, audits, investigations, hearings, and provider engagement opportunities. Through direct claim reviews and creating extrapolation audit packages, OMIG has identified and tracked over 7 million records for audit in 2023.

Healthcare Fraud Prevention Partnership

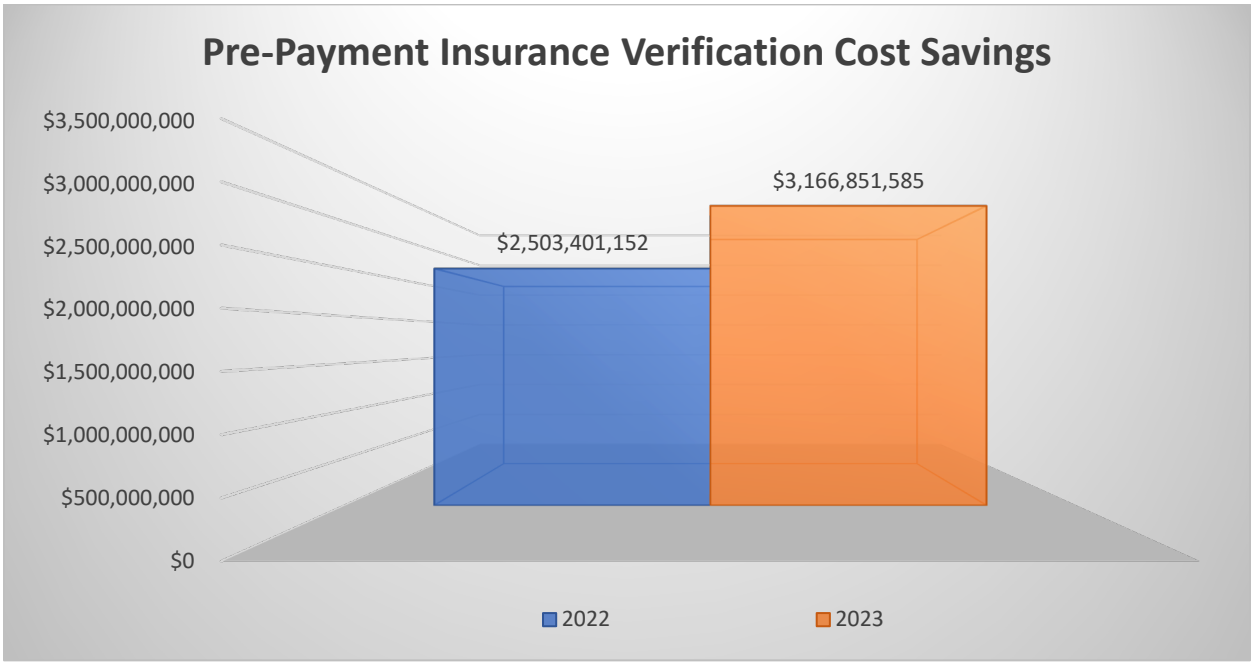
The Healthcare Fraud Prevention Partnership (HFPP) was established in 2012 to conduct nationwide studies of providers to identify trends and patterns of abusive billing practices. HFPP was created based on a federal Government Accountability Office recommendation to the Centers for Medicare and Medicaid Services (CMS) to develop a vulnerability analysis process throughout the industry to get ahead of the “pay-and-chase” approach used in program integrity. OMIG has been an active participant in HFPP since 2015. Currently, there are 306 partners in HFPP, which include federal, state and local government and law enforcement agencies, health care payors and representative associations.

In 2023, OMIG began to increase its focus on the resources available to us as a data sharing partner in the HFPP. These resources include in-depth studies based upon the data submitted by all partners on a national level, as well as alerts regarding the suspicious behavior of individual providers. OMIG reviews issues identified by the HFPP and the potential impact there may be on the NYS Medicaid program. For example, leveraging Partnership resources helped improve OMIG’s fraud detection-related to the claiming of Telehealth services. The HFPP data identified impossible claiming scenarios where the time required for all procedures claimed in one day is greater than the total time in a day. OMIG is currently working to perfect its reviews of Telehealth services as

well as explore additional opportunities to improve OMIG's fraud, waste, and abuse detection techniques.

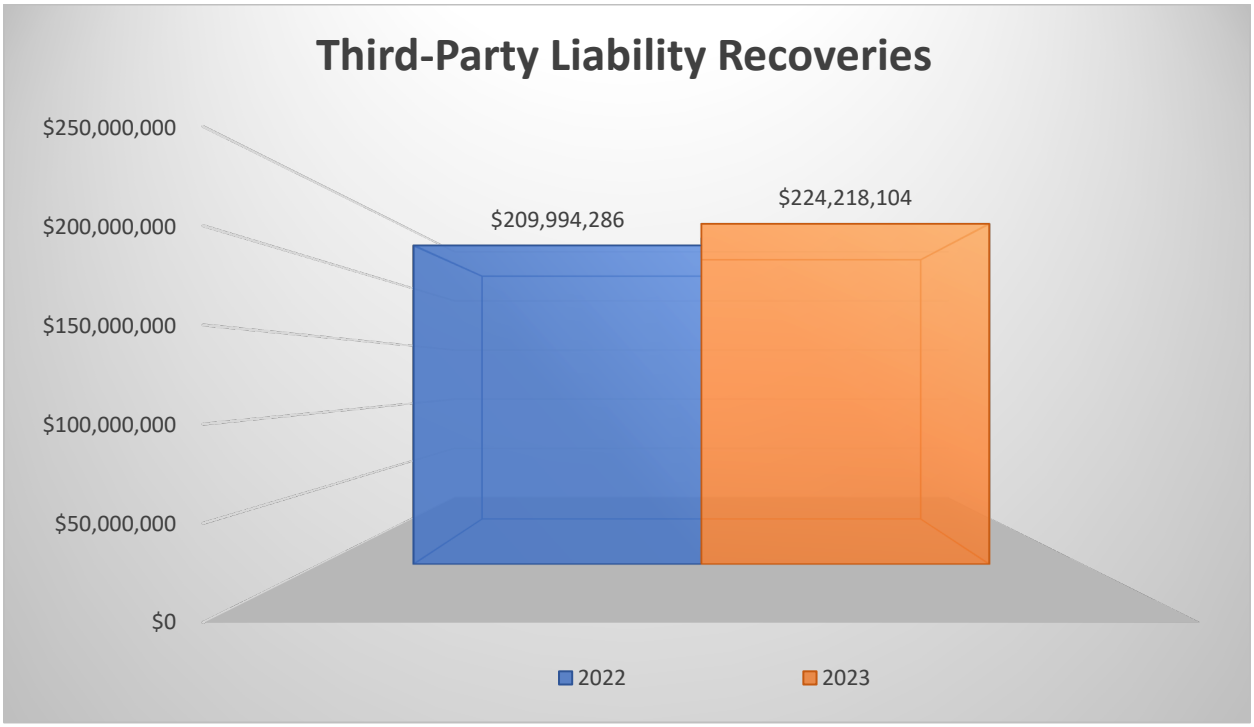
Pre-Payment Insurance Verification

Medicaid provides health care coverage under federal law and is intended only to be billed as a "last resort", after all other forms of insurance coverage have been exhausted. Under its Third-Party Liability Contract, OMIG utilizes its contractor, Health Management Systems, Inc. (HMS), to identify third-party insurers, verify insurance coverage and policy periods, and update the Medicaid claim processing system by either adding or end-dating insurance coverage information. These preventative actions supplement the requirements that Medicaid payors coordinate health care benefits, cause claims submitted to Medicaid to be denied in instances when other payors are liable and minimize the disruption of payments to Medicaid payors and providers. As a result of these activities, in 2023 the Medicaid program avoided more than $3.1 billion in payments by ensuring other forms of health care coverage were utilized.



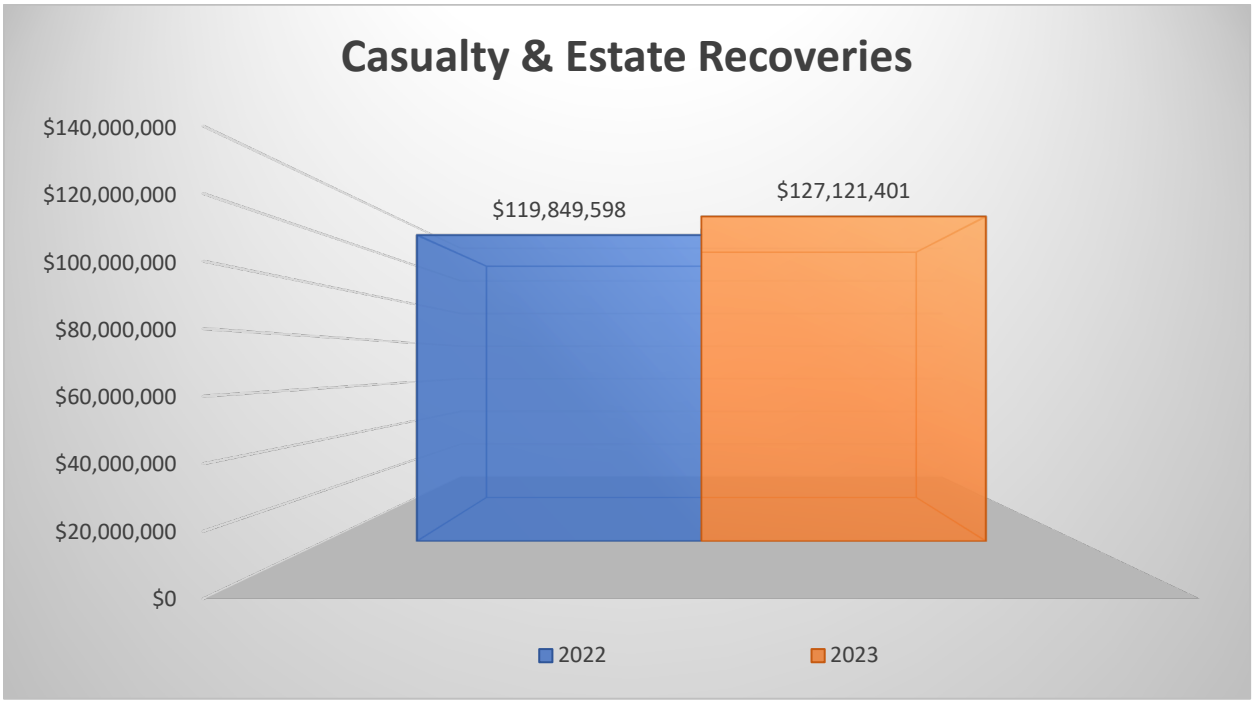
Third-Party Liability Match and Recovery Services

As the payor of last resort, Medicaid pays for covered services only after all other third-party sources of coverage have paid claims under their policies. However, not all liable third-party insurers are billed prior to claims being submitted to Medicaid. OMIG contracts with HMS to identify and confirm other third-party insurance payment sources. When valid third-party coverage existed prior to being updated to the Medicaid system, HMS initiates reviews directing providers and MCOs to bill these payment sources for services inappropriately paid by Medicaid and return the amount that Medicaid overpaid. These reviews generated more than $224 million in recoveries in 2023.



Casualty & Estate

In circumstances where a Medicaid recipient passes away or receives a settlement due to a personal injury action, certain amounts paid by Medicaid must be recovered against settlement funds or estate assets. Casualty and Estate (C&E) recoveries are pursued by OMIG's third party contract vendor HMS. Each C&E case is processed based on the particular circumstances of that case. HMS works in conjunction with the Local Departments of Social Services (LDSS) associated with the recipient's eligibility, or with DOH for recipients eligible through the New York State of Health (NYSoH), as well as with the applicable NYS court and attorneys to determine the required payment amount for each case. In compliance with DOH oversight, court appearances in litigation proceedings for all cases are made by county attorneys on behalf of the State. In 2023, the recoveries under the C&E program rose slightly from the prior year to more than $127 million.

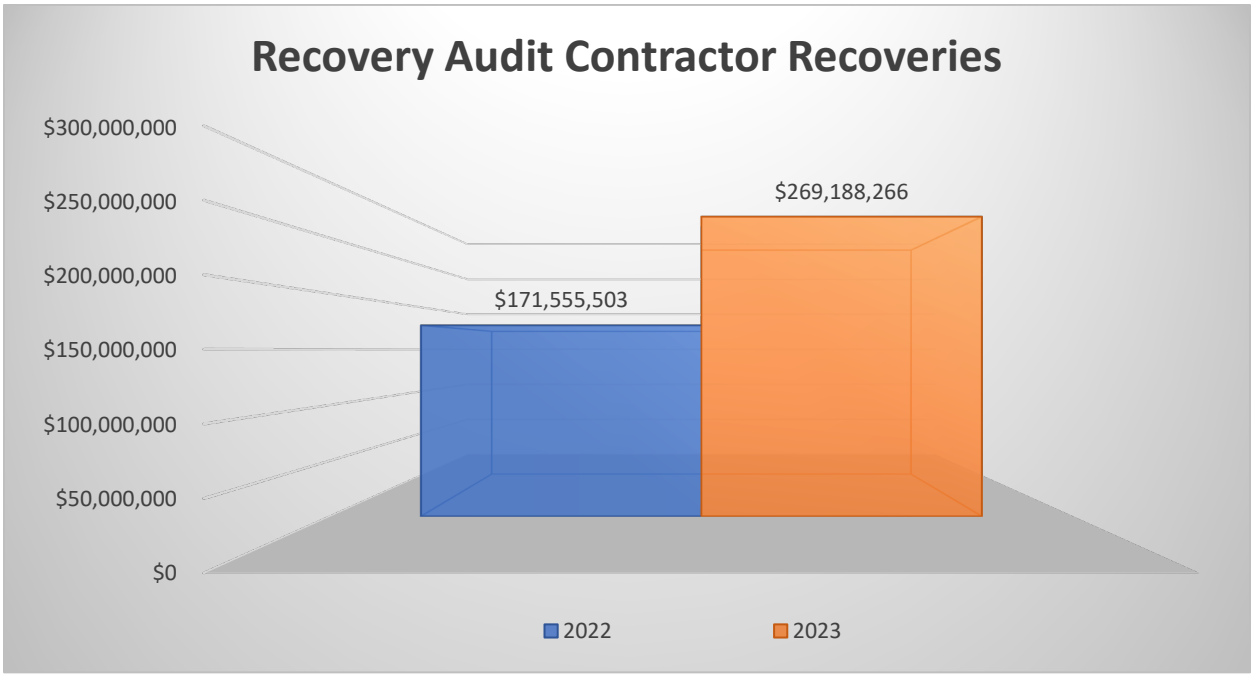


Medicaid Recovery Audit Contractor

OMIG continued its engagement with the Recovery Audit Contractor (RAC) – HMS – to supplement the agency's program integrity efforts. Pursuant to a federal requirement under the Affordable Care Act, the RAC's mission is to coordinate efforts with the State 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. The RAC utilizes data mining to identify improper payments and works with providers to recover identified overpayments. Projects performed under the RAC resulted in recoveries of more than $269 million in 2023, which is $97 million more than in 2022.

There are two main reasons for the increase in recoveries. First, the RAC continued an audit project where OMIG recovers Medicaid capitation payments for recipients determined by DOH to be simultaneously enrolled or in receipt of Comprehensive Third-Party Health Insurance (TPHI) coverage through a different MCO. The second reason for the increase is due to issuing final audit reports to providers who were non-compliant in responding to previous reviews and requests for payment. These final audit reports encompassed several projects which resulted in over $120 million in recoveries.

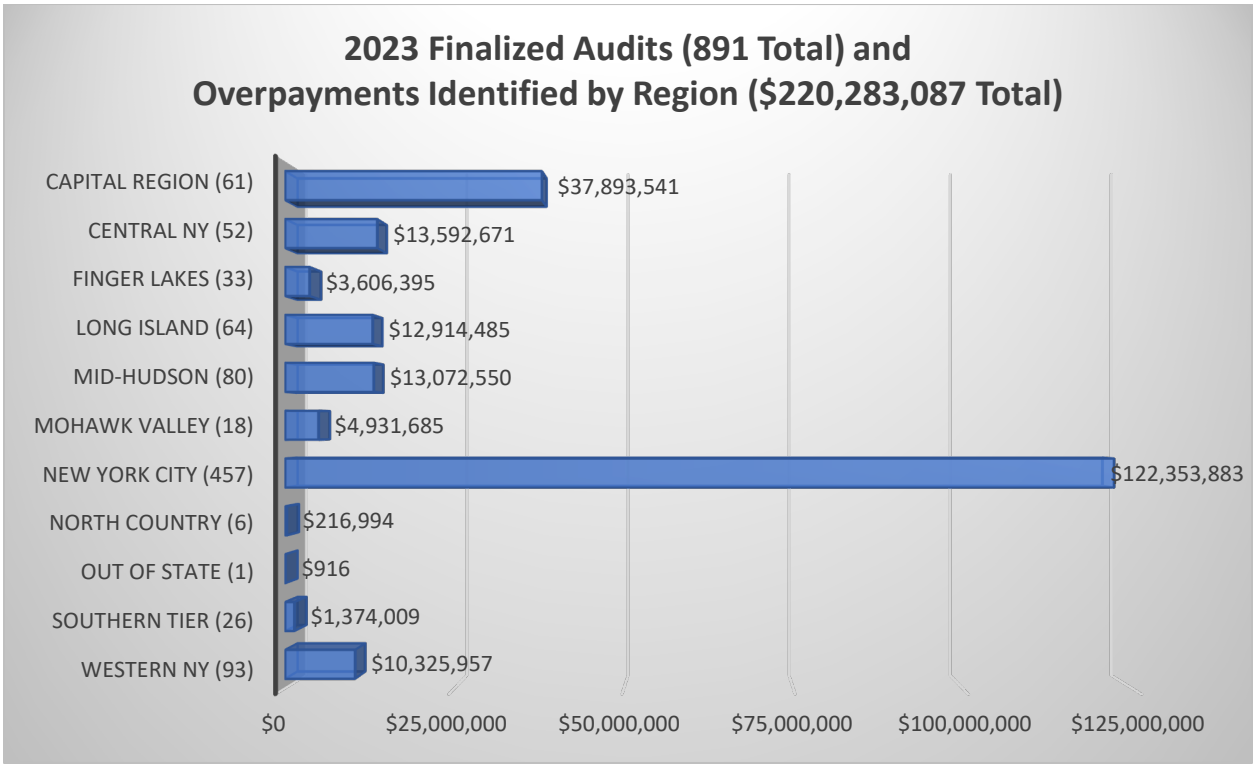
OMIG also continues to facilitate the exchange of Medicare data with CMS' Unified Program Integrity Contractor to enhance the RAC's ability to identify potential overpayments that would likely not be detected by reviewing Medicaid claims data alone.



Medicaid Audits

Medicaid Audits Overview

OMIG conducts audits of Medicaid expenditures across all provider and payor types, including MCOs, MLTCs, 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, to identify and resolve deficiencies, and to recover associated overpayments. Where appropriate, OMIG publishes protocols created in conjunction with the relevant State agencies and the provider community to ensure a common understanding and application of Medicaid requirements as part of the agency's audit procedures. 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 collaborative manner which fosters communication with providers throughout the engagement to successfully resolve disputes over potential findings. Providers are encouraged to submit documentation to support the appropriateness of claim payments. OMIG reviews the claims data along with all submitted supporting documentation to determine the appropriateness of the payments

received. Active provider participation and sharing of documentation helps facilitate the audit process and may assist to resolve audit findings and issues early in the process. Through the audit process, payments that are determined to be billed incorrectly and/or not supported by the required documentation – whether the documentation is missing, incomplete, or is otherwise not in compliance with Medicaid program requirements and guidance – are identified for recovery. In 2023, OMIG finalized 891 audits identifying overpayments of over $220 million.

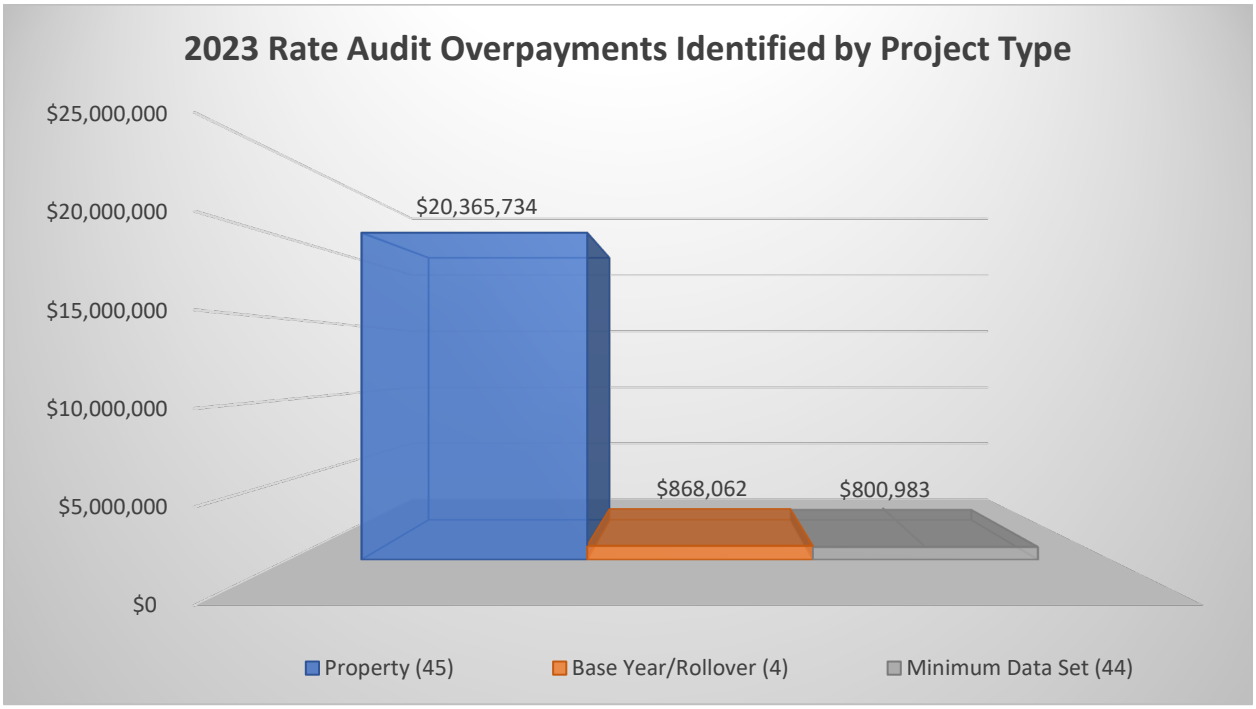
"Positive Audit Reports" – Demonstrations of Provider Compliance

The intent of OMIG's audits is to assess compliance with Medicaid program requirements and identify instances of non-compliance. During the audit process there are instances when OMIG determines that for the audit period and objectives reviewed, the provider has generally adhered to applicable Medicaid billing rules and regulations. In these cases, OMIG issues an Audit Summation Letter advising the provider that pursuant to 18 NYCRR §517.3(h), the audit is concluded and no further action is required by the provider. In 2023, OMIG issued 218 Audit Summations – which are posted on the OMIG website as "Positive Audit Reports" – and are indicative of provider compliance with Medicaid requirements in nearly 20% of completed audits.

Medicaid Policy – Loss of Records Due to Unforeseen Event

In the November 2023 *Medicaid Update*, OMIG published an updated policy pertaining to the loss of records due to an unforeseen event. This article included updated instructions on how to self-report damaged, lost, or stolen records; updated the time frame to report such situations; and added the inclusion of damaged, lost, or destroyed electronic records in this policy. OMIG issued this update based upon an increase in findings due to lost records that were not reported.

Rate Audit



Property and Provider Rate Audits

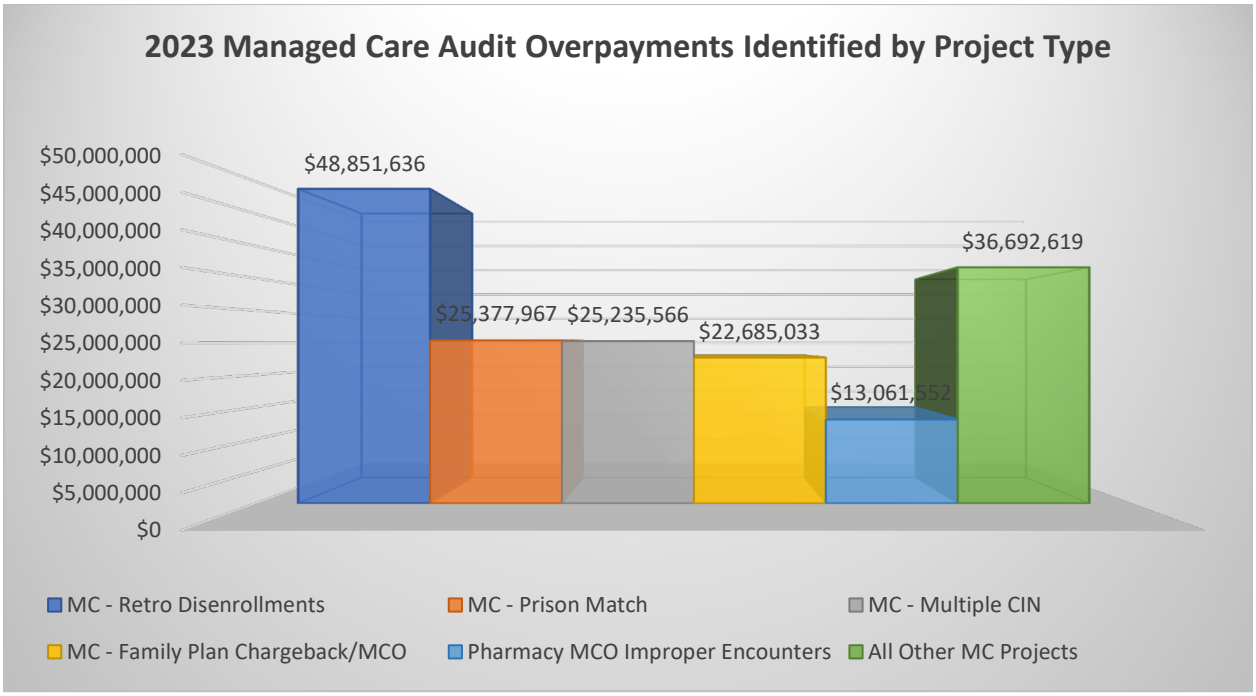
OMIG performs provider rate audits of Nursing Homes rates, related Adult Day Health Care (ADHC) rates and Traumatic Brain Injury (TBI) rates to enhance program integrity by ensuring only accurate and allowable costs are reimbursed. Unallowable or misstated costs reported to the State may artificially inflate the rate paid to that provider. OMIG conducts property component audits of nursing homes to verify reported capital costs are accurate, allowable, and substantiated. Property audits analyze and confirm the capital costs reimbursed in the property component of the rate.

Property audits can result in different disallowances stemming from various types of misstated or unallowable costs. For example, real estate taxes can be reimbursable, except if the real estate tax is for a piece of land that is not appropriate, or necessary and proper in developing and maintaining the operation and activities of the nursing home. In this situation a disallowance is considered necessary. In 2023, OMIG issued one audit summation, finalized 49 audits and notice of rate changes identifying overpayments and recovering more than $21.1 million.

Minimum Data Set Reviews

The Minimum Data Set (MDS) is part of a federally mandated process for clinical assessment of all residents in Medicaid and Medicare certified nursing homes. The process includes a comprehensive, standardized assessment of each resident's functional capabilities and health needs. OMIG conducts regular reviews of nursing homes to ensure the MDS data provided by the nursing homes is accurate. As part of these reviews, OMIG staff take a tour of the nursing home and conduct entrance conferences on-site. In 2023, OMIG issued 130 audit summations, finalized 44 audits identifying overpayments of more than $800,000, and recovered more than $1 million in this audit area. Of the 44 audits finalized, 17 audits found no fiscal impact to the nursing home's rate after completing the review of the MDS data reported by the nursing home for the period under review.

Managed Care Audit and Program Reviews



Family Planning Chargeback

Federal law states that a Medicaid recipient's access to family planning services cannot be restricted. As a result, Medicaid MC enrollees can go to any Medicaid provider, without a referral, regardless of whether the provider participates in their Medicaid MCOs provider network. The Managed Care/Family Health Plus/HIV Special Needs/Health and Recovery Plan Model Contract (Model Contract) includes a provision

that allows NYS to “charge back” any family planning services provided by out-of-network providers to the Medicaid MCO. OMIG regularly conducts a review to identify services eligible for the chargeback and works with the DOH and the Medicaid MCO to ensure funds are appropriately returned to NYS. The project includes coordination with the DOH to define the diagnostic and procedure codes to be included, data mining and analysis of claims housed in the MDW, and a detailed review of network provider contracts. In 2023, OMIG finalized 25 projects identifying overpayments of more than $22.6 million and recovered more than $18.1 million in this audit area.

Foster Care

Historically, children in agency-based foster care were ineligible to be enrolled in Medicaid MC. OMIG developed a substantive review that utilized data queries to identify children in agency-based foster care who inappropriately had remained enrolled in Medicaid MC. OMIG then identified inappropriate capitation payments paid to MCOs for these children. In many cases, when children were placed in agency-based foster care, they were assigned a new Client Identification Number (CIN), which OMIG ensured was addressed by its review by incorporating the identification and review of potential duplicate CIN into the project. Most of the recoveries in this project were associated with children assigned a new CIN; without this additional layer of review, significant payments would have remained unrecovered.

In July 2021, all children in agency-based foster care were mandated for enrollment in Medicaid MC. A description of this transition is included in the January 2021 *Medicaid Update*. In 2023, OMIG finalized 21 audits (for periods prior to mandatory enrollment) identifying overpayments and recovered more than $13 million.

Incarceration Match

When a Medicaid MC enrollee is incarcerated for an entire payment month, the capitation payment becomes eligible for recovery per the terms of the Model Contract. OMIG conducts a regular review of this recovery scenario. In February 2023, OMIG issued letters to the county jails across NYS, and used the information received to enhance the data provided by the DOH to identify incarcerated Medicaid recipients in county jails. OMIG staff then identify any capitation payments paid for members who were incarcerated for an entire payment month, and issue audit reports to the Medicaid MCOs. In 2023, OMIG finalized 55 audits identifying findings of more than $25.3 million and recovered more than $26.5 million in this audit area.

Managed Care Program Integrity Reviews

Managed Care Program Integrity Reviews are conducted to assess MCO's contractual performance as it relates to program integrity obligations under the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Contract. These reviews are limited to the program integrity obligations for Fraud and Abuse Prevention and Reporting Requirements. As there is concurrent oversight of Managed Care by other state oversight agencies, OMIG took steps to ensure prudent and appropriate coordination of efforts while conducting these reviews. In 2023, staff continued to perform MCPIR reviews, began development of 2023 reviews, and issued one Summation.

Managed Long-Term Care Eligibility Reviews

When a Medicare-eligible Medicaid recipient requires community-based long-term services and support, they are eligible to be enrolled in an MLTC which is responsible for coordinating the services and supports to meet the member's needs. This vulnerable population is often elderly and living with long-term, complex health needs. OMIG conducts regular reviews of MLTCs to identify instances where enrollees do not appear to be receiving the required services and supports. To accomplish this, OMIG staff utilize the MDW to identify periods where the encounter data does not demonstrate services having been provided to MLTC enrollees. OMIG then engages the MLTC and conducts an in-depth review of the records associated with the enrollees. In 2023, OMIG finalized four audits identifying overpayments of more than $5 million and recovered more than $8.8 million in this audit area.

Pharmacy MCO Improper Encounters

OMIG performs audits of claims for controlled substances to determine compliance with existing Medicaid regulations that require pharmacy providers to fill prescription orders of controlled substances within 30 days of being initiated by the prescriber. These audits ensure that programmatic payment will be made for controlled substances when appropriately authorized. OMIG conducted pharmacy claim validation audits of MCOs to verify providers have been adhering to this requirement. In 2023, OMIG finalized 40 audits of MCOs identifying overpayments of more than $13 million and recoveries of more than $15 million in this audit area.

PARIS Match

The Public Assistance Reporting Information System (PARIS) Match is a federal process that identifies individuals who are receiving public assistance in two or more

states. OMIG conducted a statewide, retrospective review that identified capitation payments paid for individuals who were listed on the report as receiving Medicaid in another state, but for whom eligibility staff had not attempted to recover the inappropriately paid capitation payments. To ensure the period of overlapping coverage was accurate, OMIG collaborated with CMS to use eligibility and summary-level claim data from the Transformed Medicaid Statistical Information System (T-MSIS) to assist with identifying the capitation payments eligible for recovery and shared the results of the audit with the team at CMS to demonstrate the positive outcome of the collaboration. In 2023, OMIG finalized 40 audits identifying overpayments of more than $12.5 million and recovered more than $12.6 million in this audit area.

Retroactive Disenrollment Project

When a Medicaid MC enrollee is no longer eligible for Medicaid MC per the terms of the relevant Model Contract, the enrollee's eligibility is adjusted. In most cases, those changes are prospective. In some cases, due to delays in notification, these adjustments are applied retroactively. The retroactive disenrollment project is a collaborative effort involving the DOH, the LDSS, and OMIG. This project identifies where members should be retroactively disenrolled from Medicaid MC and the associated capitation payments that are eligible for recovery. The LDSSs (inclusive of New York City – Human Resources Administration (NYC HRA) and NYSoH) notify the MCO and OMIG at the time of the retroactive disenrollment. OMIG stores the notifications received, provides semi-annual reports to the MCOs identifying the notifications already submitted and monitors to ensure they void capitation payments in a timely fashion. If the MCO fails to return inappropriately paid capitation payments in response to the notification, OMIG pursues the capitation payment for recovery via a follow-up audit. In 2023, OMIG finalized 245 audits identifying overpayments of more than $48.8 million and recovered more than $50.3 million in this audit area.

Collaboration with DOH on Managed Care Retroactive Recovery Scenarios

During the Public Health Emergency (PHE), the Families First Coronavirus Relief Act included a continuous enrollment provision designed to ensure Medicaid beneficiaries retained access to care during the PHE. Subsequent guidance issued by CMS permitted disenrollment from Medicaid MC for some scenarios. OMIG, in consultation with the DOH, resumed disenrollment-related recovery efforts from Medicaid MC for the following scenarios:

- Deceased Recipients,
- Incarcerated Recipients,

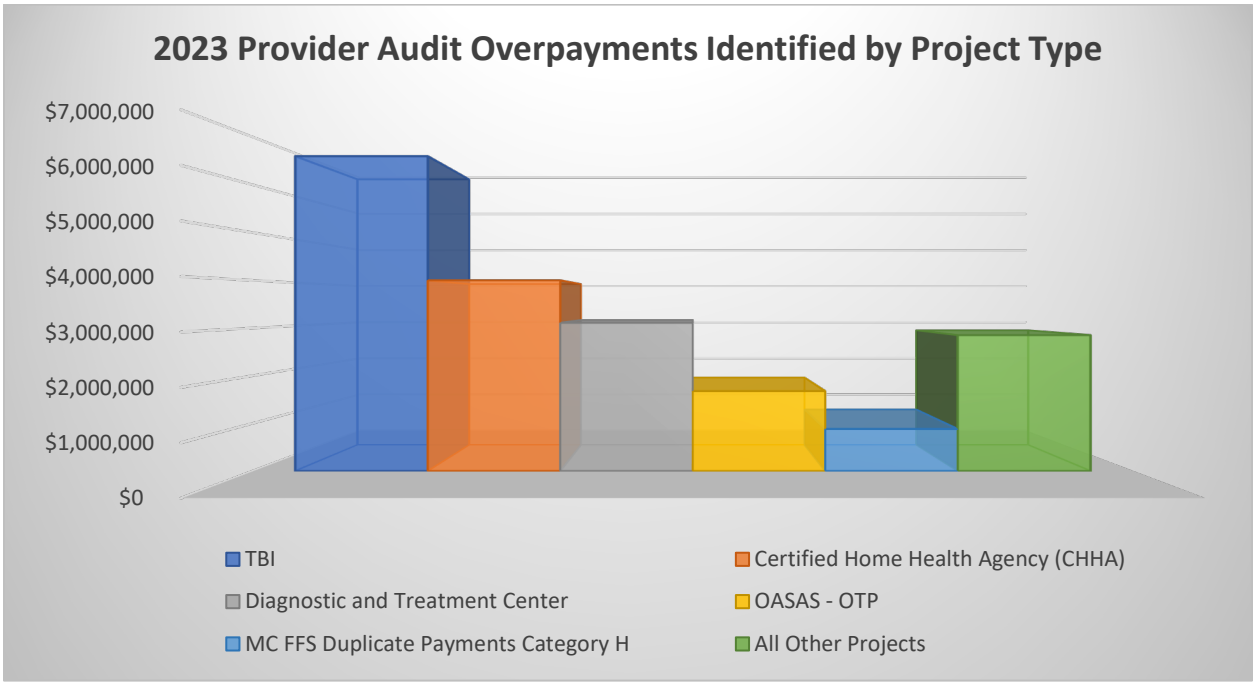
- ❖ Recipients with Multiple CINs, and
- ❖ Recipients no longer residing in NYS.

A number of smaller recovery scenarios included in the retroactive disenrollment process remained on hold until the commencement of the PHE unwind, at which time OMIG staff met with colleagues in DOH – Office of Health Insurance Programs (OHIP) regarding specific disenrollment scenarios for Mainstream MC and MLTC. OMIG confirmed the following scenarios were appropriate for retroactive recovery during the period of the PHE:

- ❖ Foster care,
- ❖ Residential Institution, Institutional Care Facility or in Receipt of Waiver Services,
- ❖ Non-consensual enrollment,
- ❖ Institution for Mental Disease,
- ❖ Third Party Commercial Health Coverage,
- ❖ Absent from the MLTCs service area for more than 30 days, and
- ❖ No Longer Resides in the MLTCs Service Area or NYS.

Following those meetings, OMIG staff updated the retroactive disenrollment project guidelines to include these scenarios going forward in keeping with the guidance provided by DOH.

Managed Care Network Provider & Fee-for-Service Review



Extrapolation

Extrapolation is a federally-conforming audit technique – used to minimize the administrative burden on providers and disruption of operations associated with a claim-by-claim review -- which tests a sample of claims against audit criteria and statistically projects the results across a defined universe. The universe of claims is a set of claims or encounters for a specified period of time and a specific set of services claimed/reported. The sample of claims is reflective of the universe and the error rate is statistically applied to the universe.

OMIG provides, early on in the engagement with the provider, comprehensive, detailed information about the audit, in particular the methodology planned for the review, documentation requirements, scope, and workflow. This collaborative approach promotes transparency, enhanced understanding and greater efficiency. OMIG then provides the universe and sample data at the exit conference along with the documentation for findings in support of the extrapolation.

OMIG's use of extrapolation and methods are overseen and certified by an independent statistical consultant and is subject to challenge and scrutiny as part of an administrative hearing and/or judicial review. When challenged, OMIG's use of extrapolation has been consistently upheld.

As part of its mission to enhance the integrity of the Medicaid program, in 2023 OMIG finalized audits utilizing extrapolation that examined over $1.8 billion in Medicaid reimbursement for FFS claims. Of this universe OMIG identified overpayments of $28 million, with an error rate of approximately 1.6%. This is down from a 4% error rate in the prior year.

Assisted Living Program

OMIG continued auditing the Assisted Living Program in 2023. OMIG meets with DOH and actively discusses audits and statewide issues in this area in a cooperative attempt to ensure patient safety and program integrity. 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. OMIG has continued to find that providers lack required documentation and authorizing documents in this program. The audits that were finalized in 2023 found 71% (617) of the errors related to personnel and training issues – these were not extrapolated – while 29% (255) of the errors were extrapolated. In 2023, OMIG issued one audit summation

and finalized three audits, identifying overpayments of more than $625,000 and recovered more than $3.4 million in this audit area.

Individualized Residential Alternatives Residential Habilitation Services

OPWDD Individualized Residential Alternatives Residential Services are offered at programs licensed by OPWDD through a home and community-based services (HCBS) Federal waiver program, established under the authority of section 1915 (c) of the Social Security Act. The intent of home and community-based waiver services is to create an individualized service environment that is consistent with meeting the person's needs, preferences and personal goals, and to provide the supports or services necessary to enable a person with a developmental disability to live, work, socialize and participate in the community. Each support or service is expected to contribute to the person's current or future capacity for self-determination, integration within the community, independence and productivity. In 2023, OMIG issued seven summations and finalized 13 audits that identified overpayments of more than $713,000 which were recovered in full. Common findings were as follows:

- Missing (Extrapolated) or Incomplete (Non-Extrapolated) Service Documentation
- Missing Monthly Summary Notes (Extrapolated)
- Missing (Extrapolated) or Incomplete (Non-Extrapolated) Habilitation Plans

OPWDD Home and Community Based Services Waiver Services

As outlined in OPWDD's HCBS waiver, OMIG and OPWDD collaborate on annual audit planning and coordination of potential Medicaid recoveries identified through OPWDD audits. OMIG works closely with OPWDD's Office of Audit Services who performs audits covering all OPWDD HCBS waiver services, including large and small programs geographically dispersed throughout the state. In 2023, OMIG issued 25 HCBS waiver service audits performed by OPWDD, identifying overpayments of more than $5.9 million and recovered more than $5.4 million. Common findings were as follows:

- Missing Service Documentation (Extrapolated)
- Missing Habilitation Plan (Extrapolated)
- Improper Billing (Extrapolated)

Traumatic Brain Injury Services

Traumatic Brain Injury (TBI) services fall within the HCBS Medicaid Waiver Program (HCBS). The waiver program is a federally approved initiative that allows for specific services that are not included in the State Medicaid Plan to be provided to individuals with a TBI that meet the eligibility criteria. The purpose of the program is to help persons with a TBI live in the community setting of their choice. The TBI program provides 11 Medicaid-funded services needed to assist participants to live in community-based settings and achieve maximum independence. Services include but are not limited to the following: Service Coordination, Independent Living Skills Training, Structured Day Programs, and Home and Community Support Services. OMIG finalized one audit identifying overpayments of more than $6.5 million which had findings such as:

- Failure to Obtain Authorized Practitioner's Signature Within Required Time Frame (Extrapolated),
- Billed More Hours than Documented (Extrapolated), and
- Overlapping of Services Not Authorized in Service Plan (Extrapolated).

OMIG recovered more than $1.6 million in this audit area in 2023.

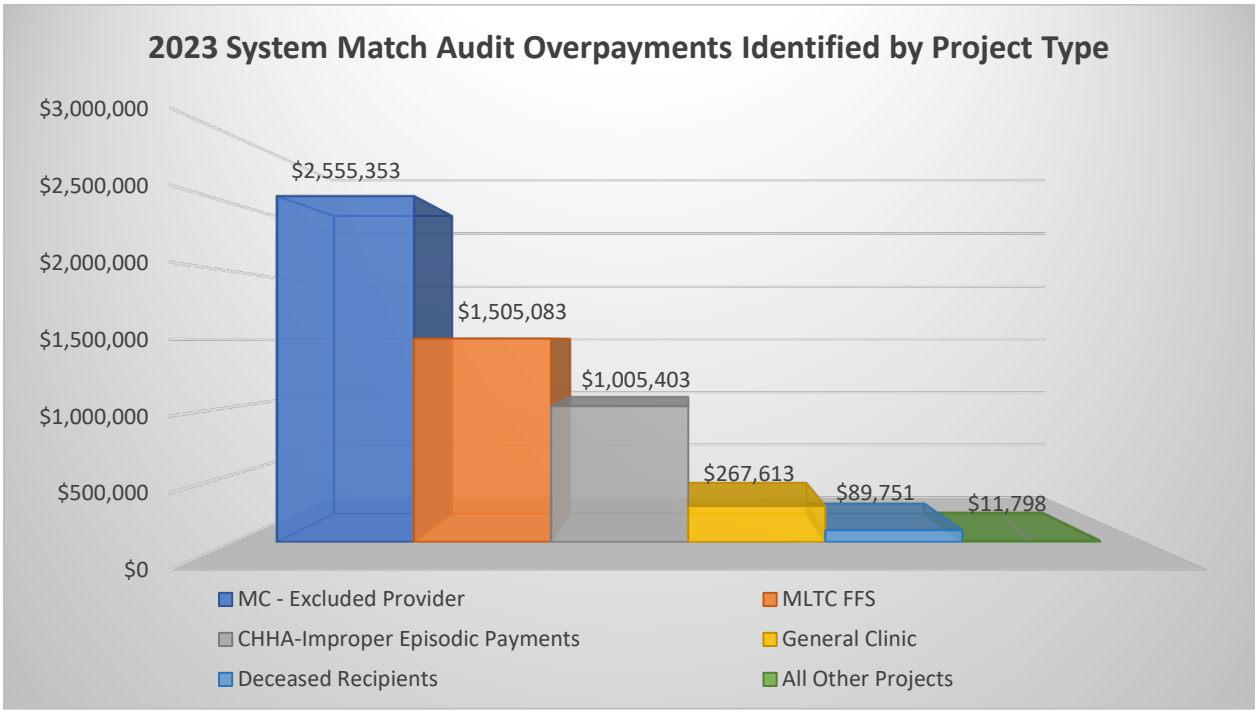
Personal Care Aide Services

Personal care aide services (PCA) are home care services provided to recipients, allowing them to stay in their own homes and communities. These services include providing individuals with partial or total assistance with personal hygiene, dressing and feeding, nutritional and environmental support functions, and other health-related tasks. OMIG conducted audits of PCA providers and had findings such as:

- Failure to Complete Annual In-Home Visit (Not Extrapolated),
- PCA Worker Not Present at Nursing Supervision Visit (Extrapolated), and
- Missing Certificate of Immunization for the aide (Not Extrapolated).

In 2023, OMIG issued one audit summation, finalized 10 audits identifying overpayments of more than $470,000 and recovered more than $1.2 million in this audit area.

System Match and Recovery



System Match and Recovery Audits are conducted to identify potentially inappropriate provider claiming patterns. Data analysis of paid claim data sets is performed to identify non-compliance 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. During the audit process, OMIG educates providers to improve their compliance with Medicaid billing rules to reduce future claim errors. In 2023, OMIG finalized 77 audits identifying overpayments of more than $5.4 million and recovered more than $5.7 million in this audit area.

Examples of these audits include:

- The Excluded Provider project determined if participating and/or non-participating providers who were excluded from participation with the NYS Medicaid program were permitted by an MCO to participate in any activity related to furnishing medical care, services, or supplies for which costs were reported to the State. In 2023, OMIG finalized 26 audits identifying overpayments of more than $2.5 million which were recovered in full.

- The Certified Home Health Agency Improper Episodic Payments audit reviewed claims paid to certified home health agencies for home care services billed under the episodic payment system, which are based on 60-day episodes of

care, instead of fee-for-service. Claims receiving full episodic payments due to improper use of discharge codes and instances of multiple episodic payments, for the same recipient within 60 days, were identified. In 2023, OMIG finalized 30 audits identifying overpayments of more than $1 million and recovered over $960,000 in this audit area.

Electronic Health Records Incentive Payment Program

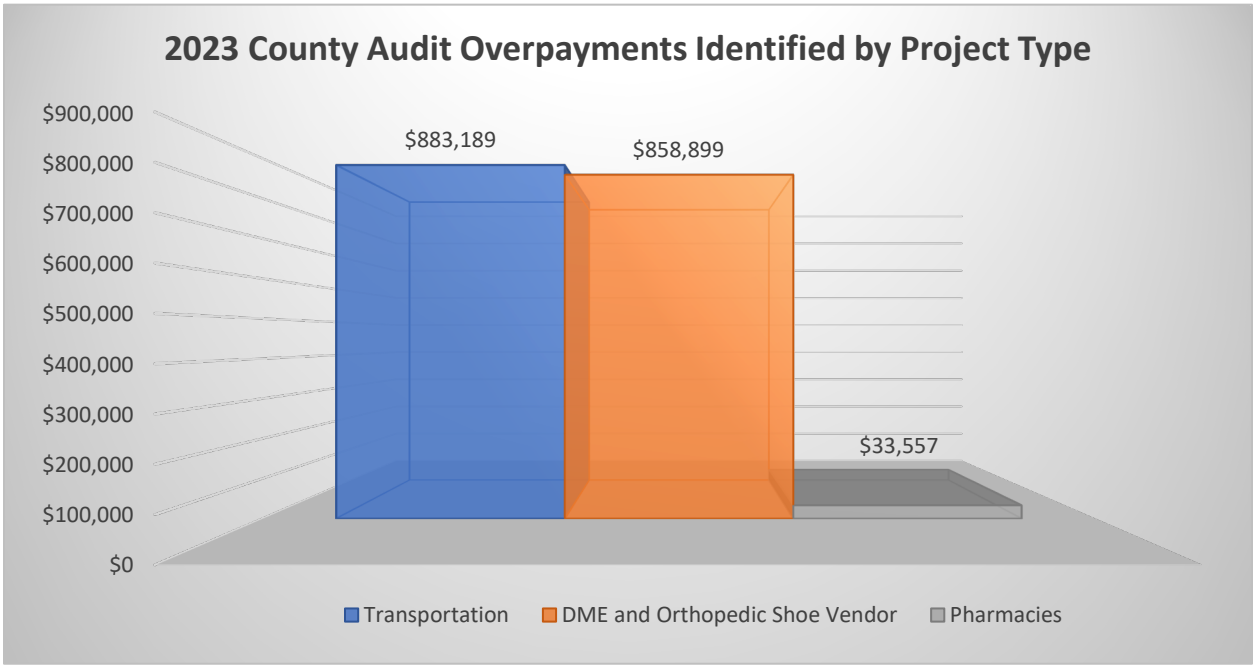
In 2009, the United States Congress included provisions in the American Recovery and Reinvestment Act allocating approximately $19 billion in federal incentives to eligible Medicaid providers and hospitals for the adoption and meaningful use of certified electronic health record technology. With CMS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

To have received an incentive payment in NYS, providers attested to their eligibility through DOH's online portal known as the Medicaid EHR Incentive Program Administrative Support Service. For a provider's first year of the program, they had to attest to the adoption, implementation, or upgrade of an EHR system certified by the Office of the National Coordinator for Health Information Technology. For subsequent years in the program, providers had to attest to meaningful use of a certified EHR system by meeting federal objectives and requirements.

The NY Medicaid EHR Incentive Program paid incentives from 2011 through the end of 2021. Where paid providers were determined ineligible for the incentive, OMIG recouped the funds and repaid the federal government at 100% federal share.
To meet its audit objectives, OMIG worked closely with program stakeholders, such as DOH, the Regional Extension Centers – NYC Regional Electronic Adoption Center for Health, New York eHealth Collaborative, as well as with program staff from other states and CMS. In 2023, OMIG issued 54 audit summations, finalized 54 audits identifying overpayments of more than $240,000 and recovered more than $480,000 in this audit area. In accordance with a CMS-approved audit strategy, OMIG's post-payment audits of providers receiving the incentive payments continued through the end of the federal fiscal year 2023. OMIG has since concluded its audit activities in this area.

County Demonstration

The Medicaid County Demonstration Program was implemented in 2006 and is a partnership between OMIG, NYS counties, and NYC to identify provider overpayments. Participating counties can recoup 40% 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 2023, OMIG issued 2 summations, finalized 10 audits identifying overpayments of more than $1.7 million and recovered more than $5 million in this audit area.



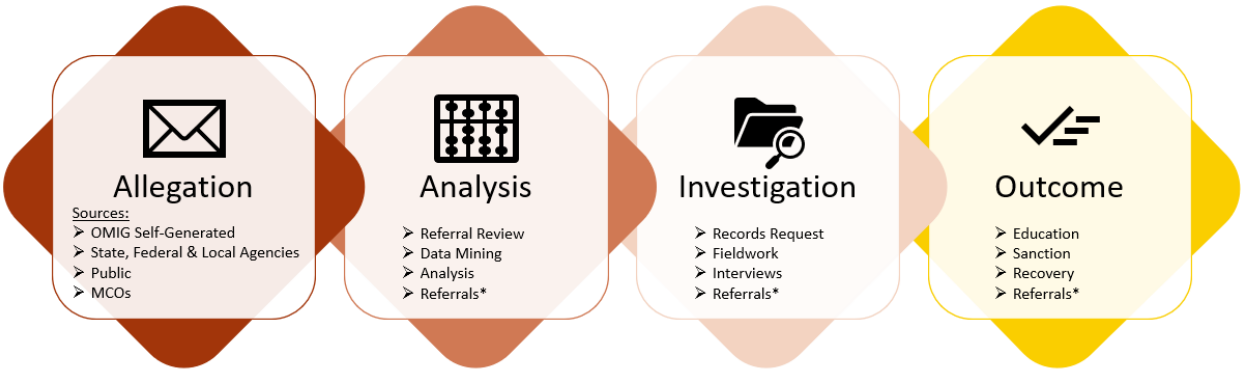
Home Health Care Medicare Maximization

To ensure that NYS Medicaid remains the payor of last resort, OMIG contracts with the University of Massachusetts Chan Medical School (UMass) to perform a Medicare Home Health Appeals Initiative. Under this initiative, providers are directed to demand bill Medicare for home health care services rendered to dual eligible Medicare/Medicaid beneficiaries that have previously been paid by Medicaid. UMass pursues coverage for Medicare payment denials via the federal Medicare appeals process. Provider audits are initiated in instances where providers fail to comply with demand billing requirements or fail to reimburse NYS Medicaid as directed, after Medicare has remitted payment. During 2023 these activities resulted in recoveries of more than $2 million.

Medicaid Investigations

395 Exclusions	655 Referrals Including 241 Referrals to MFCU
3,666 Allegations Received	2,022 Investigations Completed
231 Pre-Payment Reviews	60,000 Explanation of Medical Benefits Mailed Out

Investigation Cycle

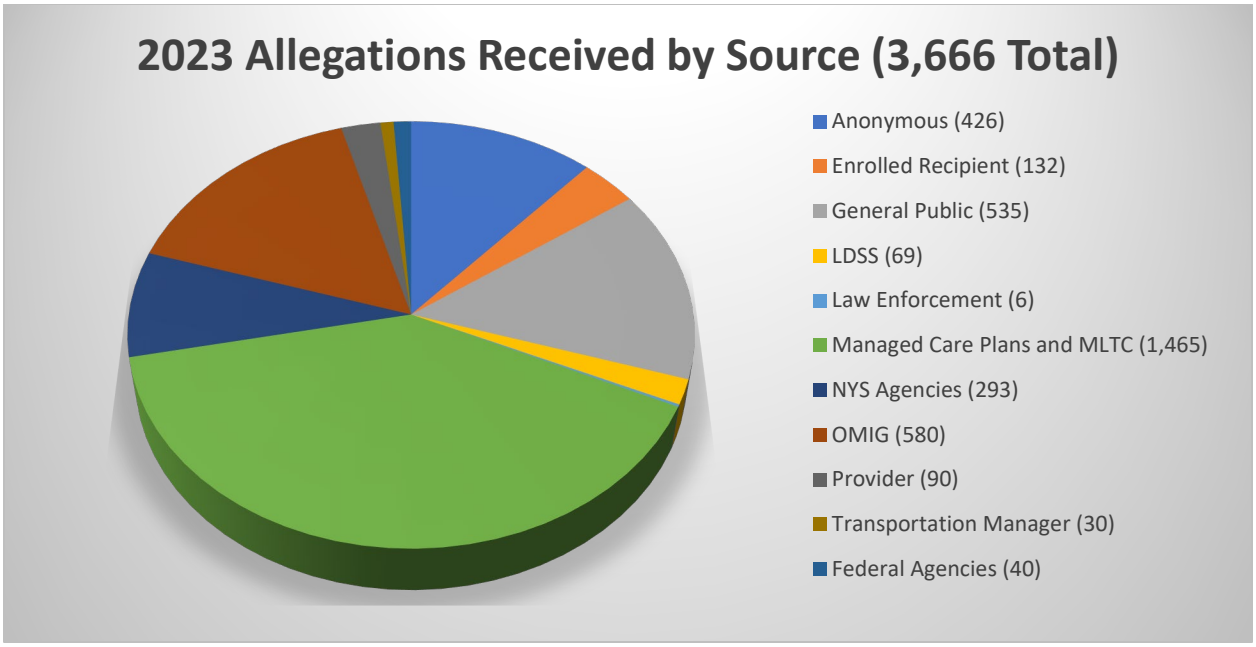


* Including to MFCU (for criminal or civil discoveries) or other courts of appropriate jurisdiction for criminal and civil actions.

Allegations

OMIG reviews all allegations received for potential Medicaid fraud, waste, and abuse. These allegations can be self-generated through data analysis performed by OMIG, or received from a variety of sources including federal, state, and local law enforcement and governmental agencies, MCOs, MLTCs, providers, Medicaid recipients, and the general public. Allegations can be submitted by calling the Medicaid Fraud Hotline or by submitting an allegation by either OMIG's online Medicaid Fraud Allegation link located on OMIG's website or by submitting a hard copy form to OMIG via mail or fax.

In 2023, OMIG received 3,666 allegations, the majority of which were received from MCOs, and over 15% were self-generated by subject matter experts within OMIG. Of these allegations,1,419 were advanced for investigation in 2023. While OMIG receives many allegations, not all provide sufficient information to support further investigation – so they are closed – or, if they are not related to Medicaid, are referred to the appropriate law enforcement or governmental agency.



Analysis

OMIG conducts an initial analysis on allegations received that includes a review of relevant claims data. A review is also conducted of the subject and includes a look at any past or current open cases, previous referrals, and/or past disciplinary actions. When the initial analysis indicates potential harm to an individual or a public safety issue a referral is made immediately for appropriate action.

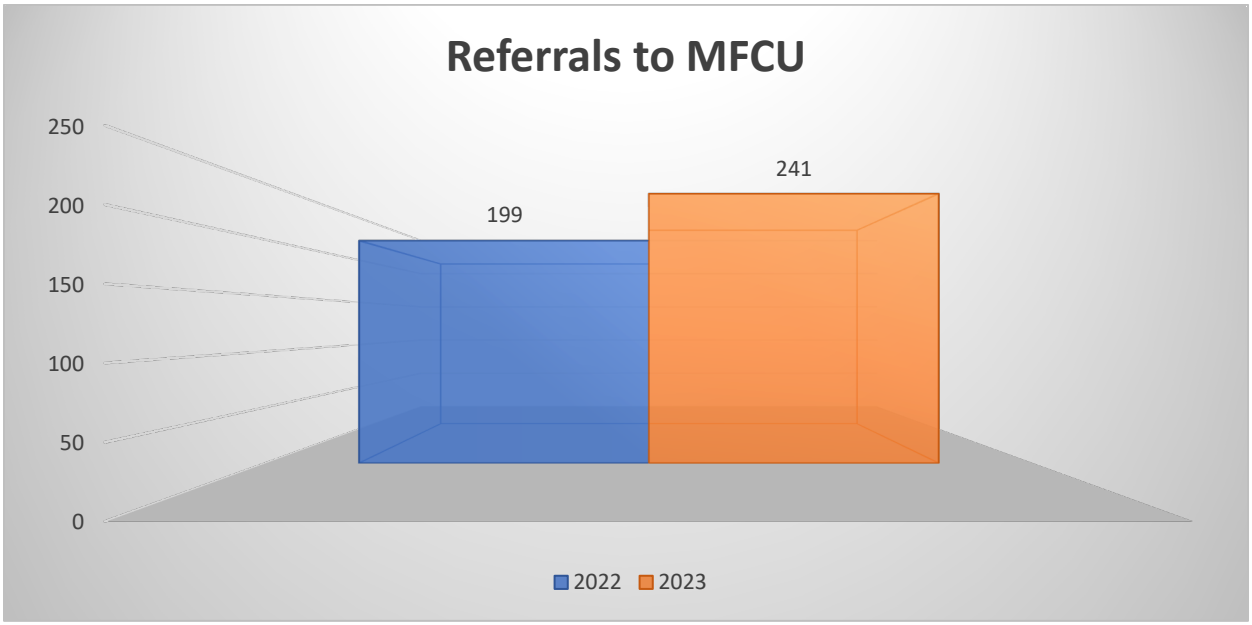
Referrals

OMIG maintains close connections to other federal and state governmental and law enforcement agencies to leverage enforcement resources and maximize joint enforcement capabilities. These relationships position OMIG to participate in joint investigations and to refer matters unrelated to OMIG's mission to the appropriate governmental entity to address the identified deficiency. In 2023, OMIG made 414 referrals to other governmental agencies and appropriate entities for further action. Not surprisingly given OMIG's oversight of Medicaid payors and providers, most of these referrals were to DOH (234).

OMIG does not have prosecutorial authority and is required to refer all credible allegations and identified instances of fraud to MFCU. OMIG works closely with MFCU during the initial investigation to identify possible additional referrals, provides a comprehensive referral and provides additional support necessary to support the prosecution of the alleged fraud. In 2023, OMIG referred 241 cases to MFCU for further

investigation or prosecution, a 21% increase from 2022. The top five referrals by type were: Transportation (59), Pharmacy (29), Physician (23), Nurse (21), and Recipient (15).

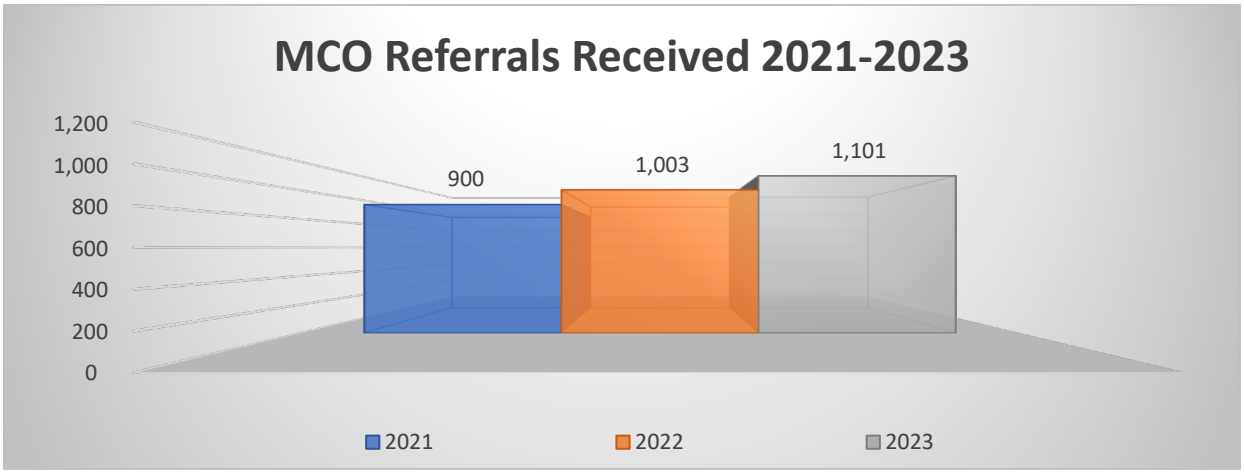
When OMIG submits a referral to MFCU, MFCU can accept the referral for prosecution or reject the referral. When the referral is accepted, OMIG continues to receive updates on the referral. When the referral is rejected, the allegation is then analyzed to determine if OMIG will continue to actively investigate.



Managed Care Referrals

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 special investigation units (SIU) and/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 managed care contracts. 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. As a result of the assessment, OMIG notifies the MCO of its determination regarding the referral and provides clearance for the MCO to recover identified overpayments where appropriate.

In 2023, OMIG received 1,101 referrals supporting OMIG's ability to pursue fraud, waste, and abuse based upon these referrals. This reflects a 10% increase in referrals from MCOs from 2022.



*MCO referrals indicate a single referral made by an MCO and may include multiple subjects as part of the Fraud, Waste, and Abuse (FWA) referral.

In January 2023, OMIG published guidance titled "Medicaid Managed Care Fraud, Waste and Abuse Prevention Programs" and implemented minimum staffing levels, minimum Medicaid claim auditing parameters, and additional reporting related to potential fraud, waste, and abuse referrals for SIU's. These changes are expected to strengthen the identification and prevention of Medicaid fraud, waste, and abuse across managed care networks.

OMIG also meets regularly with MCO SIU members to discuss and collaborate on matter of mutual interest including contractual requirements, program integrity concerns and fraud referrals.

Provider Investigations

Provider investigations proceed from allegations, impermissible practices, or substantial deviations from established Medicaid requirements. Provider investigations are advanced and supported using a team approach that includes data analysis, comprehensive medical record reviews, clinical peer reviews – conducted by a cadre of doctors, dentists, hygienists, nurses and pharmacists – and specialized investigative techniques developed to identify inappropriate behavior, Medicaid claims and payments. The duration of provider investigations can vary based upon the complexity and level of interaction with federal, state, local law enforcement and governmental agencies as OMIG strives to advance cases presenting the best enforcement potential. The conclusion of a provider investigation can result in a criminal sanction, exclusion from

the Medicaid program, a censure, recovery of Medicaid overpayment, or other administrative actions.

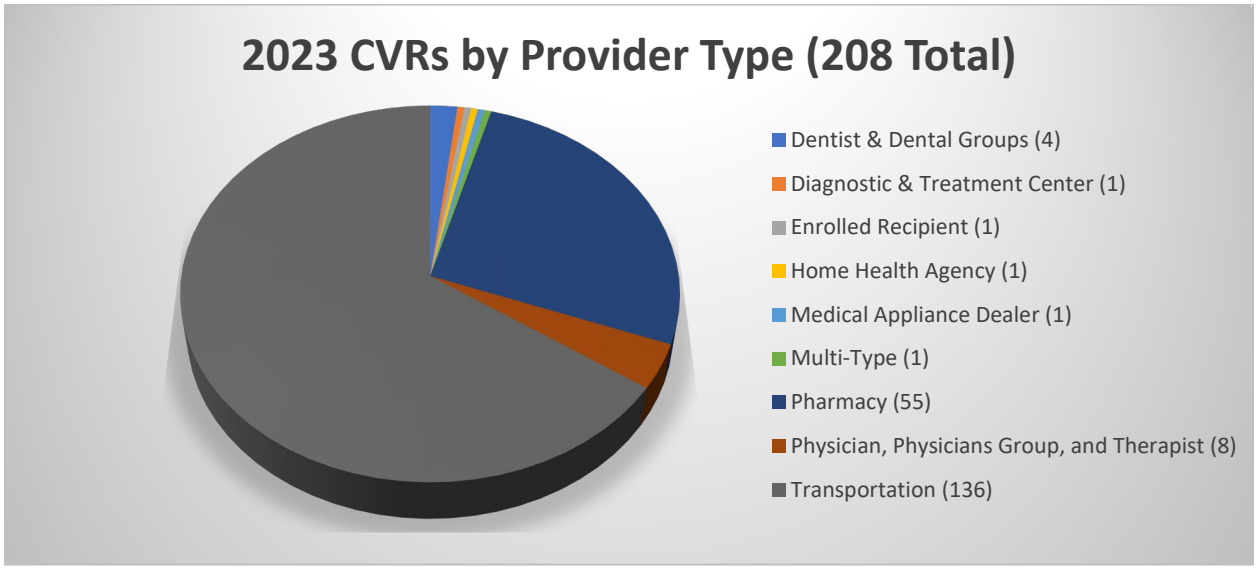
Of the 2,022 investigations completed in 2023, 1,029 were provider related investigations. These investigations largely encompassed the following provider types: transportation, pharmacy, physician, home health, and dental.

Investigative Techniques

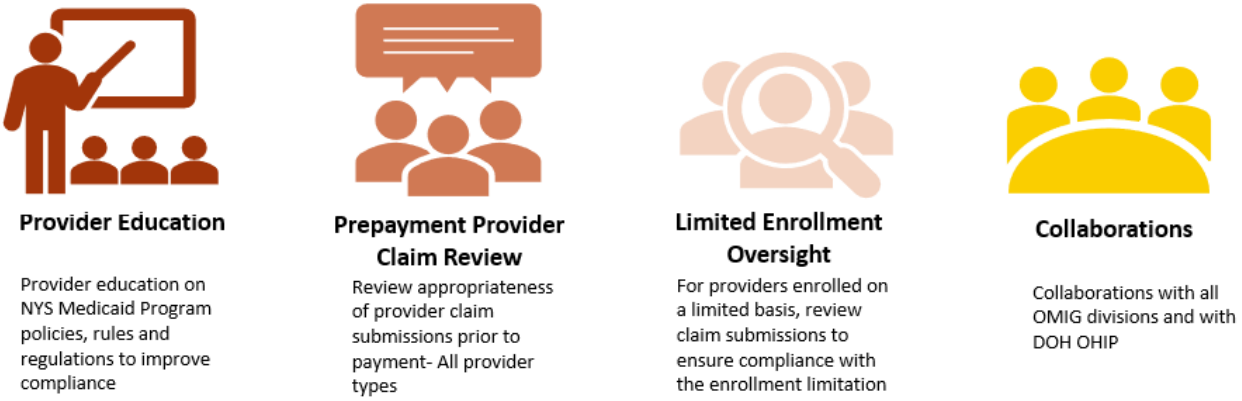
In addition to the more commonly known investigative techniques, OMIG employs a variety of specialized investigative techniques that are unique to its Medicaid program integrity mandate to educate providers on program requirements, collect evidence, advance investigations or enforce improved compliance. The most common techniques are:

- **Credential Verification Reviews (CVRs)**

  OMIG investigative staff routinely conduct on-site Credential Verification reviews to gather and verify information on staff credentials and training requirements, service delivery, the storage of pharmaceuticals and medical supplies, the physical layout of the business, record keeping protocols, and Medicaid claiming practices, all of which is utilized to determine compliance with Medicaid requirements. This process facilitates provider education and improving provider compliance with the rules and regulations of the NYS Medicaid program. In 2023 OMIG performed 208 CVRs, a 34% increase from 2022. With the transition of pharmacy from MC to FFS, pharmacy CVRs increased by 57% in 2023.



❖ Pre-Payment Review



Where OMIG identifies an aberrant claiming pattern, OMIG may initiate a pre-payment review process to both educate the provider on the procedural billing error and correct claiming on a prospective basis. Issues typically addressed include:

- Billing beyond the scope of enrollment.
- Illegible, missing, or incorrect documentation.
- Inappropriate combinations of procedures.
- Billing for services that were not performed.

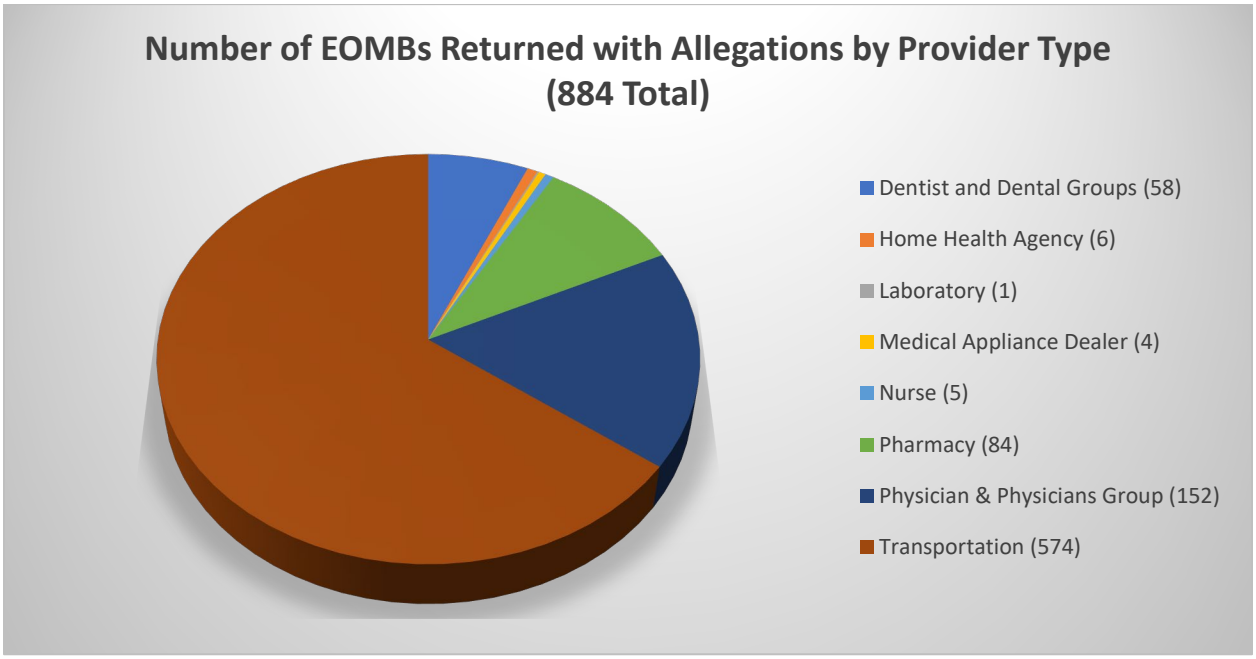
The pre-payment review process pends claims for a review to identify their compliance with Medicaid guidelines prior to payment. This process requires close collaboration between OMIG and the impacted provider to ensure that appropriate payments are made timely. This is a particularly effective strategy for smaller providers or new entrants to the Medicaid program. In 2023, OMIG conducted 231 pre-payment reviews. This largely included pharmacy, transportation, and Durable Medical Equipment providers.

❖ Explanation of Medical (Medicaid) Benefits

Explanation of Medical (Medicaid) Benefits (EOMBs) are used to communicate with recipients about the care they are receiving and to ensure that they are receiving the services NYS Medicaid is paying for based on claims submitted by their providers. EOMBs both fulfill this federal mandate, and also serve as a valuable tool to detect potential instances of fraud, waste, and abuse identified through internal data analytics. OMIG uses data analytics to identify possible subjects and generates EOMBs for recipients who may have obtained services from providers who appear as outliers due to the number and types of claims

they are submitting. Data analytics is also performed to target specific fraud schemes.

In 2023, OMIG generated 60,000 EOMBs across multiple provider categories. Of the 4,549 EOMBs returned by recipients to OMIG, 884 recipients reported not receiving services, or had concerns with the services billed. These allegations led to OMIG initiating or supporting 177 investigations.

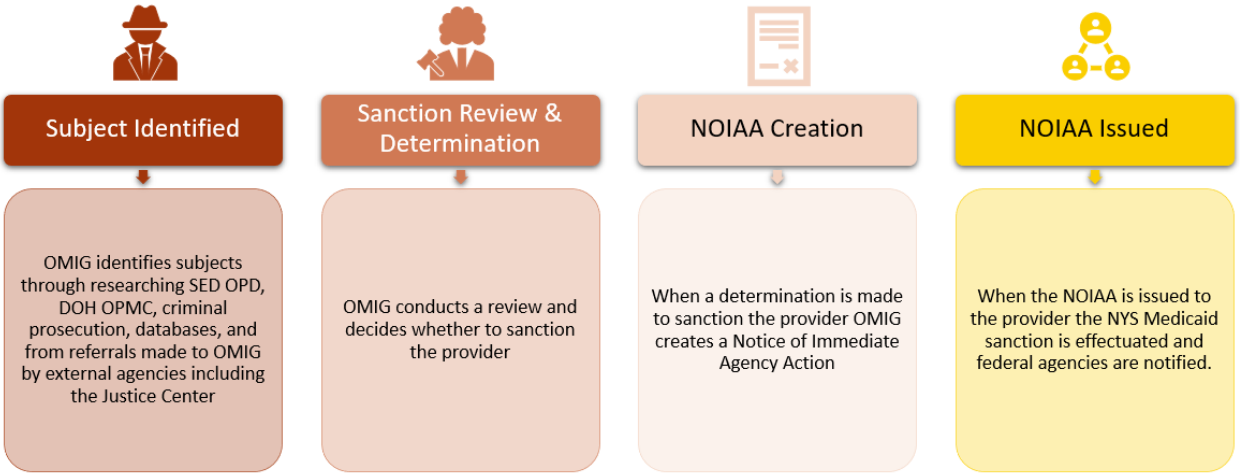


In addition to sending out EOMBs in support of investigations and based on allegations received from the public, EOMBs were sent out for the following outliers:

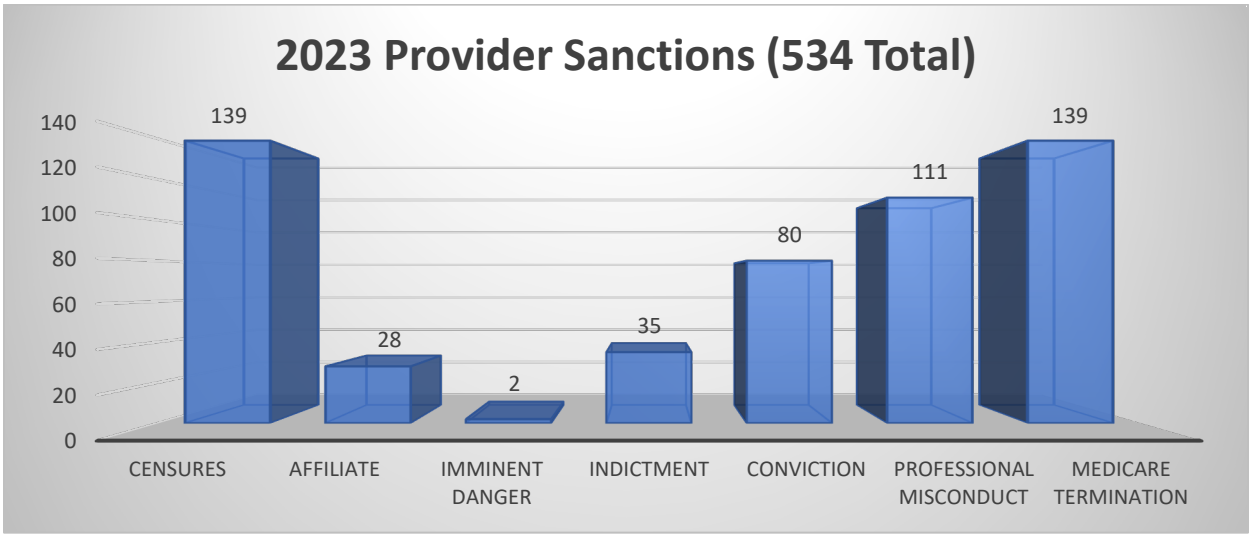
- Providers with a high number of telehealth services,
- Pharmacies billing high-cost medications,
- Transportation services billed without any corresponding medical service,
- Patients of dentists identified as top billers in NYS,
- Patients receiving Ozempic and Trulicity without diabetes diagnoses, and
- Pharmacies billing higher than average amounts of COVID test kits.

Administrative Remedies

OMIG is responsible for identifying providers who may qualify for immediate sanction by the NYS Medicaid program and effectuating those sanctions. These actions protect NYS Medicaid recipients, ensuring recipients receive quality care from providers, and also ensures the integrity of the NYS Medicaid program.



In 2023, OMIG issued 534 sanctions, including 395 exclusions from the Medicaid program.



Medical Transportation Investigations

- In 2023, DOH contracted with Medical Answering Services LLC (MAS) for non-emergency medical transportation (NEMT) brokerage services. This expanded MAS involvement in NEMT from upstate to include downstate New York. The broker model also expanded MAS responsibilities to include, among other things, establishing a network of transportation providers. The change in the transportation landscape resulted in an increased focus on transportation providers which led to 205 pre-payment reviews, saving the Medicaid program more than $4.9 million, an increase of 21% from 2022.

- OMIG investigations identified that transportation providers who received prior authorization to be reimbursed for toll costs up to $50 have been consistently submitting claim forms for a $50 reimbursement, regardless of the actual amount paid for the tolls. OMIG submitted a request to DOH focused on improving the efficiency and accessibility of essential information from transportation claims for prepayment review. The amount charged/submitted field on the form should contain the actual amount charged for these tolls. The dropdown menu in eMedNY is essential for OMIG's prepayment review unit to build criteria for reviewing claims. The option to include the actual amount charged/submitted did not exist in the dropdown menu, therefore, the process of reviewing these claims was less efficient and required the use of queries to complete the review. To prevent these amounts from being automatically paid, OMIG requested that the dropdown menu in eMedNY be expanded to include the amount charged/submitted field. This project was completed in 2024.

Case Files: EOMB

- EOMBs were sent for a transportation provider referred to OMIG by MAS based on data analysis indicating the provider was an outlier in billing patterns. OMIG received 22 EOMBs from recipients alleging the following:

    - not receiving the trips,
    - not recognizing the transportation company,
    - not having medical appointments on the day of service,
    - not being picked up because of rain, and
    - receiving services from a different company than the one billing for the transportation.

  This case is currently under active investigation.

Pharmacy Investigations

The transition of pharmacy to FFS has also had an impact on the increasing number of fraud, waste, and abuse referrals/complaints. Referrals received involving pharmacy subjects increased 10% from 2022. OMIG coordinates investigative actions with pharmacists, MFCU, and the NYS Education Department Office of Professional Discipline (OPD) to effectively address these complaints.

OMIG conducted 12 pharmacy enrollment on-site inspections, resulting in five enrollments being approved, and seven enrollments being denied, two of which were referred to agencies including NYS OPD, NYS Office of Special Narcotics Prosecutor, NYS Bureau of Narcotic Enforcement (BNE).

Case Files: Pharmacy

- In January 2023, OMIG staff assisted in an investigation, resulting in the issuance of a Notice of Immediate Agency Action for a pharmacy. The pharmacy was found on multiple occasions to be operating a pharmacy without a licensed pharmacist and was excluded from the Medicaid program.

- In July 2023, the NYS Attorney General announced the indictment, arrest, and arraignment of Juan Poveda, the owner of CSE Drug Corp dba Santiago Pharmacy, and Javier Burbano, the pharmacy's manager. Poveda and Burbano were allegedly involved in a $2.9 million Medicaid fraud scheme to pay kickbacks to NYS Medicaid recipients in exchange for filling their HIV medications at the pharmacy, as well as submitting false claims for HIV medications. OMIG assisted MFCU in executing search warrants at Corona Chemist Pharmacy and Mi Botica Pharmacy, as well as providing grand jury testimony as a subject matter witness for the case. Please see this link for the AG's press release acknowledging OMIG's participation.

Case File: Enrollment

- A Bronx pharmacy applied for enrollment into the Medicaid Program. As part of the enrollment review, OMIG staff conducted an on-site and uncovered numerous violations of NYS pharmacy regulations, and the pharmacy was denied enrollment on May 26, 2023.

  During this on-site, investigators found the pharmacy to be unsanitary, the sink to be clogged, 80 expired drugs were discovered on the active shelves of the pharmacy for sale and not quarantined, and four controlled substance

prescriptions were in the pickup bin more than 14 days since the date the prescription was billed and/or filled.

The supervising pharmacist was interviewed during the on-site and stated that Schedule II Controlled Substances, such as Oxycodone, were sold to customers for cash in the amounts of $30 to $550 per prescription, while the rest of the non-controlled prescriptions were given to the customer for free. Additionally, the supervising pharmacist was unable to provide investigators with signature logs acknowledging receipt of the Schedule II controlled prescriptions sold for cash.

OMIG staff also made referrals to NYS OPD, DOH's BNE, and the Office of the Special Prosecutor of New York based on the violations of NYS pharmacy policy observed during the on-site. In addition, the Medicaid recipients who paid cash for oxycodone were referred to RRP for restriction review.

Cost Savings: Compound Prescriptions

- OMIG staff identified that the payment system's current compound payment process was not taking the ingredient cost into account, and that the brand name versus generic pricing was not working as expected, resulting in possible overpayments. OMIG collaborated with DOH to finalize a system change to improve the prescription compound payment logic. This project introduced a new payment logic that considers the brand versus generic pricing along with the pharmacy submitted cost at the ingredient level when determining the payment. The improved compound payment logic system project was implemented in March 2023. Implementation of this project coincided with the NYRx pharmacy benefit transition where all MC outpatient prescriptions, including compounds, would be processed through the FFS NYRx program. The FFS three-year average (2019-2021) payment per compound claim was $193.04. Claims analysis post the system change implementation showed an average payment per compound claim of $99.11, a difference of $93.93 per claim.

  After the pharmacy benefit transition went into effect, a total of 185,480 compound claims were paid totaling more than $18.3 million, rather than the $38.5 million that would have been paid if the payment logic had not been updated. Using the estimated cost avoidance of $93.93 per claim, this project saved the Medicaid program more than $17.4 million. Due to the logic being implemented this was a onetime cost savings as this will only happen in the year the transition from MC to NYRx took place.

Pharmacy CVRs

- OMIG began an engagement initiative with pharmacy providers statewide following the NYRx transition. OMIG staff began conducting standard CVRs in the Albany and NYC regions. The pharmacy CVR process includes checking for prescriptions billed but not furnished within 14 days, as required by NYS Medicaid pharmacy policy. Pharmacies are expected to reverse those prescription claims. Historically, the reversal amounts were not captured. In 2023, OMIG staff began tracking the prescription claim reversal figures for prescriptions not furnished within 14 days of billing. The detailed findings noted during a pharmacy CVR are uploaded and stored by case number in OMIG's system of record. There has not traditionally been a means to aggregate and evaluate pharmacy CVR findings statewide and by region. This new data allows OMIG to see how many CVRs are conducted by region, and where pharmacies are most or least compliant. This information will be used for future analysis to identify areas of vulnerability needing closer review and inform recommendations for policy change, legislative proposals and provider communications.

Pharmacy Education

- In 2023, following the NYRx transition, OMIG launched a Pharmacy Program Integrity Spotlight series for the *Medicaid Update*. The series was created in response to the NYRx transition to keep providers informed on various topics impacting pharmacy program integrity. Topics are selected based on trends from internal data analysis, referrals, fieldwork, investigation, and audit activities. Topics addressed in 2023 were:

    - Pharmacy enrollment requirements and responsibilities
    - Record Retention, Furnishing of Records, and Permitting Audit and Cooperation with Governmental Agencies
    - Pharmacist supervision and supervising pharmacist enrollment requirements
    - Prior authorization requirements for non-preferred drugs
    - Pharmacy credential verification review overview

Physician Investigations

Case Files: EOMB

- OMIG sent EOMBs to recipients for whom the doctor billed a high percentage of claims with a telehealth modifier. OMIG received EOMBs from 26 recipients, with allegations including not receiving the services, never seeing the provider, not recognizing the provider's name, and receiving the services from a different provider. The high return of EOMBs supports OMIG investigators in linking outliers identified in data with the actual experiences of the recipients purported to have received the services NYS was billed for. The case is being actively investigated.

Dental Investigations

In 2023, OMIG conducted four dental CVRs. The CVRs conducted this past year had the following results:

- education letters,
- corrective actions being taken regarding spore testing and medical waste disposal,
- collaboration with the MCO with whom the provider contracts,
- a referral to New York State Education Department (NYSED) with patient care concerns, and
- verbal education regarding spore testing and medical waste disposal helping to facilitate the provider's application for group enrollment.

Case File: CVR

- OMIG had initiated an investigation based on a referral alleging the dentist billed for services while a recipient was in the hospital. OMIG attempted to conduct a CVR and found no dental office operating at the service address listed in the provider's billing records, and the provider was unable to produce records to support 389 claims billed for 22 recipients. Upon completion of its investigation, OMIG issued a Notice of Agency Action excluding the provider from the NYS Medicaid program and seeking a recovery of $24,945. The provider requested a hearing, and in March 2023, an Administrative Law Judge (ALJ) rendered a favorable decision affirming the exclusion of the dentist from the NYS Medicaid Program and the recovery of $24,945.

Case Files: EOMB

- OMIG issued EOMBs for a dentist based on data analytics for billing higher than the average number of claims. OMIG subsequently received four EOMBs from Medicaid recipients alleging they did not receive any of the treatments, they did not go to the dentist on the listed dates, and they only received one service and not any of the other services listed. Based on the EOMBs received and another allegation received through OMIG's hotline, the provider was referred to MFCU.

Case Files: Dentist

- In April 2023, OMIG issued a Notice of Agency Action to censure a dentist and to recover identified overpayments of $35,783. A review of the patient records found the services and records associated with 470 dental claims failed to comply with the requirements of the NYS Medicaid program. OMIG had referred the dentist to NYSED in June 2022 after OMIG investigators identified multiple concerns related to the sterilization areas, including the potential for cross-contamination, a lack of secure storage for hazardous materials, and other safety concerns while conducting a CVR at the provider's office.

- In March 2023, a dentist agreed to pay the OMIG identified overpayments of $42,702. The overpayment was the result of a recovery in a peer review of 50 recipient medical records that determined 1,199 claims failed to comply with NYS Medicaid requirements.

In 2023, OMIG increased its program integrity activities on dental providers by closing 44 investigations, issuing eight exclusions, 17 censures, and identifying findings of more than $375,000.

Recipient Investigations

OMIG is the single contact point for all statewide Medicaid eligibility and prescription drug diversion investigations to ensure that only those who qualify for Medicaid are receiving those benefits. It conducts proactive investigations generated from internal data mining and data analysis, as well as responsive investigations resulting from allegations from the general public, other state, federal and local governmental, and law enforcement agencies. Additionally, OMIG coordinates with New York's 58 LDSS, the NYSoH, as well as local, county, state, and federal law enforcement and regulatory agencies to advance the integrity of the Medicaid program.

Of the 2,022 investigations completed in 2023, 993 were recipient related investigations. These investigations led to corrective actions including prosecution, fiscal recovery, other administrative action, or provider education.

Cost Savings

In 2023 OMIG continued working on identifying, investigating, and finalizing investigations of recipients who were found to be residing out of NYS and inappropriately receiving NYS Medicaid eligibility leading to MCOs receiving capitation payments. OMIG finalized 148 investigations as part of this initiative, resulting in a total cost savings for the program of more than $1.2 million.

- Field investigations remain an essential function for addressing internally generated complaints against Medicaid recipients allegedly residing out of state and therefore not eligible for continued Medicaid benefits. Throughout 2023, field visits were conducted in the following counties: Rockland, Dutchess, Erie, Greene, Hamilton, Fulton, Albany, Orange, Schenectady, and Essex in an attempt to verify a recipient's NYS address. When a completed OMIG investigation validates the indication of a recipient residing out of state, the cases are referred to DOH for eligibility redetermination. OMIG sent over 200 referrals to DOH for out of state residency, verification of income, and verification of household composition.

Collaborations

- In December 2023, OMIG staff collaborated with DOH Consumer Investigation staff regarding the new federal "Unwinding" rules requiring DOH to redetermine eligibility for all Medicaid enrollees. DOH has re-activated all state and federal income verification systems that were suspended during the PHE. The reactivation of these systems will have a positive impact on OMIG's program integrity initiatives, and an impact on OMIG's cost savings initiative. The Unwinding period started in June 2023 and is now scheduled to end on June 30, 2025. The new Unwinding rules will allow the OMIG to resume pre-established program integrity investigative functions to address the various statewide eligibility related allegations.

- In 2023, OMIG staff met with Essex, Erie, and Rockland County to provide an overview of investigative functions, resources, and interpretation of NYS Medicaid eligibility application documents, and provided updated guidance for the end of the PHE continuous coverage requirements that were in place since March 2020. OMIG will continue to meet with counties across NYS to explain its

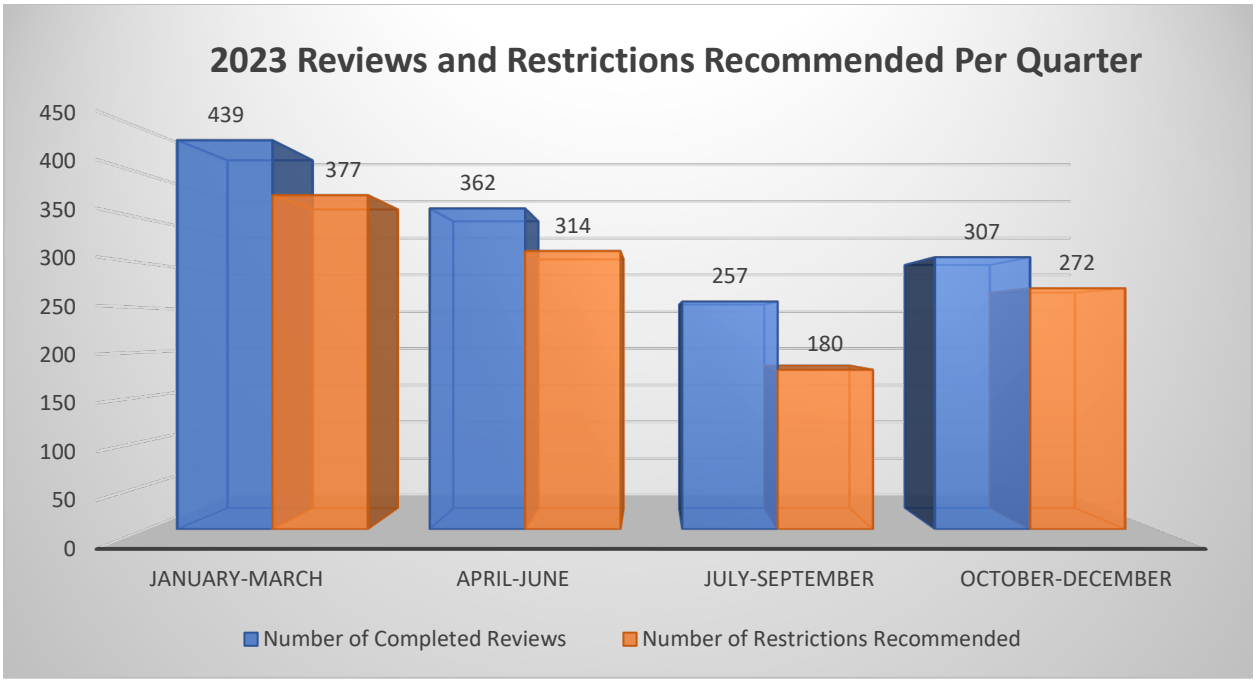
investigative functions as well as how we can partner with the LDSS to assist in and conduct joint investigations in order to reduce Medicaid fraud.

Recipient Restriction Program

The Recipient Restriction Program (RRP) coordinates medical services to improve quality of care for Medicaid recipients. Coordination of care reduces the potential over-utilization of health care services and prevents abusive or fraudulent behavior on the part of recipients and providers. OMIG performs analysis on recipients' utilization patterns to identify those who may be misusing the program in an attempt to obtain more services than medically necessary, or committing fraudulent acts with their Medicaid benefit, (i.e., receiving duplicative, excessive, contraindicated, or conflicting health care services, drugs, or supplies, or committing fraudulent acts with their benefit card such as forged prescriptions, card loaning, doctor shopping, etc.).

When a recipient is identified as possibly misusing the program, OMIG performs a comprehensive medical review of the recipient and, if determined to be appropriate, the recipient is entered into RRP. When a recipient is placed in the RRP, they are assigned to providers that will control the misuse most effectively (i.e., a primary care provider or primary clinic; pharmacy; inpatient facility; etc.). Restriction edits in eMedNY prevent the incorrect billing of providers that are not assigned to the restricted recipient. Claims submitted for a restricted recipient will be denied if the assigned primary care provider's information is not included on the claim as the referring provider when billing. There are exceptions in place to ensure the recipient has access to necessary emergency and Methadone Maintenance Treatment Program services.

In 2022, OMIG had an average of 4,737 recipients restricted, resulting in $91.7 million in cost savings. In 2023, OMIG had an average of 4,763 recipients restricted, resulting in $31.5 million in cost savings for January through March of 2023. Beginning in April of 2023, to align with the pharmacy carve out, system edits in eMedNY were relaxed to ensure that no recipients were adversely impacted while recipients were placed back into the FFS Medicaid pharmacy benefit.



- The About the Recipient Restriction Program (RRP) section of the OMIG website includes an overview of the program, contact information, and links to information pages for recipients, providers, and MCOs. Unlimited access to information on the website allows stakeholders and providers to search for answers to questions on RRP procedures and billing anytime.
- After the implementation of the Pharmacy Benefit Transition on April 1, 2023, Medicaid members now get their prescriptions filled through NYRx, the Medicaid Pharmacy Program. RRP initiated new processes for MC initiated restrictions and MC pharmacy misuse referrals. Since pharmacy services are no longer covered by the MCOs, OMIG reviews new MC initiated restrictions for possible addition of a pharmacy restriction.

- In July 2023, an eMedNY edit was implemented to allow Medication Assisted Treatment (MAT) drugs such as buprenorphine and naloxone, to bypass prescriber restrictions for RRP members. Medical treatment, when combined with counseling and behavior therapies, can be effective in the treatment of opioid use disorders and can help some people to sustain recovery. Limiting these restrictions allows RRP to help more people secure MAT, and RRP recipients now have access to these medications at their primary and alternate pharmacy locations.

- OMIG identified an increase in human immunodeficiency virus (HIV) medication abuse and/or misuse, with some recipients obtaining multiple complete regimen

HIV medications per month, which are very costly. For example, a one-month supply of Biktarvy is $3,800, Juluca is $3,400, and Symtuza is $4,500. RRP is working to create a query to identify recipients who have obtained multiple complete regimens in a month or have obtained a complete regimen in addition to other medications used for HIV treatment indicating duplicative therapy. The query will also be able to identify the recipient's that have used multiple pharmacies and/or prescribers to obtain these medications increasing the potential for fraud, waste, or abuse. Identifying these recipients and coordinating their care to one medical provider and one pharmacy has the potential for additional cost savings to the Medicaid program as well as enhanced care oversight for the recipients.

Outreach with the Provider Community

- In March 2023, OMIG conducted a training session with all MCOs regarding RRP and the anticipated pharmacy benefit transition. Attendees discussed key points of the transition including communications and how to refer possible pharmacy restrictions to OMIG. Other topics covered included changes to the currently used notification forms, when the new forms will be posted to the Health Commerce System, restriction continuations, who the restricted recipient should contact for provider changes, and how emergency situations should be handled.

- In March 2023, OMIG conducted a training session with the local districts, the NYC HRA and NYSoH regarding RRP and the anticipated pharmacy benefit transition. A brief overview of the transition was presented, as well as anticipated benefits summarized from the DOH website. The current restriction process and changes that needed to be made were detailed. Other topics included the role of the districts in restricting recipients and who the restricted recipient should contact for provider changes.
- In November 2023, OMIG participated in a Technical Workgroup meeting with DOH OHIP to discuss the RRP program and provider responsibilities to MCOs and Health Plan Associations.

- In November 2023, OMIG also presented at the DOH/OHIP Pharmacy Association Monthly Meeting. This event enabled OMIG to engage with key participants involved in the billing of claims by educating and aiding pharmacy associations on the RRP process.

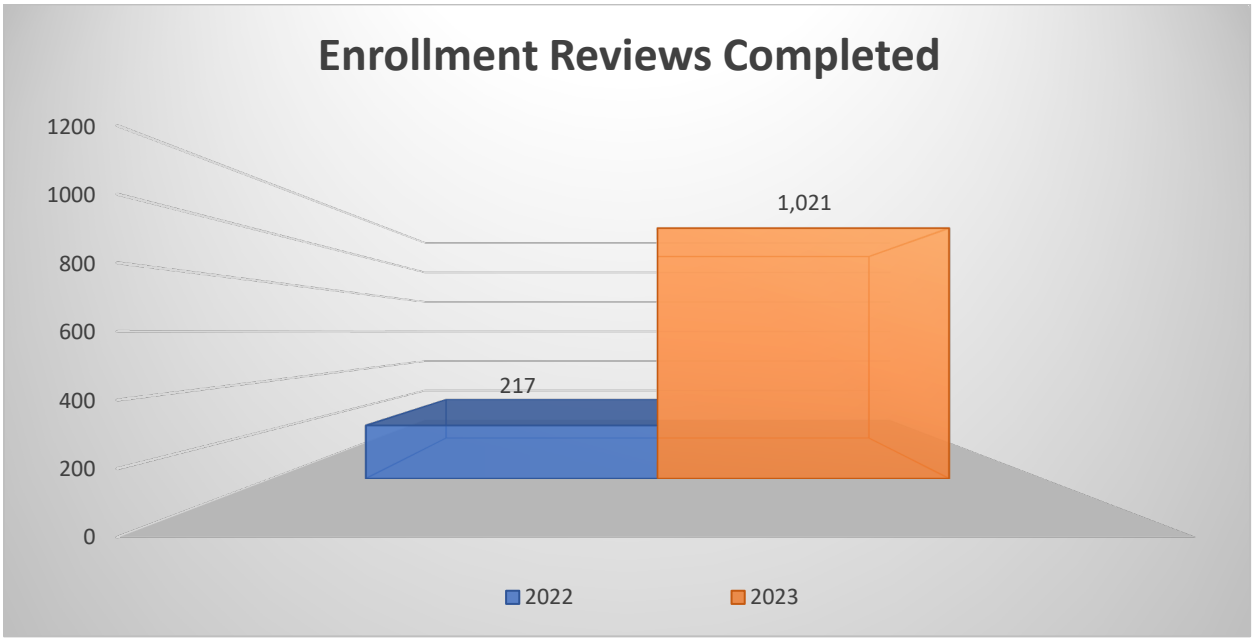
Enrollment and Reinstatement (EAR)

OMIG assists DOH in reviewing applications for certain high-risk providers such as transportation providers (excluding ambulance), independent pharmacies, DME suppliers, dental groups, laboratories, physical therapists, and physical therapy groups. Additionally, all provider types applying to be reinstated into the Medicaid program, removed from the Excluded Provider List, or to change ownership are also reviewed. Determinations on all applications are made in accordance with state and federal regulations.

- In 2023, OMIG staff completed 1,021 reviews including new enrollment, ownership change, and reinstatement applications. Reviews of those applications resulted in the issuance of 91 denials. These denials were a result of a fraud, waste, and abuse review by OMIG and a review by the respective policy unit within DOH. 35 of these denials were for fraud, waste, or abuse concerns.

  These reviews included a significant increase in pharmacy applications attributed to the pharmacy benefit carve-out. In 2023, 333 pharmacy applications were received versus 229 in 2022, which was an increase of 45%.

- In 2023, OMIG staff received 68 requests for removal from the NYS Medicaid Exclusion List. Of those 7 were denied and 55 were approved. This process allows rehabilitated providers to return to serve the Medicaid program and recipients, thereby increasing the number of available providers.



Office of Counsel

44 Hearings Resolved Preserving $31 Million in Identified Medicaid Funds

35 Hearings Requested

15 Administrative Hearings Conducted

57 Settlements

345 Medicaid Lien Matters Resolved

Mission

OMIG employs attorneys and administrative staff who are located in the agency's Albany and NYC offices. OMIG attorneys serve a number of different functions, such as representing the agency at administrative hearings and defending litigation matters involving New York's Medicaid program. Attorneys also regularly review New York laws and regulations pertaining to the Medicaid program to identify changes that may impact policies and procedures related to program integrity activities. Other functions performed by OMIG attorneys include the provision of legal support to all agency divisions and executive staff; this legal support includes, but is not limited to, reviewing audit reports, notices of agency action, and audit protocols, drafting proposed regulations and legislation, drafting and/or negotiating contracts and contract amendments, conducting legal research, and issuing legal opinions.

Due Process Protections

All providers that engage with OMIG in the audit and investigative activities are afforded "due process" throughout their engagement with OMIG. Due process is an integral and essential part of OMIG's regulatory structure. Due process is based on the concept of fundamental fairness and requires that individuals be provided with both "notice" and an "opportunity to be heard."

OMIG effectuates notice through several mechanisms: audit notification letters, credential verification reviews, and preliminary findings in Draft Audit Reports or Notices of Proposed Agency Action (NOPAA). Providers are afforded the right to respond to OMIG's preliminary findings within 30 days of the Draft Audit Report or NOPAA. After the provider submits its response, OMIG must consider that response prior to issuing a Final Audit Report or Notice of Agency Action (collectively referred to as a "Final Determination") to the provider. OMIG's Final Determination may include identified Medicaid overpayments, the imposition of penalties, and/or sanctions for unacceptable practices.

Providers that have received a Final Determination are entitled to challenge OMIG's Final Determination by requesting an administrative hearing. Such request must be made in writing within 60 days of the date of the Final Determination. The DOH Bureau of Adjudications assigns an ALJ to preside over and conduct the hearing.

Administrative Hearing Process

In furtherance of due process, prior to commencement of the hearing, OMIG is required to hold a pre-hearing conference with the provider. At this conference, the OMIG attorney and provider (or its representative) exchange witness lists, documentation, and other information that may be presented at the hearing. At the hearing, OMIG attorneys defend the agency's Final Determination, and the provider or its representatives have the opportunity to introduce exhibits into evidence, present witnesses, and cross-examine OMIG witnesses in their efforts to prove that OMIG's Final Determination was incorrect. If the ALJ issues a decision that is favorable to OMIG, the provider has the right to appeal in an Article 78 Proceeding in NYS Supreme Court.

2023 Administrative Hearings

Throughout 2023, a total of 35 new requests for administrative hearings were received by OMIG, and a total of 44 hearings cases were closed. Administrative hearings that were resolved in 2023 included cases in which the request for a hearing was received prior to 2023. Additionally, not all hearing requests received in 2023 had hearings scheduled and completed within the calendar year. This is because a given case may have multiple hearing dates before the matter is ready for disposition by the ALJ. Most hearing requests were resolved by a stipulation of settlement in lieu of proceeding to an administrative hearing. The administrative hearing cases that were closed in 2023 were resolved in the following manner:

- 11 resulted in hearing decisions issued by an ALJ,
- 9 were subsequently withdrawn by the provider,
- 23 resulted in stipulations of settlement negotiated by OMIG attorneys with the providers, and
- 1 matter resulted in a determination by an ALJ that the request for a hearing was untimely made.

Hearing decisions issued during 2023 can be found at:
https://www.health.ny.gov/health_care/medicaid/decisions.

Stipulations of Settlement

Providers have the right to challenge the OMIG's final determination by requesting an administrative hearing. However, cases are often resolved (settled) prior to an administrative hearing and memorialized in a formal written document or Stipulation of Settlement (stipulation) executed by the provider and OMIG. The stipulation defines the

terms of settlement, the review period in question, the overpayment amount owed, and the repayment terms. OMIG attorneys negotiate and facilitate the execution of the stipulation between the agency and providers. Stipulations may result from a provider agreeing to resolve an audit or investigation, following or prior to the issuance of a draft audit report or notice of proposed agency action, or after the issuance of a final audit report or notice of agency action to resolve a request for hearing. Additionally, providers who self-disclose Medicaid overpayments may also request a stipulation. In 2023, OC finalized 57 stipulations, of which 25 were in lieu of proceeding to an administrative hearing, and 32 were for pre-final determinations and self-disclosure cases.

Freedom of Information Law

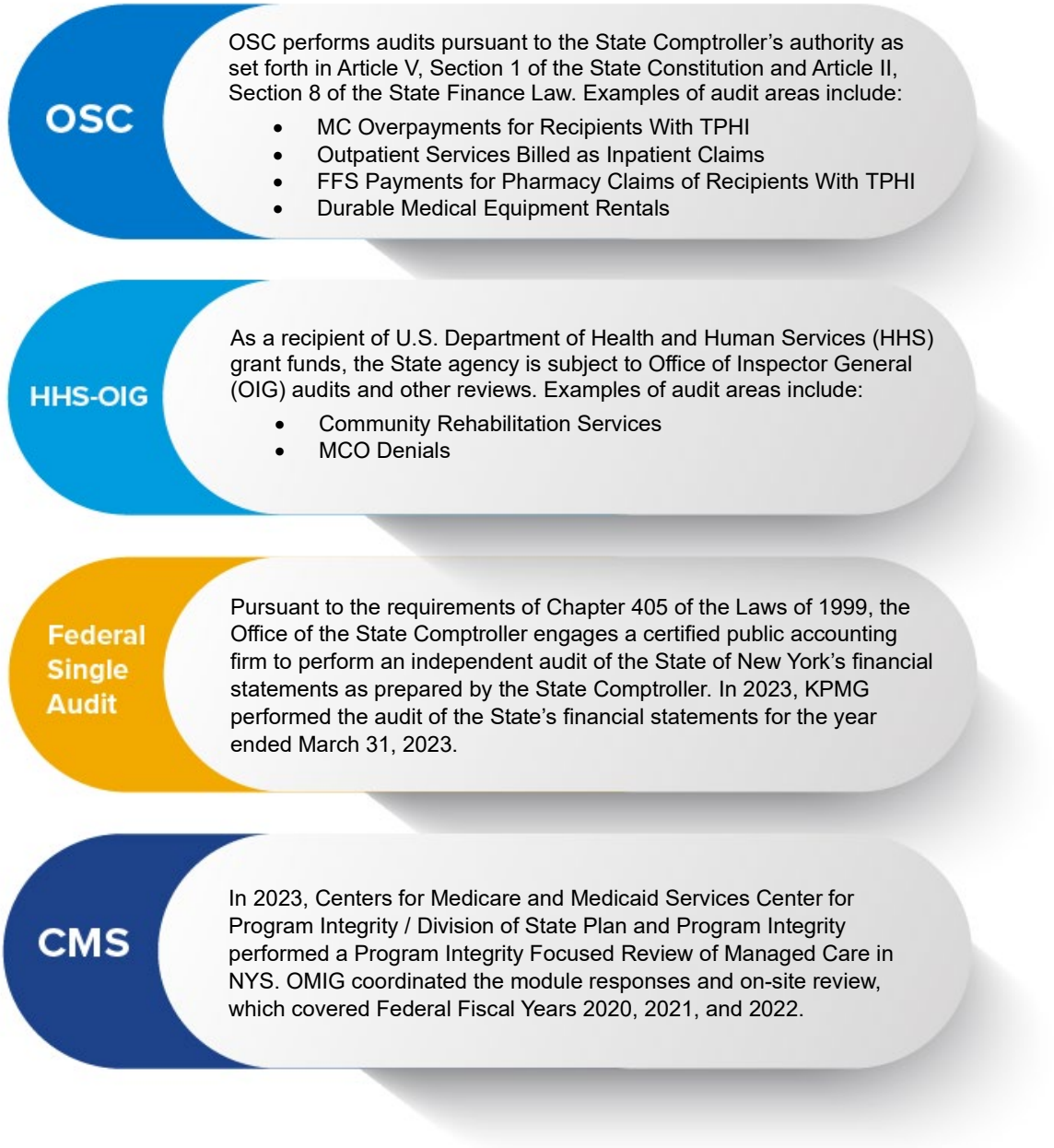
OMIG responded to 65 Freedom of Information Law (FOIL) requests throughout 2023 in which members of the public sought records in the possession of OMIG. In addition to addressing those requests, OMIG, in its continuing efforts to enhance public access to its records, committed to transitioning to a statewide on-line FOIL platform-GovQA. GovQA is an application that facilitates a FOIL records request through a user-friendly, secure platform. As OMIG fully migrates to GovQA, it is anticipated that the public will have more features and options to choose from when making a records request.

Medicaid Liens

OMIG staff was also involved with 345 Medicaid lien cases in 2023. In those cases where the Agency has been named as a defendant, the assigned OMIG attorney contacts and works regularly with the County Attorneys in the county where the action is pending and requests representation in the matter by the County Attorney.

External Audits

OMIG's External Audit Unit (EAU), working with DOH, coordinates and manages audits of the Medicaid program conducted by outside audit 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 2023. In 2023, EAU received a total of 49 audit reports/reviews containing millions of claims and MC encounters. OMIG staff from all divisions across the agency are engaged to address these audits. Staff are involved in all stages of the audit process, including fieldwork, meetings, data analysis, follow-up questions, and preparing responses to all reports received.



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 the following agencies: 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 LDSS to discuss the status of ongoing cooperative efforts between the 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 LDSS 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.

Frequently Used Acronyms

Acronym	Term
ALJ	Administrative Law Judge
BBI	Bureau of Business Intelligence
BNE	Bureau of Narcotic Enforcement
BOC	OMIG's Bureau of Compliance
BPCM	OMIG's Bureau of Payment Controls and Monitoring
C&E	Casualty and Estate
CDPA	Consumer Directed Personal Assistance
CIN	Client Identification Numbers
CMS	Centers for Medicare and Medicaid Services
CON	Certificate of Need
CVR	Credential Verification Reviews
DFS	Department of Financial Services
DME	Durable Medical Equipment
DMI	OMIG's Division of Medicaid Investigations
DOH	Department of Health
EAU	External Audit Unit
EHR	Electronic Health Records
EOMB	Explanation of Medical Benefits
EVV	Electronic Visit Verification
FAQ	Frequently Asked Questions
FFS	Fee-for-Service
FOIL	Freedom of Information Law
HCBS	Home and Community-Based Services
HFPP	Healthcare Fraud Prevention Partnership
HHS-OIG	U.S. Department of Health and Human Services, Office of the Inspector General
HIV	Human Immunodeficiency Virus
HMS	Health Management Systems, Inc.
HWB	Health Care and Mental Hygiene Worker Bonus
ITS	NYS Information Technology Services
LDSS	Local Departments of Social Services
MA	Medical Assistance
MAS	Medical Answering Service
MAT	Medication Assisted Treatment
MC	Managed Care
MCO	Managed Care Organization
MDS	Minimum Data Set

Acronym	Term
MDW	Medicaid Data Warehouse
MFCU	New York State Attorney General's Medicaid Fraud and Control Unit
MLTC	Managed Long-Term Care
NEMT	Non-Emergency Medicaid Transportation
NOPAA	Notice of Proposed Agency Action
NPI	National Provider Identifier
NPPES	National Plan & Provider Enumeration System
NYC	New York City
NYC HRA	New York City Human Resources Administration
NYCRR	New York Codes, Rules and Regulations
NYS	New York State
NYSED	New York State Education Department
NYSoH	New York State of Health
OC	OMIG's Office of Counsel
OHIP	Office of Health Insurance Programs
OMIG	Office of the Medicaid Inspector General
OPD	Office of Professional Discipline
OPWDD	Office for People with Developmental Disabilities
OSC	Office of the State Comptroller
PARIS	Public Assistance Reporting Information System
PBH	Public Health Law
PCA	Personal Care Aide
PCS	Personal Care Services
PHE	Public Health Emergency
PPIU	Pharmacy Program Integrity Unit
PPR	Pre-Payment Review
RAC	Recovery Audit Contractor
RIU	Recipient Investigations Unit
RRP	Recipient Restriction Program
SFY	State Fiscal Year
SIU	Special Investigative Units
SOS	Social Services Law
TPHI	Third-Party Health Insurance
UMass	University of Massachusetts Chan Medical School

Data Tables

2023 Initiated Audits by Region				
Region	**County Demo**	**Managed Care**	**Provider**	**Total**
Capital Region	0	25	10	**35**
Central NY	0	22	11	**33**
Finger Lakes	0	9	63	**72**
Long Island	0	19	75	**94**
Mid-Hudson	0	21	31	**52**
Mohawk Valley	0	9	2	**11**
New York City	5	156	246	**407**
North Country	0	0	7	**7**
Out of State	0	0	2	**2**
Southern Tier	0	14	16	**30**
Western NY	3	44	21	**68**
Grand Total	**8**	**319**	**484**	**811**

2023 Finalized Audits by Region				
Region	**County Demo**	**Managed Care**	**Provider**	**Total**
Capital Region	0	46	15	**61**
Central NY	0	40	12	**52**
Finger Lakes	0	14	19	**33**
Long Island	0	29	35	**64**
Mid-Hudson	0	37	43	**80**
Mohawk Valley	0	15	3	**18**
New York City	7	242	208	**457**
North Country	0	0	6	**6**
Out of State	0	0	1	**1**
Southern Tier	0	18	8	**26**
Western NY	3	61	29	**93**
Grand Total	**10**	**502**	**379**	**891**

2023 Overpayments Identified by Region				
Region	**County Demo**	**Managed Care**	**Provider**	**Total**
Capital Region	$0	$36,817,447	$1,076,094	**$37,893,541**
Central NY	$0	$13,049,342	$543,329	**$13,592,671**
Finger Lakes	$0	$2,796,006	$810,389	**$3,606,395**
Long Island	$0	$2,312,756	$10,601,729	**$12,914,485**
Mid-Hudson	$0	$6,070,778	$7,001,772	**$13,072,550**
Mohawk Valley	$0	$4,927,066	$4,619	**$4,931,685**
New York City	$1,742,088	$99,910,879	$20,700,917	**$122,353,883**
North Country	$0	$0	$216,994	**$216,994**
Out of State	$0	$0	$916	**$916**
Southern Tier	$0	$1,235,473	$138,536	**$1,374,009**
Western NY	$33,557	$4,784,626	$5,507,775	**$10,325,957**
Grand Total	**$1,775,645**	**$171,904,372**	**$46,603,070**	**$220,283,087**

2023 Recoveries by Region				
Region	**County Demo**	**Managed Care**	**Provider**	**Total**
Capital Region	$0	$39,077,409	$1,850,452	**$40,927,861**
Central NY	$0	$11,580,282	$2,334,885	**$13,915,167**
Finger Lakes	$0	$4,442,643	$1,816,610	**$6,259,253**
Long Island	$0	$2,263,710	$7,149,303	**$9,413,013**
Mid-Hudson	$105,560	$6,048,035	$6,642,720	**$12,796,315**
Mohawk Valley	$0	$4,927,066	$341,433	**$5,268,499**
New York City	$4,665,486	$108,413,196	$26,071,452	**$139,150,134**
North Country	$0	$0	$658,303	**$658,303**
Out of State	$0	$0	$17,764	**$17,764**
Southern Tier	$0	$1,883,139	$614,063	**$2,497,203**
Western NY	$285,147	$3,689,489	$3,234,759	**$7,209,394**
Grand Total	**$5,056,193**	**$182,324,969**	**$50,731,743**	**$238,112,905**

2023 Audit Summations	
Audit Department	**Amount**
County Demonstration Program	2
Managed Care	2
Provider	83
Rates/AM&D	131
Total Summations	**218**

2023 Self-Disclosures				
Region	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Capital Region	38	44	$448,779	$459,081
Central NY	48	27	$321,120	$651,415
Finger Lakes	49	47	$1,120,283	$563,116
Long Island	48	33	$451,458	$532,320
Mid-Hudson	91	87	$1,165,553	$1,338,207
Mohawk Valley	11	8	$363,166	$128,127
New York City	175	129	$5,804,725	$6,119,745
North Country	28	23	$105,732	$206,566
Out of State	10	10	$6,377	$208,021
Southern Tier	34	29	$254,406	$263,566
Western NY	46	43	$560,209	$648,677
Grand Total	**578**	**480**	**$10,601,809**	**$11,118,840**

2023 Summary of Investigations by Source of Allegation and Region								
Initial Source	**Downstate**		**Upstate**		**Out of State**		**Totals**	
	Opened	**Completed**	**Opened**	**Completed**	**Opened**	**Completed**	**Opened**	**Completed**
Anonymous	143	132	130	144	2	3	275	279
Enrolled Recipient	39	34	28	29	1	1	68	64
Federal Agencies	9	37	3	3	0	0	12	40
General Public (Non-Enrolled)	199	181	164	157	2	2	365	340
Law Enforcement	0	11	6	2	0	0	6	13
Local Departments of Social Services	14	24	58	78	0	0	72	102
Managed Care Organizations	129	127	19	25	1	9	149	161
Managed Long Term Care Plans-MLTC	54	22	5	5	0	0	59	27
OMIG	314	333	267	294	3	7	584	634
Provider	26	45	56	55	1	1	83	101
State and City Agencies	78	78	142	171	2	3	222	252
Transportation Manager	12	8	11	1	0	0	23	9
Total	**1,017**	**1,032**	**889**	**964**	**12**	**26**	**1,918**	**2,022**

2023 Referrals to MFCU	
Provider Type	**Amount**
Clinical Psychologist	1
Clinical Social Worker (CSW)	1
Consumer Directed Aide	14
Dentist	4
Diagnostic and Treatment Center	1
Home Health Agency	14
Home Health Aide	6
Laboratory	1
Medical Appliance Dealer	2
Multi-Type	13
Multi-Type Group	4
Non-Enrolled Provider	21
Nurse	5
Optician	1
Optometrist	2
Other	1
Personal Care Aide	3
Pharmacy	29
Physician	23
Physicians Group	13
Recipient	15
Social Adult Day Care	5
Therapist	3
Transportation	59
Total	**241**

2023 Referrals to Other Agencies	
Agency	**Amount**
Bureau of Narcotic Enforcement	6
Centers for Medicare and Medicaid services (CMS)	1
Joint Commission	3
Law Enforcement Agency	4
Local Departments of Social Services	14
Managed Care Organizations	1
MAS-Medical Answering Service	4
Nassau County DSS Adult Protective Services	2
NYC Department of Sanitation	2
NYC HRA Adult Protective Services	1
NYC HRA Bureau of Client Fraud Investigations	24
NYC Office of the Special Narcotics Prosecutor	2
NYS Department of Environmental Conservation	3
NYS Department of Health	234
NYS Department of Labor	4
NYS Division of Human Rights	2
NYS DOH Office of Professional Medical Conduct	26
NYS Education Department – Not Professional Discipline	1
NYS Education Department – Office of Professional Discipline	46
NYS Justice Center	4
NYS Office for People with Developmental Disabilities (OPWDD)	1
NYS Office of Mental Health (OMH)	3
Offices of the U.S. Attorney	6
U.S. Department of Justice	7
U.S. Dept of State-Office of Inspector General	1
U.S. Health and Human Services (HHS-OIG)	12
Total	**414**

2023 Exclusions	
Reasons for Exclusions	**Number of Actions**
18 NYCRR 504.1(d)(1) – Affiliations	28
18 NYCRR 515.7(b) – Indictments	35
18 NYCRR 515.7(c) – Convictions	80
18 NYCRR 515.7(d) – Imminent Danger	2
18 NYCRR 515.7(e) – Professional Misconduct	111
18 NYCRR 515.8 – Mandatory Exclusion	139
Total	**395**

2023 Contractor Recoveries	
Activity Area	**Amount**
Third-Party Liability	$224,218,104
Recovery Audit Contractor	$269,188,266
Casualty & Estate	$127,121,401
Home Health Care Medicare Maximization Project	$2,096,798
Total	**$622,624,569**

2023 Recoveries (All Sources)	
Activity Area	**Amount**
Managed Care	$182,324,969
Third-Party Liability	$224,218,104
Recovery Audit Contractor	$269,188,266
Casualty & Estate	$127,121,401
Provider	$50,731,743
Self-Disclosure	$11,118,840
County Demonstration Program	$5,056,193
Home Health Care Medicare Maximization Project	$2,096,798
Investigation Financial Activities	$191,237
Total	**$872,047,552**

2023 Cost Savings Activities	
Activity Area	**Amount**
Pre-Payment Insurance Verification Commercial	$2,867,292,089
Pre-Payment Insurance Verification Medicare	$299,559,496
Recipient Restriction	$31,506,975
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	$8,224,061
Enrollment and Reinstatement Denials	$6,655,747
Medical Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	$6,440,526
Exclusions/Terminations – External	$1,822,531
Recipient Medicaid MC Benefits - Case Closures for False Information	$1,229,826
Exclusions/Terminations – Internal	$582,656
Dental Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	$325,758
Total	**$3,223,639,665**

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To report Medicaid fraud, waste, or abuse
fill out the online Medicaid Fraud Allegation Online Form
or call the toll-free Fraud Hotline:
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