NEW YORK STATE | Office of the Medicaid Inspector General

ANNUAL REPORT

2024

Kathy Hochul
GOVERNOR

Frank T. Walsh, Jr.
ACTING MEDICAID INSPECTOR GENERAL

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MESSAGE FROM THE ACTING MEDICAID INSPECTOR GENERAL

Frank Walsh

Acting Medicaid

Inspector General

I am pleased to present the Office of the Medicaid Inspector General (OMIG) 2024 Annual Report, which provides a comprehensive overview of our ongoing efforts to detect, prevent, and combat Medicaid fraud, waste, and abuse across New York State's Medicaid program. The report highlights key achievements, program initiatives, and strategic priorities aimed at safeguarding public funds and strengthening program integrity.

These include:

- Sustained education and engagement with stakeholders to de-mystify process and improve outcomes.
- Improved use of Medicaid data to identify trends and support activities.
- Reemphasized provider compliance, improving awareness and completing 83 reviews.
- Enhanced self-disclosure, facilitating provider reporting and finalizing 635 full self-disclosures, a 32% increase in cases from 2023.
- Identified and referred 705 cases for enforcement, including 454 to the Attorney General's Medicaid Fraud Control Unit (MFCU).
- Completed over 2,500 audits and investigations and over $4.5 billion in cost savings and recoveries for the Medicaid program. Overall, OMIG increased its cost savings and recoveries by $468 million from 2023.
- Recognized program impacts, granting 33 providers with relief in instances when an OMIG audit could pose a financial hardship to the organization and to ensure beneficiaries' continued access to health care services.
- Strengthened due process protections during OMIG audits, investigations, and reviews, and resolved 21 hearings.
- Issued 162 Audit Summations, known as "Positive Audit Reports," indicating that a substantial number of providers are compliant with Medicaid program requirements.

The 2024 Annual Report underscores OMIG's unwavering commitment to integrity, accountability, and transparency in administering Medicaid. Through rigorous enforcement, proactive prevention, and strategic partnerships, OMIG aims to sustain a robust Medicaid program that serves the needs of New Yorkers effectively and efficiently.

These achievements would not be possible without the awareness, commitment, and dedication of OMIG staff statewide. They deserve any recognition conferred and I am honored to serve as a member of the OMIG team.

Sincerely,

Frank T. Walsh, Jr.

Acting Medicaid Inspector General,

KEY ACHIEVEMENTS 2024

3,675
Received Allegations of Fraud

454
Cases Referred to MFCU

2,530
Completed Audits & Investigations

635
Processed Self-Disclosures, 32% increase from 2023

$4.5B
In Cost Savings & Recoveries

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

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.

VISION

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

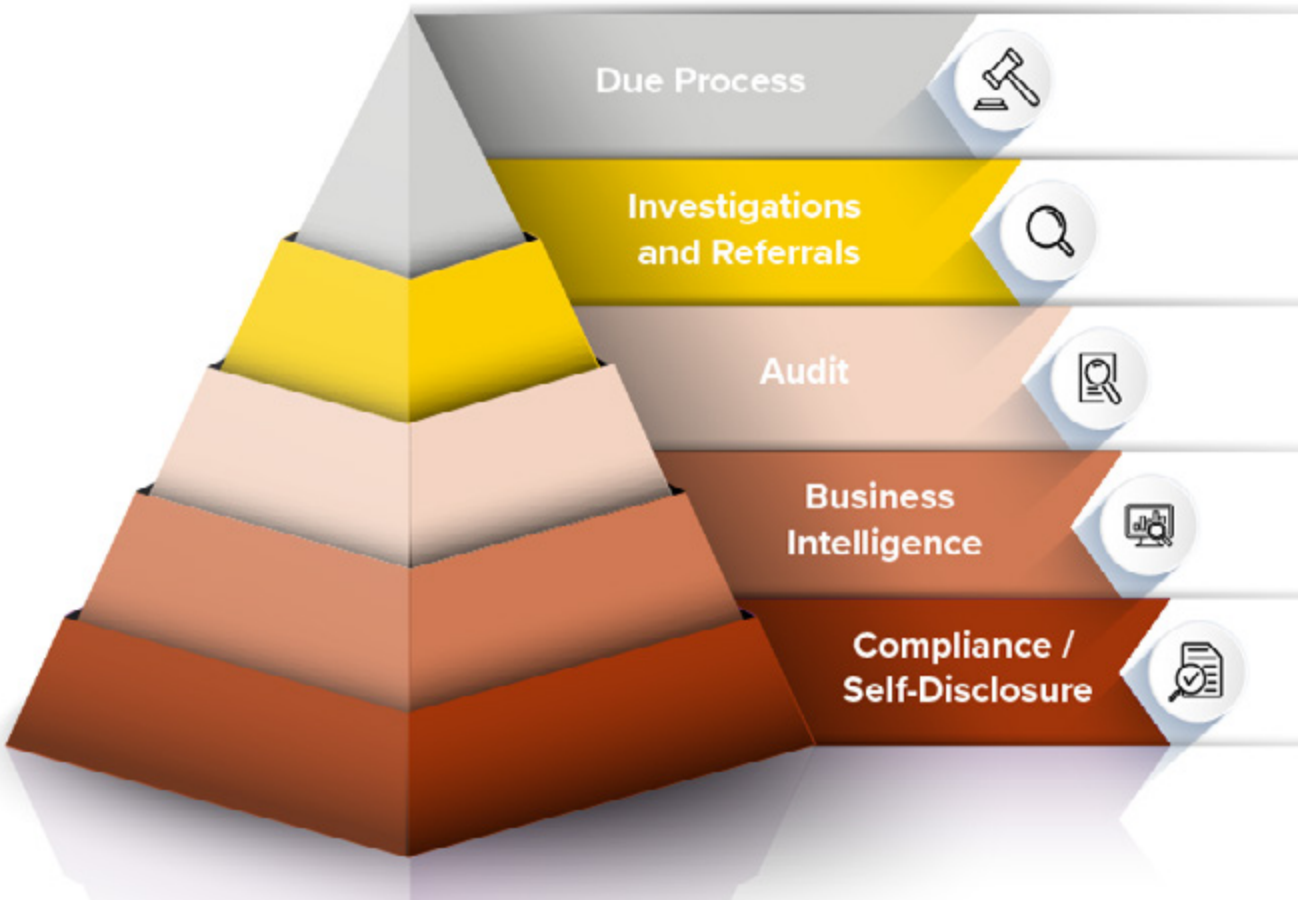
GENERAL OVERVIEW

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. The following 2024 Annual Report speaks to the achievements of the past year, including relevant data and statistics in the appendix.

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, and/or supplies for which payment should not have been made. OMIG recovers these amounts by receipt of check, money order, ACH, provider withholds, and/or voided/adjusted 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



GENERAL OVERVIEW

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 an average of more than 7.1 million Medicaid recipients in 2024.

In realizing these objectives, OMIG actively seeks to:

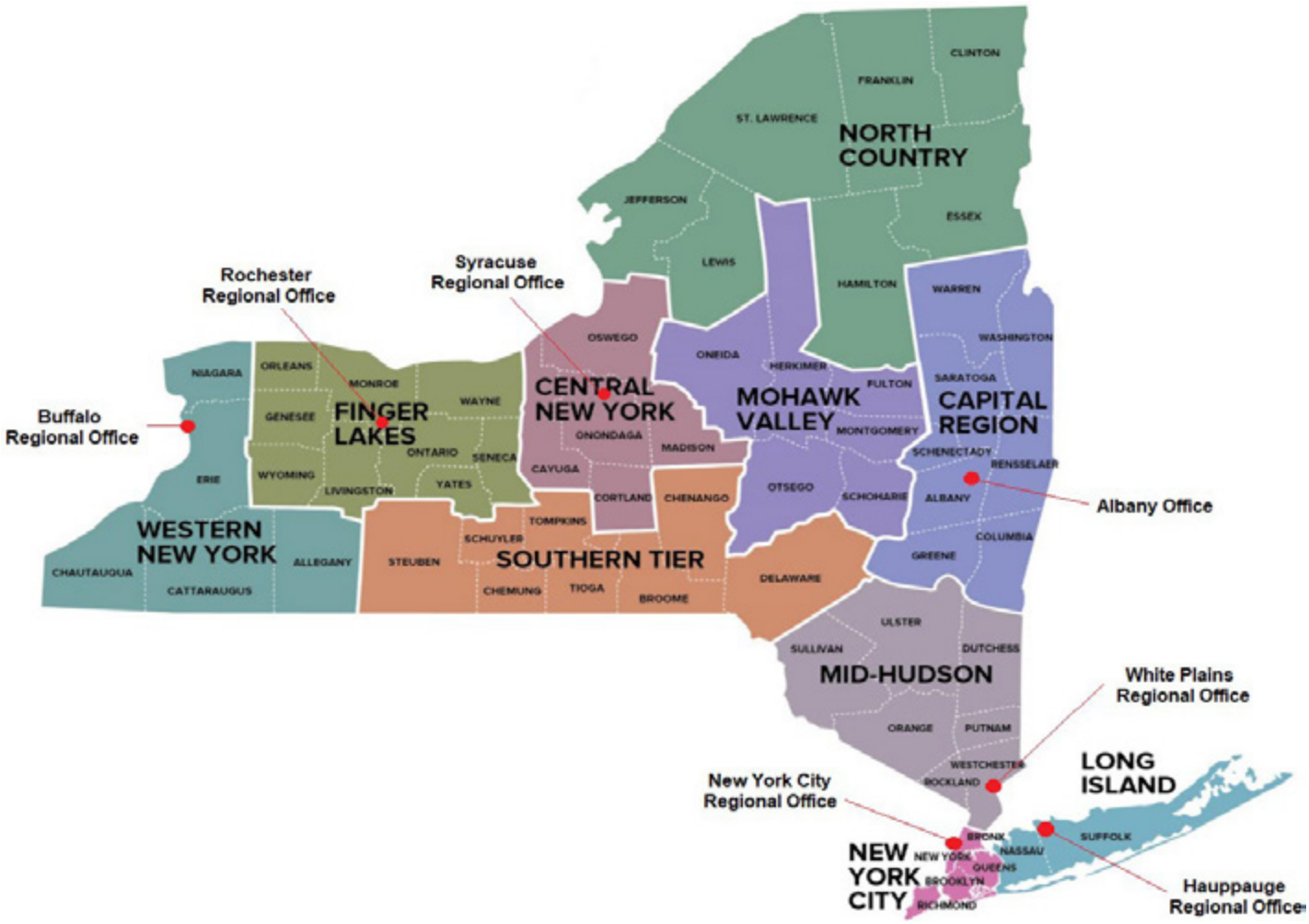
- Understand, promote, and advise on Medicaid policies and procedures that advance program integrity objectives.
- Closely coordinate with DOH and other state agencies involved in the administration of the Medicaid program to identify their priorities and objectives and develop enforcement strategies that align with these priorities and objectives.
- Educate and collaborate with Medicaid providers and payors, including MCOs, to improve their understanding and compliance with current Medicaid requirements.
- Encourage the adoption of provider compliance programs that address identified Medicaid risks, establish minimum standards to strengthen these compliance programs and integrate them within provider operations and evaluate and correct identified deficiencies in these compliance programs.
- Require and support the self-disclosure of Medicaid overpayments by a provider and enforcement of the federal and state requirements that these overpayments be reported, explained and returned within 60 days of being identified.
- 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 MCOs which strengthens program integrity and increases the number of referrals to OMIG.
- Refer credible allegations or identified instances of fraud to 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, reviews, and associated final agency actions. Defend final agency actions at administrative hearing or Article 78 judicial proceeding.

GENERAL OVERVIEW

EXECUTIVE ORGANIZATIONAL CHART

GENERAL OVERVIEW

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.

2024 AGENCY HIGHLIGHTS

1.43%
ESTIMATED IMPROPER PAYMENT RATE (NATIONAL AVERAGE 5.09%)

33
FINANCIAL HARDSHIP APPLICATIONS RECEIVED AND REVIEWED

1,299
HEALTHCARE WORKER BONUS SELF-DISCLOSURES AND 30 AUDITS FINALIZED

6
NEW AUDIT PROTOCOLS POSTED

2024 AGENCY HIGHLIGHTS

PAYMENT ERROR RATE MEASUREMENT

The Centers for Medicare & Medicaid Services (CMS) measures improper payments in the Medicaid and State Child Health Insurance programs under the Payment Error Rate Measurement (PERM) program. NYS is required to participate in this program once every three years which is comprised of the following three components:

- Eligibility Review,
- Data Processing, and
- Medical Review.

OMIG is responsible for the Medical Review component, which includes gathering medical records to support a random sample of claims selected by CMS with the goal of ensuring that all requested records are furnished to CMS. CMS' most recent project cycle comprised of a review of payments made from July 1, 2022, through June 30, 2023. For this review, the sample size increased by over 50% from the previous cycle. Tasks performed by OMIG included requesting records for 786 sample claims for CMS to review, conducting additional follow up with providers, and providing information to CMS to overturn claims that CMS found to be in error. By project conclusion, CMS had reversed over 100 claims originally found to have errors. For this PERM cycle, CMS determined that NYS' Medicaid estimated federal improper payment rate is 1.43% which includes the results of the Medical Review component. This result places NYS well below the combined national Medicaid estimated federal improper payment rate of 5.09%.

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. OMIG has been an active participant in HFPP since 2015. Currently, there are 314 partners in HFPP, which include federal, state, and local government and law enforcement agencies, health care payors, and representative associations.

In 2024, OMIG continued to increase its focus on the resources available to the agency 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 that are refreshed on a continual basis, 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 and refers any cases that have a potential impact for investigation. One HFPP study examined the prescribing of GLP1s to patients without previous diabetic diagnosis or claim history, as well as patients with overlapping prescriptions for GLP1s, which resulted in two providers referrals. Another example of an alert made by an HFPP partner that has resulted in referrals include specific DME providers allegedly involved in the fraudulent billing of catheters when recipients did not request, receive, or have medical necessity for the urinary catheters. As a result of the HFPP studies and alerts, OMIG has completed 28 research projects which have resulted in seven referrals for investigation. OMIG has significantly increased its efficiency in the tracking of HFPP research findings as sources for investigation and continues to explore additional opportunities to improve OMIG's fraud, waste, and abuse detection techniques.

2024 AGENCY HIGHLIGHTS

HEALTHCARE WORKER BONUS

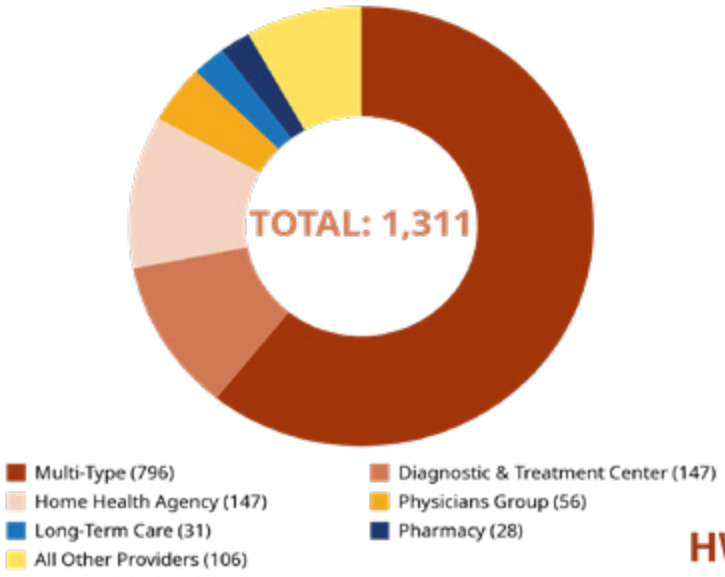
As part of the Fiscal Year 2022-23 Budget, Governor Kathy Hochul announced the launch of the Health Care and Mental Hygiene Worker Bonus (HWB) Program, which allocated $1.3 billion for the payment of recruitment and retention bonuses to certain frontline health care and mental hygiene workers, a key initiative in the Governor's aim to increase the state's health care workforce by 20 percent over the next five years. Bonuses were awarded to eligible workers who make less than $125,000 annually and remained in their positions for at least six months. Disbursements were commensurate with the number of hours worked and duration of service within designated vesting periods for up to a total of $3,000 per employee.

OMIG staff, in collaboration with DOH, developed processes to support audits, investigations, and reviews of HWB claims and payments. This included the self-disclosure of employer-identified HWB overpayments, and the submission of employee inquiries and allegations of nonpayment, to ensure that these bonuses were appropriately distributed.

HEALTHCARE WORKER BONUS SELF-DISCLOSURE

In 2024, OMIG continued to receive and process HWB employer self-disclosures of overpaid HWB funds; 1,311 HWB self-disclosure submissions were received and 1,299 were finalized, identifying more than $16.9 million in overpayments and more than $19.7 million in recoveries.

HWB SELF-DISCLOSURES INITIATED IN 2024



HWB SELF-DISCLOSURE FINDINGS COMPARISON BY YEAR

FINDING AMOUNT	2023	2024	%
$0 to $1,000	53	94	+77.4%
$1,001 to $10,000	598	888	+48.5%
$10,001 to $100,000	182	294	+61.5%
$100,001 to $1,000,000	22	22	0%
$1,000,001+	0	1	+100%

2024 AGENCY HIGHLIGHTS

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, a webform that employees used 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. The deadline for submitting inquiries was July 31, 2024.

OMIG received a total of 2,583 phone calls related to HWB, 3,285 emails related to employee inquiries, and a total of 4,461 inquiries submitted through the HWB Employee Allegation portal. OMIG reviewed and processed all employee-submitted inquiries and allegations. Requests for information were sent to employers based on OMIG analysis of the inquiry and data. OMIG completed a review of the information obtained and determined whether the employer should have submitted a bonus and/or if the employee should have received a bonus.

2024 AGENCY HIGHLIGHTS

FINANCIAL HARDSHIP

OMIG is sensitive to the financial stability of the healthcare provider community and to this end, offers providers the opportunity to request financial hardship that results from OMIG's audit activities. The mission is to ensure fair and reasonable repayment relief for providers facing financial hardship and balance the collection of Medicaid overpayments while helping to maintain uninterrupted access to necessary health care services.

Providers who have received a final notice (e.g., final audit report, notice of agency action, etc.) where they are required to make a repayment to Medicaid and wish to request financial hardship consideration may contact OMIG's Bureau of Collections Management, which will send them a Financial Hardship Application. This application is to be filled out in its entirety. Examples of the application are located on OMIGs website under Information & Resources – Financial Hardship Application Information.

Once the completed application and supporting documentation is received by OMIG, the submitted information is reviewed and analyzed by the Financial Hardship team to determine if the provider is in financial hardship and when appropriate, an extended repayment plan is granted. The determination and repayment plan are communicated to the provider. Providers who have been granted hardship relief must reapply annually to allow OMIG to evaluate any changes in their financial situation.

In 2024, 33 hardship applications were received and reviewed by OMIG, including 17 new financial hardship applications and 16 applications for continued hardship relief.

Of the 17 original financial hardships received:

- 16 were approved based on the documentation submitted by the provider
- One of the providers appealed their initial determination resulting in a second hardship review. Based on the updated information and further review the repayment plan was lowered.

Of the 16 providers who have received hardship relief prior to 2024 and re-applied and submitted hardship application renewals:

- 10 of the renewals maintained the established repayment plan,
- Three renewals resulted in a reduced payment amount under the repayment plan,
- One request was withdrawn by the provider,
- One request was returned to provider due to missing information, and
- One application is still under review.

2024 AGENCY HIGHLIGHTS

PROVIDER ENGAGEMENT AND LESSONS LEARNED

Delivering educational presentations and other forms of outreach to provider organizations offers numerous benefits to both the health care sector and OMIG. First, it enhances the overall quality of care delivered to Medicaid beneficiaries by ensuring providers are well-informed about program policies, billing procedures, and clinical guidelines. When providers understand the specific requirements and best practices associated with Medicaid, they are better equipped to deliver compliant, efficient, and effective care. This proactive approach reduces errors, claim denials, and potential fraud, ultimately leading to improved health outcomes and more efficient use of resources within the Medicaid program.

Second, engagement sessions serve as a valuable platform for fostering collaboration and communication between OMIG and provider organizations. By engaging directly with providers, the agency can clarify policy changes, gather feedback on implementation challenges, and identify areas where additional support or resources may be needed. This two-way communication helps build trust and transparency, encouraging providers to participate actively in Medicaid initiatives, comply more readily with program requirements, and share insights that can inform future policy development.

Finally, delivering targeted education and presentations enables OMIG to promote innovative practices and the adoption of new technologies. These efforts help providers stay current with evolving standards and tools, which not only supports the agency's strategic program integrity goals but also ensures that providers are prepared to meet emerging healthcare needs efficiently. Overall, these educational efforts strengthen New York's Medicaid system, improve provider engagement, and foster a more sustainable and responsive healthcare system.

In 2024 the following compliance and self-disclosure modifications/improvements were made based on provider input/feedback:

- Brought numerous efficiencies to the Compliance Program Review (CPR) process: increased communications with providers engaged in reviews, added new educational resources to the Compliance section of OMIG's website, and developed and presented targeted, topic-specific presentations to providers across the delivery system.
- Continuously updated guidance materials to inform the provider community about Self-Disclosure requirements, resources available, and program updates.
- Increased the volume of and topic areas covered in both Compliance and Self-Disclosure presentations and communications.

In 2024 the following audit enhancements were made based on input/feedback from providers:

- Added new educational resources to the Audit section of OMIG's website, including updated audit protocols.
- Updated guidance materials to inform the provider community about audit requirements, resources available, and agency updates.
- Developed and presented targeted, topic-specific presentations to providers across the delivery system.

2024 AGENCY HIGHLIGHTS

AUDIT PROTOCOLS

Audit protocols are developed for each fee-for service- (FFS) category or program audited by OMIG. The established review process includes gathering feedback from the oversight agency responsible for the respective program.

Subsequently, OMIG shares the audit protocols with the applicable provider association for comment. OMIG provides clarification and education to the associations, based on their respective comments and concerns. Once the process of vetting the audit protocols is complete, they are posted on OMIG's website.

In 2024, OMIG began the process of updating audit protocols to account for regulation changes and guidance issued during the COVD-19 Public Health Emergency (PHE). This process required OMIG's consultation with program agencies in order to obtain relevant guidance issued and incorporating guidance into Audit Protocols where applicable.

In 2024, the following sets of updated audit protocols were fully reviewed and posted:

PROJECT TYPE	FOR SERVICE DATES	PUBLISHED DATE	TARGETED NEXT PUBLICATION
Opioid Treatment Program (OTP) Protocol	11/23/2015-06/30/2024	9/25/2024	2026
Substance Use Disorder Outpatient Programs Protocol	11/23/15-06/30/2024	9/25/2024	2026
Independent Provider for Private Duty Nursing Protocol	01/01/2018-12/31/2023	10/29/2024	2026
Licensed Home Care Services Agency (LHCSA) for Private Duty Nursing Protocol	01/01/2018-12/31/2023	10/29/2024	2026
Durable Medical Equipment Protocol	04/01/2013-03/13/2024	11/15/2024	Pending
Diagnostic & Treatment Center (DTC) Services Protocol	01/01/2018-02/05/2023	11/25/2024	2027

*Targeted next publication dates are estimated and are subject to change.

COMPLIANCE & SELF-DISCLOSURE

86 CPRs Initiated

83 CPRs Finalized

11 Presentations

1,650+ Attendees

3,634 Successful Abbreviated Self-Disclosure Submissions Received

92% Average Compliance Program Review Score

635 Finalized Full Self-Disclosures

$27M+ Identified Overpayments

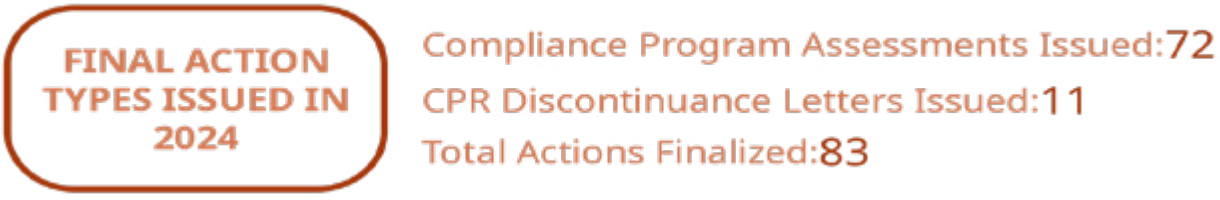
COMPLIANCE

Compliance programs should be reasonably designed and implemented so that the program is generally effective in preventing, detecting, and correcting fraud, waste, abuse, and non-compliance with Medicaid program requirements. Title 18 of the New York Codes, Rules and Regulations (NYCRR) Part 521 outlines the requirements of a compliance program for Medicaid-enrolled providers subject to Articles 28 and 36 of the Public Health Law and Articles 16 and 31 of the Mental Hygiene Law and/or received more than $1 million in Medicaid funding within a calendar year. Providers subject to these requirements consist of enrolled Medicaid program providers such 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. Medicaid program enrollment data for the providers under these Articles indicates there are more than 4,000 providers required to have a compliance program.

During 2024, OMIG continued conducting compliance program reviews (CPRs) to determine whether providers had met their compliance program obligations. These reviews encompassed a specific three-month review period and focused on determining whether the provider adopted, implemented, and maintained an effective compliance program that satisfied the Medicaid program requirements outlined in NYCRR Part 521.

Upon completion of a compliance program review, OMIG notified providers of the results of the review by issuance of a:

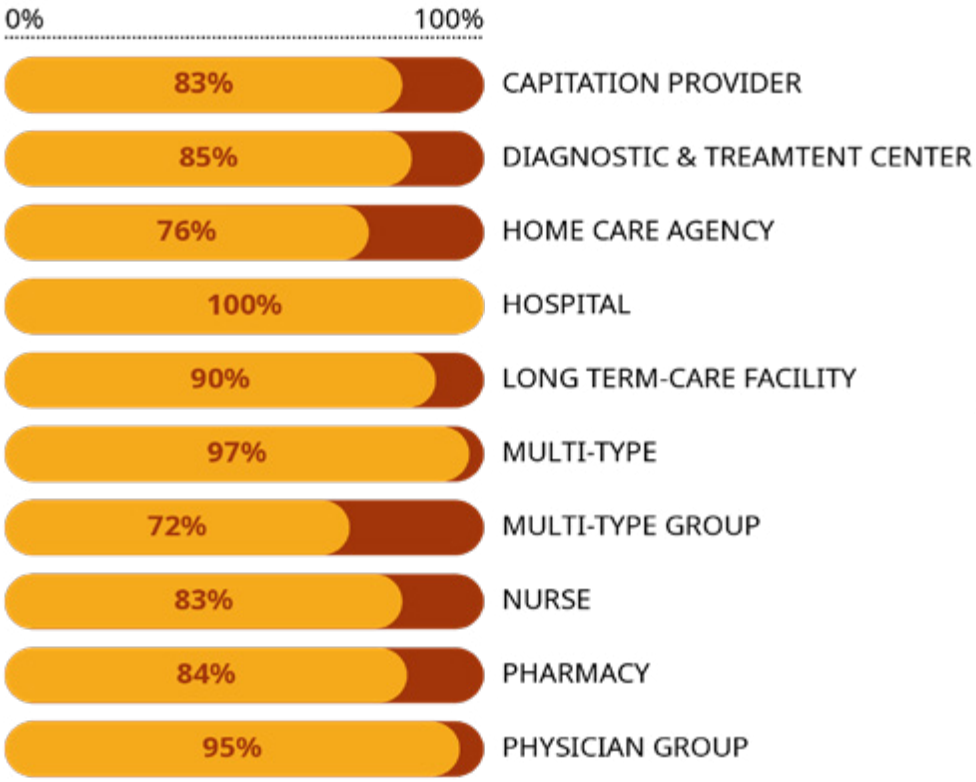
- **Compliance Program Assessment** which informs the provider whether OMIG's assessment determined the provider's compliance program satisfactorily met the requirements and if it has areas that need to be corrected. Additionally, Pursuant to 18 NYCRR § 521-1.4(h), the Provider is required to promptly implement corrective actions in all areas OMIG identified as deficient. In 2024, OMIG issued 72 Compliance Program Assessments.
- **CPR discontinuance letter** which informs the provider that OMIG concludes its review for the stated review period and has determined that no further action is currently warranted. This action is generally taken when a provider has had a change in their enrollment status, such as disenrollment from the Medicaid program. In 2024, OMIG issued 11 CPR discontinuance letters.



In 2024, all providers that had a compliance review all passed, with an average score of 92%, which is indicative of the effectiveness of their programs at meeting minimum program requirements.

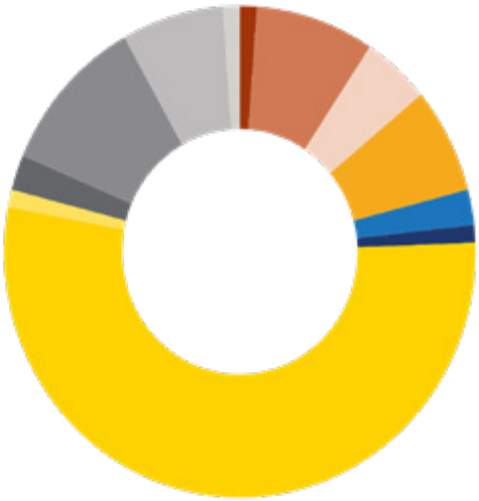
COMPLIANCE

2024 COMPLIANCE PROGRAM REVIEWS AVERAGE SCORE BY PROVIDER TYPE



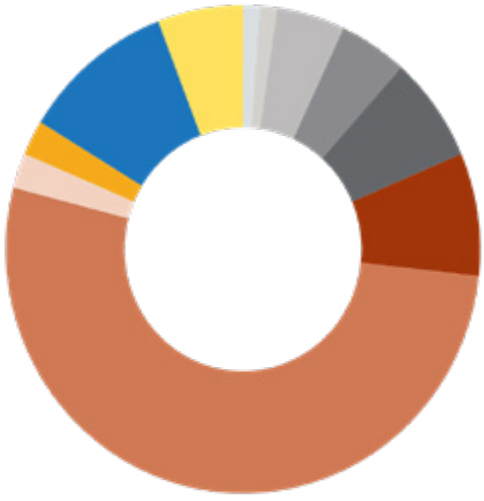
92% OVERALL AVERAGE

2024 REVIEWS INITIATED BY PROVIDER TYPE



- Capitation Provider (1)
- Diagnostic and Treatment Center (7)
- Home Care Agency (4)
- Hospital (6)
- Long Term Care Facility (2)
- Medical Appliance Dealer (1)
- Multi-Type (46)
- Multi-Type Group (1)
- Nurse (2)
- Pharmacy (9)
- Physician Group (6)
- Transportation (1)

2024 FINAL ACTIONS BY PROVIDER TYPE



- Capitation Provider (1)
- Child Care Institution (1)
- Diagnostic and Treatment Center (4)
- Home Care Agency (4)
- Hospital (6)
- Long Term Care Facility (7)
- Multi-Type (45)
- Multi-Type Group (2)
- Nurse (2)
- Pharmacy (9)
- Physician Group (5)

** The majority of the multi-type providers are part of/affiliated with larger hospital systems*

COMPLIANCE

EDUCATION/OUTREACH

OMIG sent letters to 102 hospital systems to request their assistance to facilitate an efficient and effective compliance program review for both the agency and the hospital community by streamlining the review process through identification of all provider IDs within a healthcare system that are required to have a compliance program. This outreach was successful in establishing connectivity for hospital system compliance program activities, which enabled OMIG to conduct consolidated compliance program reviews for hospital systems that included all providers under the same compliance program. This approach minimized disruptions to hospital systems during compliance program reviews.

In response to provider requests to better understand compliance program requirements, OMIG engaged in education and outreach related to common findings and recommendations for each element outlined in 18 NYCRR 521-1. During 2024, OMIG gave 11 presentations to over 1,000 attendees to healthcare associations and organizations.

Additionally, OMIG participated in an interagency workgroup to identify providers subject to Articles 28 and 36 of the Public Health Law and Articles 16 and 31 of the Mental Hygiene Law. The workgroup consisted of representatives from OMIG as well as DOH, Office of Mental Health (OMH), Office for People with Developmental Disabilities (OPWDD), and Office of Addiction Services and Support (OASAS). The group confirmed the method used to identify providers subject to the above articles that are required to have a compliance program regardless of how much they receive in payments from the Medicaid program.

OMIG identified providers required to have a compliance program that are no longer billing and still have an active enrollment. As a reminder, providers must notify DOH as soon as there are any changes in their enrollment status. OMIG referred two providers, who had enrollment issues, to the DOH.

COMPLIANCE

COMPLIANCE PROGRAM REVIEWS INSIGHTS AND BEST PRACTICES

OMIG has identified the following areas where providers performed well in their 2024 compliance program reviews:

- Designating a compliance officer who is responsible for the day-to-day operation of the compliance program who reports directly to the chief executive, or another senior manager as designated by the chief executive.
- Ensuring the compliance officer and appropriate compliance personnel have access to all records and documents, information, facilities, and affected individuals that are relevant to carrying out their compliance program responsibilities.
- Implementing a designated compliance committee comprised of senior managers that meets at least quarterly.
- Maintaining lines of communication that allowed for questions regarding compliance issues to be asked and compliance issues to be reported.
- Maintaining a method for anonymous reporting of potential fraud, waste, abuse, and compliance issues directly to the compliance officer.
- Enforcing disciplinary standards fairly and consistently.
- Reporting, returning, and explaining Medicaid program overpayments.
- Taking prompt corrective action to prevent overpayments from recurring.

OMIG has identified the following areas within the compliance program reviews where providers had difficulty meeting the requirements in 2024:

- Performing an annual review of written policies.
- Conducting an annual review and update of the compliance committee charter.
- Maintaining a compliance program training plan.
- Publicizing compliance program information on the provider's website.
- Performing auditing and monitoring of all required risk areas identified.
- Performing exclusion checks for all affected individuals at least every 30 days.

OMIG recommends that providers review compliance program resources available on OMIG's website at: https://omig.ny.gov/compliance/compliance.

SELF-DISCLOSURE

Medicaid Entities, including Medicaid-enrolled providers, MCOs, and other entities involved in the billing or receipt of Medicaid funds (i.e., Medicaid entities/providers), are required to report, return, and explain any overpayments they have received to OMIG's Self-Disclosure Program within 60 days of identification, or by the date any corresponding cost report was due, whichever is later. OMIG's Self-Disclosure Program gives Medicaid entities/providers a method to comply with federal and state requirements to report, return, and explain Medicaid overpayments. OMIG's approach is designed to encourage providers to investigate and report matters involving possible fraud, waste, abuse, or inappropriate payment of funds that they identify through self-review, compliance programs, or internal controls. Providers can also self-disclose as a result of internal or external audits, Medicaid guidance, or policy updates. Identification and self-disclosure of Medicaid overpayments are elements of an effective compliance program.

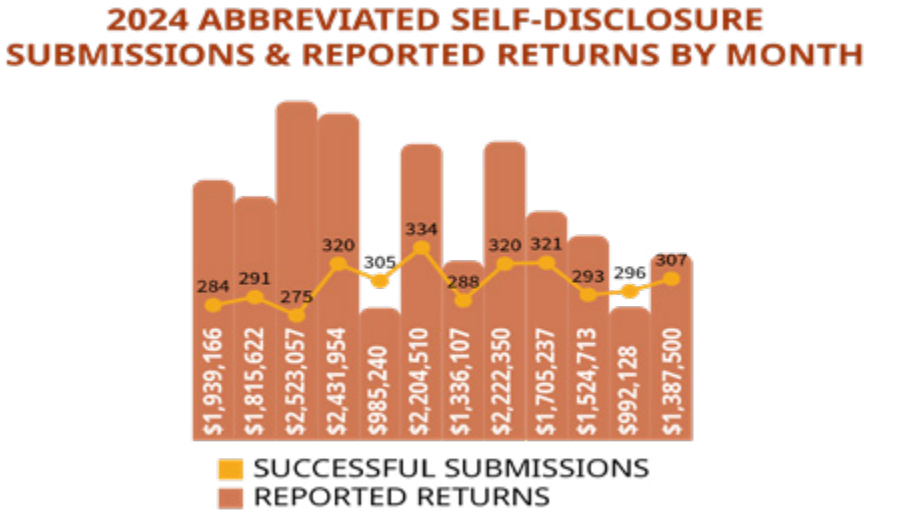
OMIG offers two avenues for providers and other Medicaid entities to meet their requirement to self-disclose Medicaid overpayments. The Abbreviated Self-Disclosure Process, implemented in August 2023, is the mechanism to report and explain Medicaid FFS claim overpayments that were received due to errors considered to be transactional or routine, and have been voided or adjusted to repay Medicaid. The Full Self-Disclosure Process is the mechanism to report, return, and explain any other FFS claim, or non-claim-based, Medicaid overpayment.

As per NYS regulation 18 NYCRR Part 521 and OMIG published guidance, Medicaid managed care overpayments must be self-disclosed to the applicable Medicaid MCO. MCOs are required to report, return, and explain any identified overpaid capitation payments to OMIG within 60 days of identification through the Full Self-Disclosure Process. For encounter overpayments self-disclosed by participating providers or subcontractors to the MCO, MCOs have an obligation to process the submitted self-disclosure, report recoveries made via the appropriate vehicle (i.e., Provider Investigative Report (PIR) and Medicaid Managed Care Operating Report (MMCOR)) and remain responsive to the provider throughout the process.

It is important to note that although self-disclosure submissions increased in 2024, the percentage of Medicaid providers that participated in the Self-Disclosure Program was relatively small. In 2024, more than 80,000 entities billed Medicaid (grouped by Federal Employer Identification Number – FEIN); of those, only 6% submitted a full or abbreviated Self-Disclosure.

ABBREVIATED SELF-DISCLOSURE

As part of outreach and engagement efforts in 2024, OMIG received feedback on the Abbreviated process from the provider community. Through ongoing discussions with several provider associations, OMIG has identified potential improvements to the Abbreviated Self-Disclosure Process and has explored potential avenues for process improvements. Through the Abbreviated self-disclosure process, OMIG received 3,634 successful submissions with a reported returns of $21,067,583.



SELF-DISCLOSURE

ABBREVIATED SELF-DISCLOSURE STATISTICS 2024

Category	Totals
Total submissions received	3,827
Improperly formatted submissions	193
Viable Submissions	3,634
Reported Returns	$21,067,584

DISCLOSURE COUNT BY OVERPAYMENT REASON

Overpayment Reason	Submission Count
Credit Balance	1,879
Typographical error made during billing entry	770
Missing or insufficient support documentation	518
Inappropriate rate, procedure, or fee code used	446
Recipient Enrollment issue	409
Provider submitted no response	296
Authorization for services faulty/missing	165
Provider provided description	118
NAMI Adjustment	108

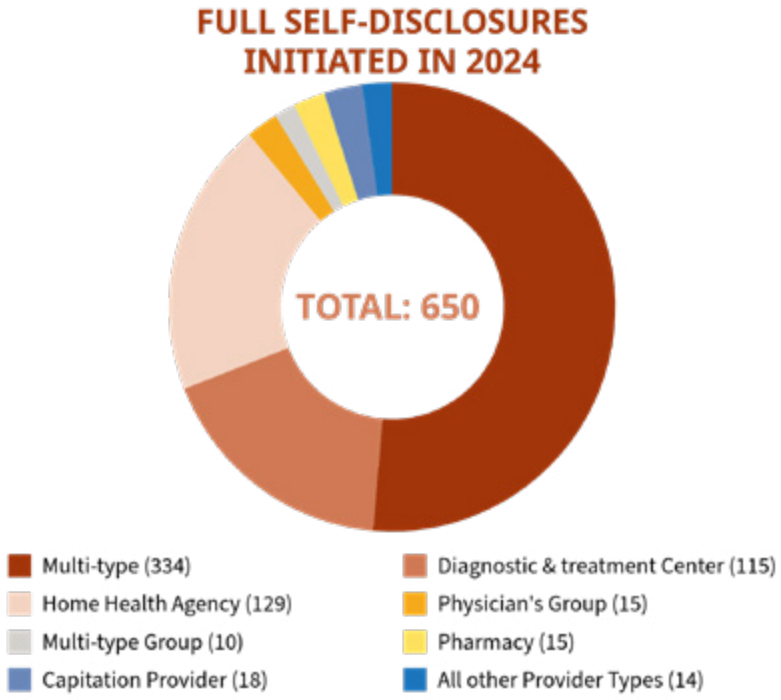
Note: A submission may contain multiple error reasons

SELF-DISCLOSURE

FULL SELF-DISCLOSURE

Throughout 2024, OMIG participated in conferences, meetings, and engagement forums with the Medicaid community, reaching participants that included providers, Medicaid MCOs, and other state agencies impacted by Medicaid funds. As a result of these interactions with the provider community, OMIG made updates to the self-disclosure section of OMIG's website to include specifics about how the self-disclosure requirement relates to MCOs and information about OMIG's financial hardship application process.

As a result of engagement with the provider community, full self-disclosure submissions increased by 12% in 2024 from those submitted in 2023. In 2024 OMIG finalized 635 full self-disclosures identifying overpayments of more than $27.1 million and recovered more than $25.3 million.



FINALIZED SELF-DISCLOSURES BY IDENTIFIED OVERPAYMENTS

FINDING AMOUNT	2023	2024	%
$0 to $1,000	218	274	+25.7%
$1,001 to $10,000	146	184	+26%
$10,001 to $100,000	97	139	+43.3%
$100,001 to $1,000,000	18	33	+83.3%
$1,000,001+	1	5	+400%

BUSINESS INTELLIGENCE & ADVANCED ANALYTICS

1,904,115

CLAIMS LOADED TO CASH CLAIMS DATABASE TOTALING

$671,283,082

6,471,826

CLAIMS LOADED TO CLAIMS/ENCOUNTER DATABASE TOTALING

$761,996,082

BUSINESS INTELLIGENCE

In 2024, NYS Medicaid program services were administered to an average of more than 7.1 million recipients via a care network of more than 200,000 enrolled providers. This resulted in over one billion Medicaid FFS claims or MCO encounter transactions being entered in the Medicaid Data Warehouse (MDW) in 2024, consisting of more than 660 million original claims, 385 million adjustment transactions of various types, and 38 million void transactions.

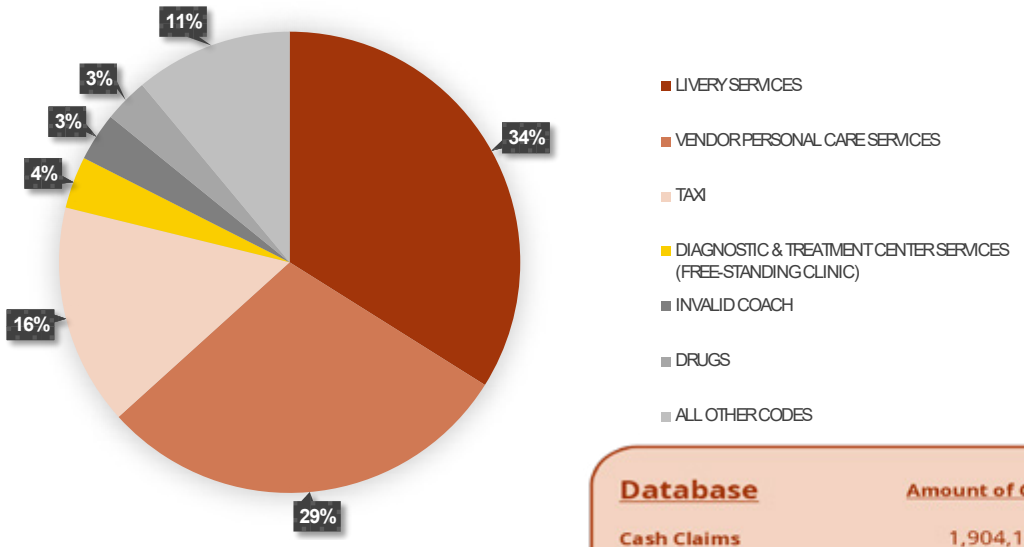
OMIG utilizes technology to assist the agency in its oversight of the Medicaid program, confirm the appropriateness of provider payments, and provide timely, accurate, and defensible data and analysis to support the agency with program integrity initiatives. OMIG staff employ specialized knowledge of Medicaid services, data, and systems to apply technological solutions and develop complex data analytics to inform and support management decisions, audits, investigations, reviews, hearings, and provider engagements.

OMIG tracks all claims and encounters that have been included in projects to prevent duplication of efforts within the agency. This ensures that claims and encounters that the agency has recovered, or intends to recover, will not be included within subsequent agency activities, thereby preserving the integrity of the identification and recovery process. These claims and encounters are housed in two databases, the Cash Claims Database, and the Claim/Encounter Universe Database.

The Cash Claims Database is a central repository that stores claims and encounters that have been identified for recoupment in an OMIG project. The Claim/Encounter Universe Database is a central repository that stores claims and encounters that have been identified in an audit universe for FFS or encounter projects where sampling is utilized are loaded into the claim/encounter universe database.

All claim and encounter extracts from the MDW, including extracts that support audits and investigations are verified against these databases. If the claim/encounter was previously identified, it is flagged within these databases as “not for recovery” with an explanation stating the claim/encounter has already been included in other OMIG projects. Any claim/encounter with this identifier may still be used for data analysis purposes but cannot be recouped. This process ensures that recoveries cannot be made more than once on any particular claim/encounter record. In 2024, OMIG loaded the following claims into these databases:

PERCENTAGES OF UNIVERSE CLAIMS IDENTIFIED IN 2024 BY CATEGORY OF SERVICE



Database	Amount of Claims	Value of Claims
Cash Claims	1,904,115	$671,283,082
Claim/Encounter Universe	6,471,826	$761,996,082

BUSINESS INTELLIGENCE

ADVANCED ANALYTICS

With an eye toward focusing program integrity efforts on data trends, potentially problematic areas and behaviors while minimizing disruption to honest delivery of care, OMIG has established an Advanced Analytics unit in 2024. The unit seeks to provide insight for all agency projects aiming to utilize new technologies such as data visualization, complex statistical modeling, and machine learning.

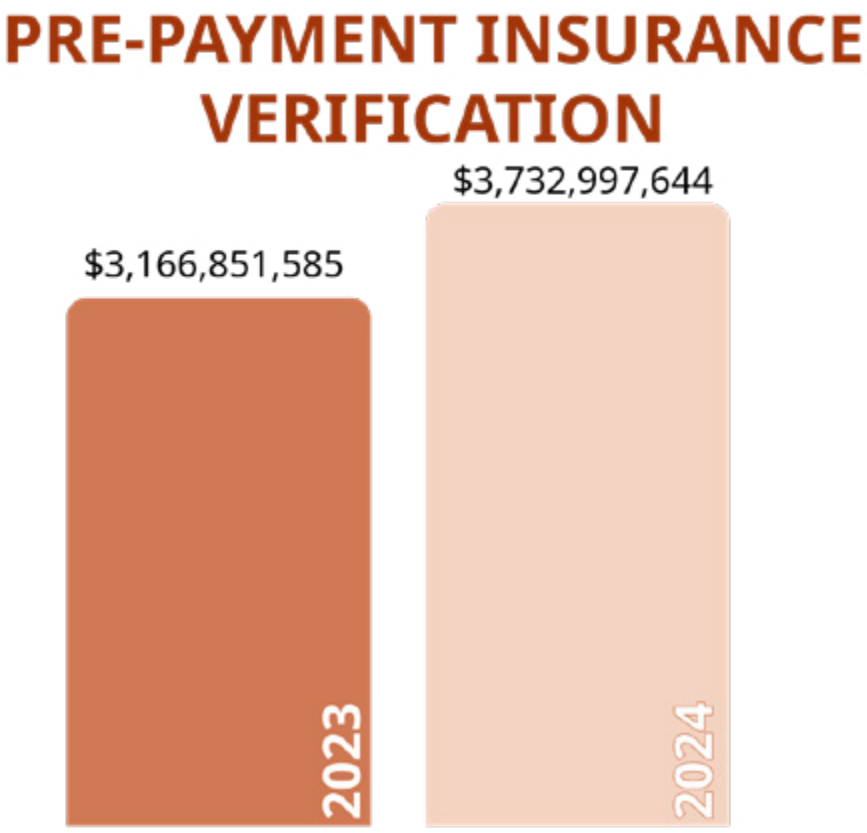
The core mission of the unit is to enhance collaboration between the OMIG data staff and the provider and member facing divisions who perform the audit, investigative and program reviews. In order to develop new methods to help identify new audits, investigations, and preventative measures for the submission of claims by providers, the unit meets regularly with the audit and investigations divisions. A more formal method, a biannual "Summit", has been started to bring analytics staff together with area-specific staff from the other divisions. The first "Transportation Summit" was held to show investigation staff the larger trends in Non-Emergency Medical Transportation. Investigators were able to verify the identified trends in the data, such as the decrease in high dollar toll claims, learn of new ones, such as an increase in the volume of medium dollar toll claims, and give analytics staff insight into how important certain data elements are for identifying areas for investigation. The process is expanding to other areas, such as pharmacy and durable medical equipment (DME).

The unit is also developing stronger collaborations with other NYS agencies and Medicaid servicing companies in its program integrity efforts. For example, the unit has utilized data from Medical Answering Services (MAS) to expand the scope of OMIG's knowledge of what happens during transportation services. This new data gives the unit the ability to determine exact pick-up and drop-off times and locations, which is not available in the MDW.

BUSINESS INTELLIGENCE

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. As part of its Third-Party Liability oversight, 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, the Medicaid program avoided more than $3.7 billion in payments by ensuring other forms of health care coverage were utilized.



MEDICAID AUDITS

702
AUDITS FINALIZED

133
POSITIVE REPORTS ISSUED

1,190
AUDITS INITIATED

$193M TOTAL AUDIT OVERPAYMENTS IDENTIFIED

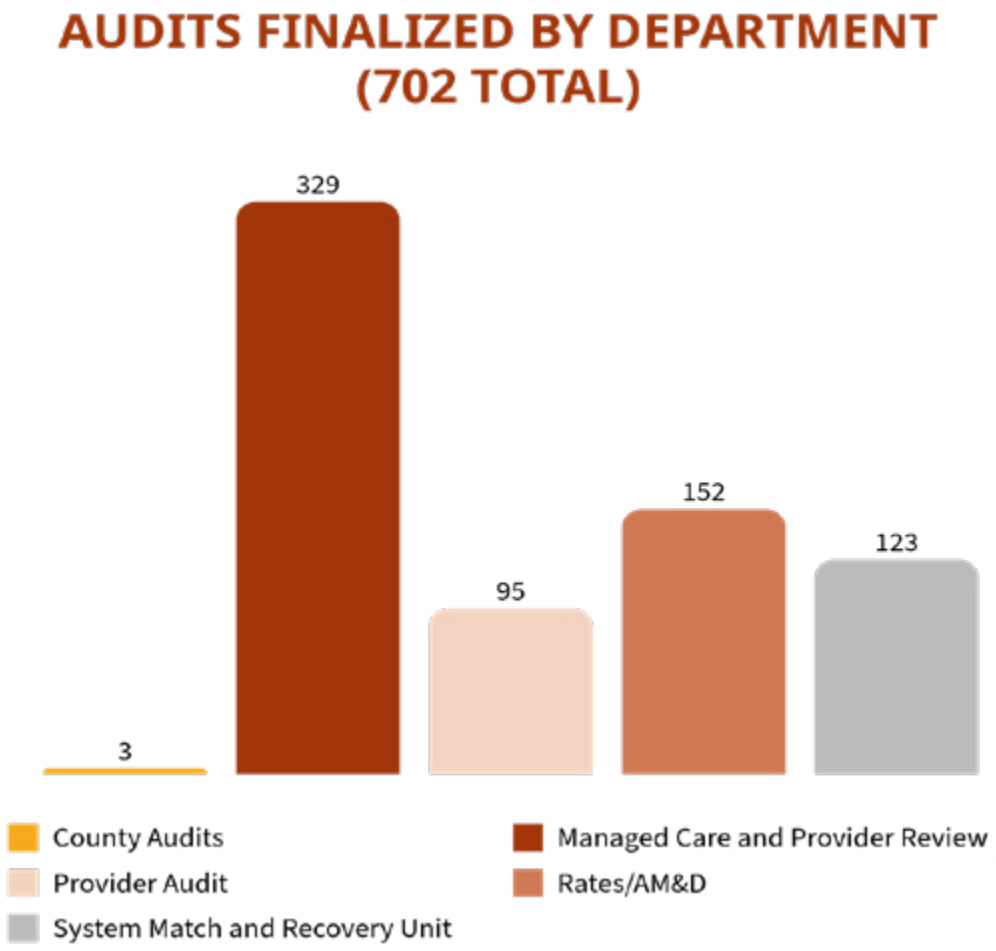
$14M MANAGED CARE PENALTIES

$220M TOTAL AUDIT RECOVERIES

MEDICAID AUDITS

OVERVIEW

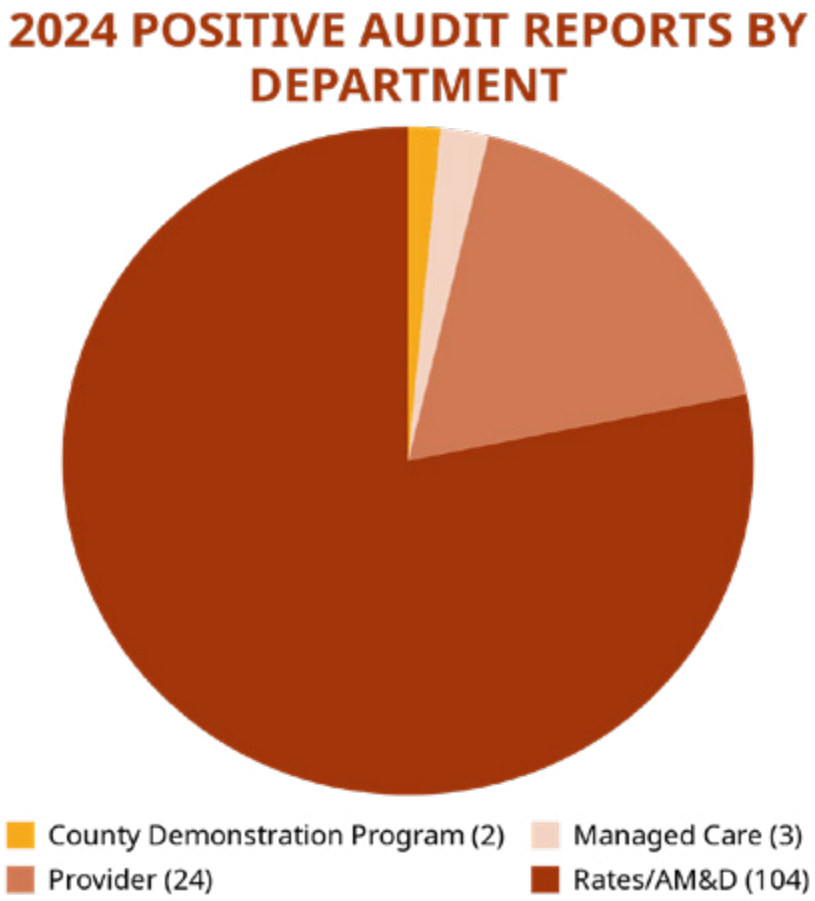
OMIG conducts audits of Medicaid expenditures across all provider and payor types, including MCOs, MLTCs, hospitals, clinics, nursing homes, home health, assisted living, and medical practitioners. These providers are entrusted with the health and safety of their patients. The purpose of these audits 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. 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. As with all OMIG audits, if it is determined that there is a significant issue concerning quality of care, OMIG cooperates with relevant State oversight agencies, including DOH to take appropriate action.



MEDICAID AUDITS

"POSITIVE AUDIT REPORTS" – DEMONSTRATION OF PROVIDER COMPLIANCE

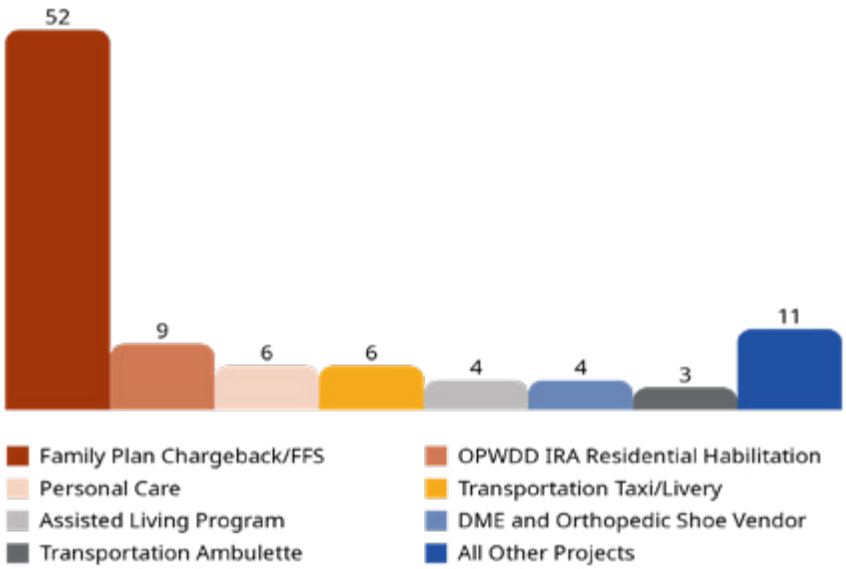
During the audit process OMIG may determine, for the audit period and objectives reviewed, that the provider generally adhered to applicable Medicaid billing rules and regulations. In these cases, OMIG issues an Audit Summation Letter advising the provider that pursuant to 18 NYCRR §517.3(h), the audit is concluded, and no further action is required by the provider. In 2024, OMIG issued 133 Audit Summations – which are posted on the OMIG website as "Positive Audit Reports" – and are indicative of provider compliance with Medicaid requirements in audits spanning FFS providers, MCOs, and nursing home minimum data set audits.



MEDICAID AUDITS

PROVIDER AUDIT

2024 PROVIDER AUDITS FINALIZED BY PROJECT TYPE (95 TOTAL)



EXTRAPOLATION

Extrapolation is a widely accepted audit technique for healthcare audits – 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 number 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.

Early in the engagement with the provider, OMIG provides, 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 any proposed 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.

In 2024, as part of its mission to enhance the integrity of the Medicaid program, OMIG finalized 46 audits utilizing extrapolation that examined over $440 million in Medicaid claims. Additionally, 26 summation letters were issued for audits that utilized sampling and examined over $175 million in Medicaid claims. Of the more than $620 million total universe examined, OMIG, through extrapolation, identified overpayments that exceeded $17 million - which represents approximately 2.9% of the universe reviewed. This is up from a 1.6% error rate in 2023. In addition, OMIG issued audits conducted by OPWDD that also utilized extrapolation. For these audits, OMIG issued 17 reports with identified overpayments that exceeded $13 million from a universe that exceeded $450 million, approximately 3% of the total universe reviewed.

MEDICAID AUDITS

PROVIDER AUDIT

ASSISTED LIVING PROGRAM

The assisted living program (ALP) audits determine whether the provider claims for Medicaid reimbursement complied with applicable Federal and State laws, regulations, rules and policies governing the NYS Medicaid program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed
- Appropriate rate codes were billed for services rendered
- Resident-related records contained the documentation required by the regulations
- Claims for payment were submitted in accordance with regulations and the appropriate Provider Manuals

OMIG audited 400 claims with a universe of $13,851,402 and a combined count of 827 errors in 16 error categories. The 16 unique error categories are related to employee training and oversight, employee health, and required documents including service documentation.

There were 377 instances where employee training requirements were not met. These include:

- Employee minimum training standards were not met in 8 instances
- Employees missed their annual performance evaluation in 206 instances
- The required in-service training for home health aide was not found in 163 instances

There were 352 instances of patient health and safety, and personnel health-related deficiencies found. These include:

- 172 instances of missing documentation of a Tuberculosis Screening/missing the required Tuberculosis Screening
- 133 instances of missing required Health Assessment/annual Health Assessment
- 40 instances of missing Certificate of Immunization for patients/immunization records for staff members
- 7 instances of missing Personnel Records/personnel files

OMIG's reviews also found 98 instances of an incomplete document set to support the claim as filed:

- 43 instances of missing Plans of Care or not updated as required
- 27 instances of missing Medical Evaluations/Medical reassessments
- 10 instances of missing Service Documentation
- 9 instances of missing UAS-NY entry
- 7 instances of incorrect rate code billed
- 2 instances of missing patient records

The errors listed above illustrate the results of OMIG's audits of providers ensuring residents are receiving quality care by trained and health screened staff to ensure that the needs of the patient are met in a safe and healthy manner. The training findings ensure that the services providers are rendering are safe and rendered in compliance with the needs of the resident.

The personnel health screening findings allow for the resident to receive services free of communicable diseases such as Tuberculosis, Mumps, Measles, and Rubella. OMIG reviews the document set to ensure that the residents are receiving the services deemed required by the residents' assessments. The review ensures that the required assessments are timely and in place for the dates of service under review.

In 2024, OMIG finalized four audits identifying overpayments of more than $1.4 million. Recoveries in this audit area, including audits finalized in prior years, were more than $3.2 million.

MEDICAID AUDITS

PROVIDER AUDIT

DIAGNOSTIC AND TREATMENT CENTER

Diagnostic and Treatment Centers (D&TC) provide primary health care services to recipients in need of immediate care.

D&TC audits examine claims for general medical services in active treatment of medical conditions and specialized condition-based therapies related to conditions in developmentally disabled patients. Both audits focus on care planning and patient safety via examination of service documentation in both environments.

The main finding in the D&TC audits was Incorrect Servicing Provider on the claim. This accuracy-related issue calls into question the quality of the billing and not ensuring that all claims filed are true, accurate, and complete. In 2024, OMIG issued three audit summations and finalized one audit identifying overpayments of more than $1.5 million. Recoveries in this audit area, including audits finalized in prior years, were more than $1.2 million.

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 the HCBS program 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. 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 Plan

In 2024, OMIG issued two audit summations and finalized nine audits identifying overpayments of more than $4.4 million. Recoveries in this audit area, including audits finalized in prior years, were more than $3 million.

MEDICAID AUDITS

PROVIDER AUDIT

FAMILY PLANNING CHARGEBACK FEE-FOR-SERVICE AUDIT

The Family Planning Chargeback Fee-for-Service Audit is a follow up to the Family Planning Chargeback to MCOs. In the course of the Family Planning Chargeback to MCOs, if the MCOs show evidence that the provider was in their provider network and the contract between the plan and provider included family planning services, the claims are removed from the MCO's chargeback liability. OMIG then issues a Fee-for-Service audit that recovers the inappropriately billed claims from the network provider who should have billed the MCO instead of directly billing Medicaid FFS. In 2024, OMIG finalized 52 audits identifying overpayments of more than $3.6 million, and recovered more than $2.2 million.

OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES 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 2024, OMIG issued 16 HCBS waiver service audits performed by OPWDD, identifying overpayments of more than $13.3 million and recovered more than $12.1 million. Common findings were as follows:

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

DURABLE MEDICAL EQUIPMENT AND ORTHOPEDIC SHOE VENDOR AUDITS

DME and Orthopedic Shoe Vendor audits review claims for devices and equipment, medical/surgical supplies, orthotic and prosthetic appliances, and devices which have been ordered by a practitioner in the treatment of a specific medical condition. The specific standards and criteria pertaining to DME are outlined in Title 18 NYCRR Section 505.5 and the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Policy Guidelines issued by DOH. Common findings were as follows:

- Original signed orders not received within 30 calendar days (extrapolated);
- Order refilled more than 180 days from the original date ordered (extrapolated); and,
- Missing documentation confirming receipt/delivery (extrapolated).

In 2024, OMIG issued one audit summation and finalized four audits identifying overpayments of more than $2 million. Recoveries in this audit area, including audits finalized in prior years, were more than $681,000.

MEDICAID AUDITS

PROVIDER AUDIT

PERSONAL CARE AIDE SERVICES

Personal Care Aide (PCA) services are home care services provided to recipients by personal care aides who are employed by a home care agency, thus allowing them to stay in their own homes and communities. Personal care aides must meet certain qualifications, such as training, evaluations, and background checks in order to provide services 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:

- Missing Documentation of Nursing Supervision Visit (Extrapolated),
- Failure to Complete Required In-Service Training (Not Extrapolated), and
- Missing Documentation of Hours Billed (Extrapolated).

In 2024, OMIG issued three audit summations and finalized six audits, identifying overpayments of more than $1.7 million. Recoveries in this audit area, including audits finalized in prior years, were more than $1.8 million.

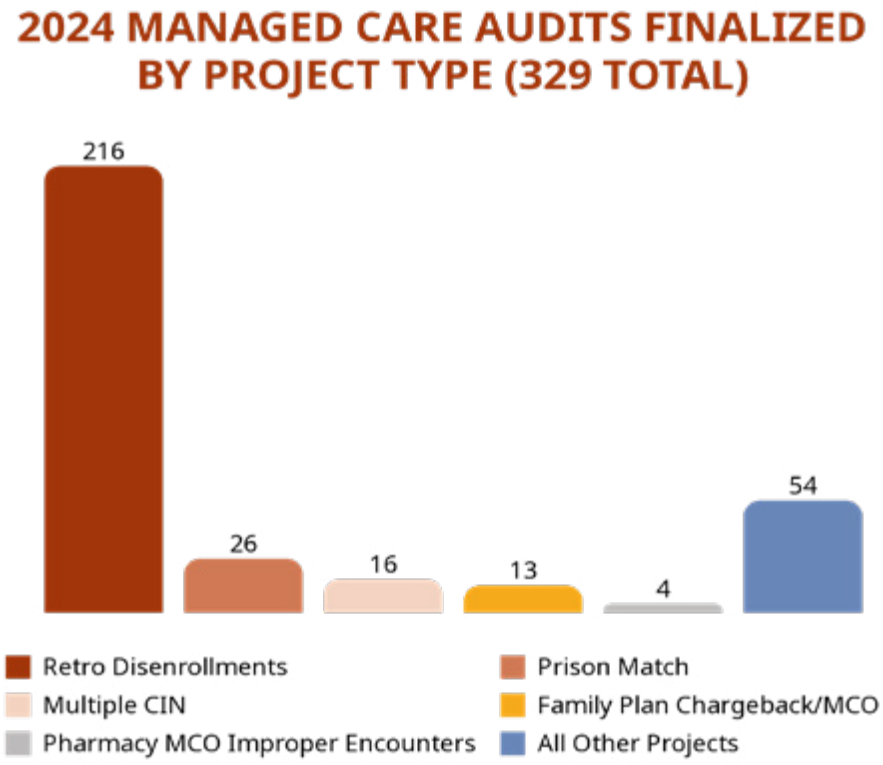
CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

The Consumer Directed Personal Assistance Program (CDPAP) is a Medicaid Program that allows Medicaid members who are eligible for home care services to choose and hire their own personal caregiver, or “personal assistant”. CDPAP provides services to chronically ill or physically disabled individuals who have a medical need for help with daily activities or who require skilled nursing services. The goal of the program is to assist consumers with maintaining their independence and remaining in their home.

In 2024, OMIG initiated 34 audits in this area to ensure that services were being billed and documented in compliance with Medicaid rules and regulations. OMIG also issued two audit summations in this audit area.

MEDICAID AUDITS

MANAGED CARE AUDITS



ENHANCED NURSING HOME RATE CODE

Until mid-2025, Mainstream Medicaid Managed Care recipients who were permanently placed in a nursing home were allowed to retain their Medicaid Managed Care eligibility. The Managed Care/Family Health Plus/HIV Special Needs/Health and Recovery Plan Model Contract (Model Contract) details the procedures regarding a recipient's nursing home placement and the obligations of the MCO to cover nursing home costs. An enhanced capitated rate was established to address the additional expenses associated with nursing home care. To ensure compliance, OMIG reviews encounter data and recipient eligibility information to identify instances where the system did not show evidence of a recipient having been placed in a nursing home, the nursing home having been paid, or the recipient meeting the eligibility requirements for nursing home placement. If it is determined that the recipient was not receiving nursing home care, and the MCO received the enhanced payment, OMIG would recover those payments.

In 2024, OMIG finalized 11 audits identifying overpayments of more than $59.4 million and recoveries totaling $58.3 million. In addition, during calendar year 2024, one specific provider self-disclosed over $1 million in Medicaid overpayments in this area.

MEDICAID AUDITS

MANAGED CARE AUDITS

FAMILY PLANNING CHARGEBACK TO MANAGED CARE ORGANIZATIONS

Historically, federal Medicaid law has not permitted a Medicaid Managed Care enrollee to be limited to their MCO's provider network for family planning services. As a result, Medicaid Managed Care members can receive family planning services from any Medicaid provider, without a referral, regardless of whether the provider participates in their Medicaid MCO's provider network. The Model Contract includes a provision that allows NYS to "charge back" any family planning services provided by out-of-network providers to the MCO. OMIG regularly conducts a review to identify services eligible for the family planning chargeback and works with DOH and the MCOs to ensure funds are appropriately returned to NYS. The project includes coordination with DOH to define the diagnostic and procedure codes to be included, data mining and analysis of claims housed in the MDW, and a detailed comprehensive review of network provider contracts for each MCO.

In 2024, OMIG finalized 13 audits identifying overpayments of more than $20.4 million. Recoveries in this audit area, including audits finalized in prior years, were more than $24.9 million.

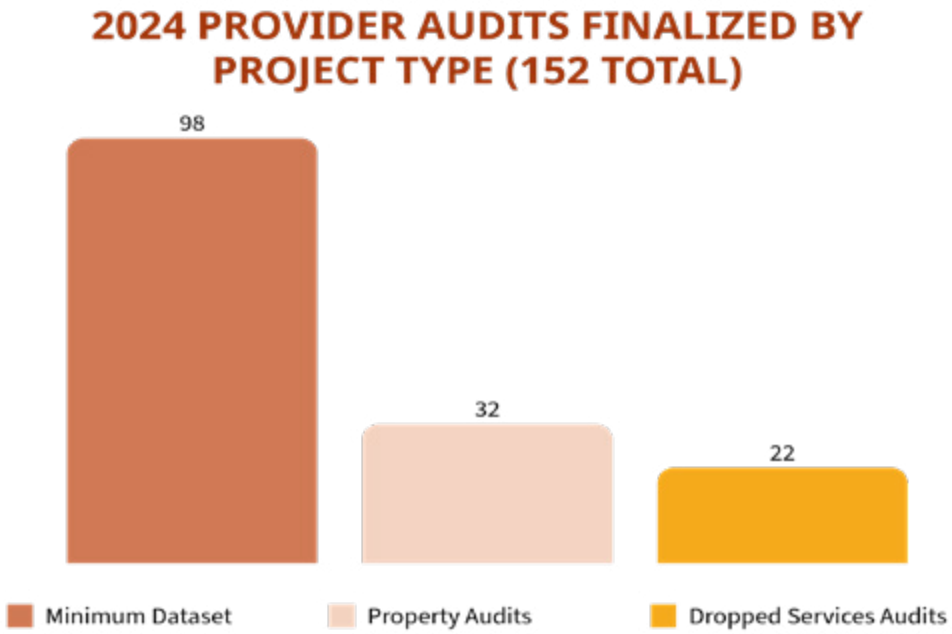
MEDICAID MANAGED CARE OPERATING REPORT

Medicaid Managed Care Operating Report (MMCOR) reviews are conducted to validate the costs reported by the MCOs in their cost report submission. These reviews ensure that pertinent costs and data reported on MMCORs submitted to DOH is accurate, complete, and allowable. OMIG performs these reviews of both Mainstream and MLTC plans' cost reports. Social Services Law (SOS) §364-j(38) was enacted in 2020 allowing OMIG to impose a penalty of twice the amount of any misstatement in the cost report. To support these reviews, OMIG staff conduct quarterly meetings with DOH regarding ongoing MMCOR reviews.

In 2024, OMIG issued one summation and finalized one review with penalties of more than $14 million.

MEDICAID AUDITS

NURSING HOME RATE AUDITS



Provider rate audits are conducted 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, property insurance costs may include insurance premiums for business income/interruption insurance. Since this type of insurance is not related to the loss of or damage to the provider's physical property a disallowance is considered necessary.

In 2024, OMIG issued 32 final audit reports identifying overpayments of more than $12.2 million. Recoveries in this audit area, including audits finalized in prior years, were more than $12.9 million.

MEDICAID INVESTIGATIONS

3,675
ALLEGATIONS OF FRAUD OPENED

247
PRE-PAYMENT REVIEWS

597
EXCLUSIONS

1,828
INVESTIGATIONS COMPLETED

135
EDUCATION LETTERS

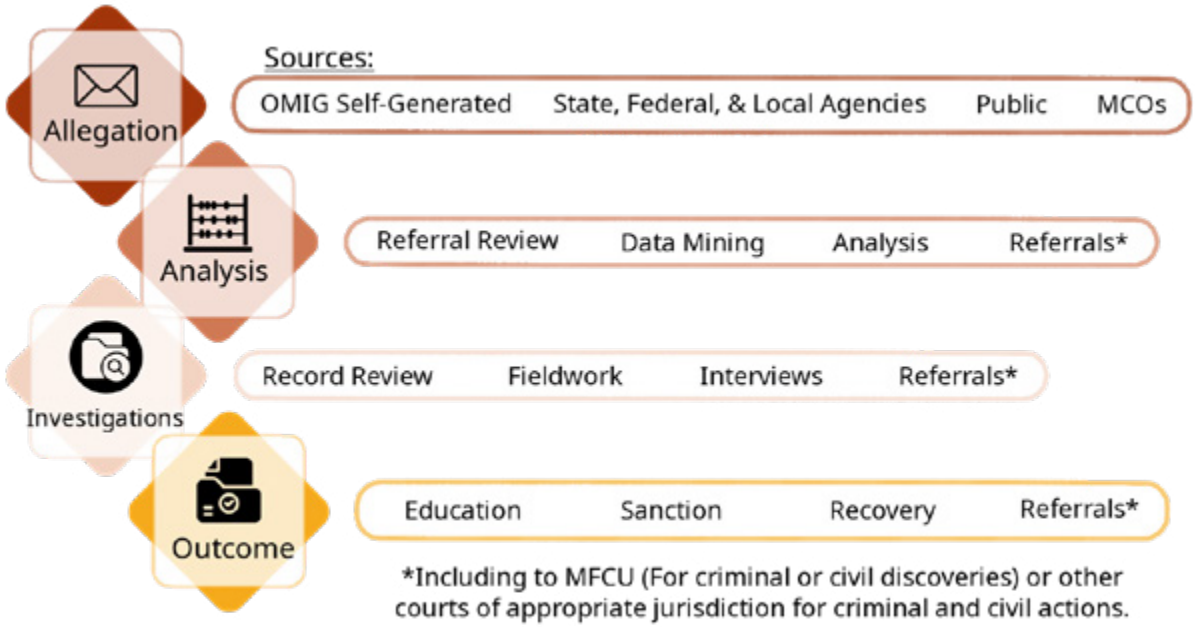
239
CVRs PERFORMED

MEDICAID INVESTIGATIONS

OVERVIEW

Investigations proceed from allegations, impermissible practices, or substantial deviations from established Medicaid requirements and are advanced and supported using a team approach that includes data analysis, comprehensive medical record reviews, clinical peer reviews – conducted by doctors, dentists, hygienists, nurses and pharmacists – and specialized investigative techniques developed to identify inappropriate behavior, Medicaid claims and payments. The duration of 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 an investigation can result in a criminal sanction, exclusion from the Medicaid program, a censure, recovery of Medicaid overpayment, or other administrative actions.

INVESTIGATION CYCLE



MEDICAID INVESTIGATIONS

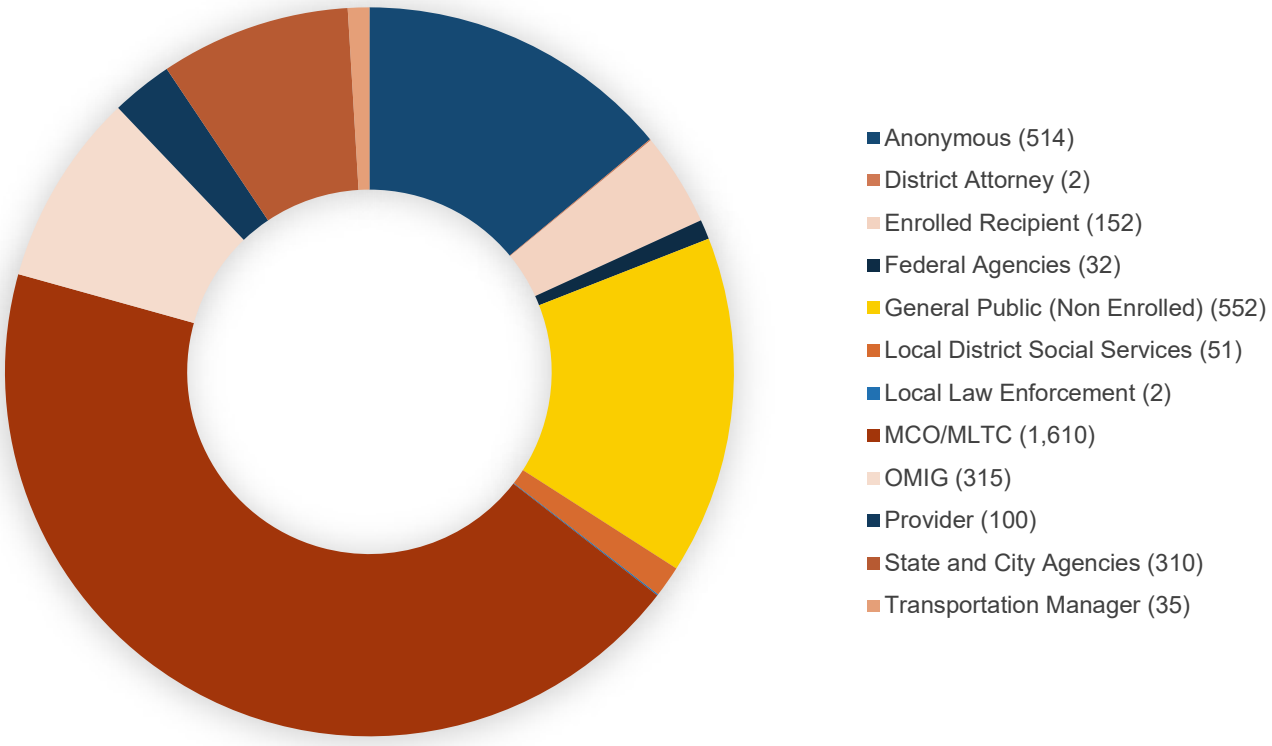
ALLEGATIONS

OMIG reviews all allegations to identify 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 using either OMIG's Medicaid Fraud Allegation Online Form located on OMIG's website or submitting a hard copy form to OMIG via mail or fax. Allegations are also submitted by MCOs, who as agents of the State Medicaid program, are contractually required to conduct oversight of their provider networks to ensure compliance with Medicaid program requirements and refer all identified instances of fraud, waste, and abuse to OMIG using a specific referral form.

In 2024, OMIG received 8,736 phone calls and emails through the hotline and the online submission form, as well as 1,169 referrals from MCOs and MLTCs identifying 1,602 subjects. While OMIG receives many allegations, not all provide sufficient information or are related to Medicaid, which are resolved without a project being opened. Based on preliminary review of the information received, OMIG opened projects on 3,675 subjects in 2024.

2024 ALLEGATIONS OPENED BY SOURCE (3,675 TOTAL)



MEDICAID INVESTIGATIONS

ANALYSIS

OMIG conducts an initial analysis on opened allegations that includes a review of relevant claims data. A review is also conducted on the subject and includes a look at any past or current cases, previous referrals, and/ or past disciplinary actions. All allegations received from MCOs and MLTCs are assessed for compliance with the reporting requirements outlined in the managed care contracts. In reviewing these allegations, OMIG determines those necessitating further investigation, any overlap with existing activities that merits review, and allegations that are best addressed by the MCO. As a result of the assessment, within 30 days of receiving the MCO referral, OMIG notifies the MCO of its determination regarding the referral and either provides clearance for the MCO to recover identified overpayments where appropriate or notifies them that OMIG will be pursuing the referral.

ANALYSIS REFERRALS

When the initial analysis indicates potential harm to an individual or a public safety issue, a referral is made to the appropriate agency or entity immediately for action. Allegations best handled by other oversight agencies or involving subjects currently under investigation by other law enforcement entities, are also referred to those respective entities. OMIG maintains close working relationships with these agencies to coordinate and enhance enforcement resources and avoid duplication of efforts. Based on the initial analysis OMIG referred 195 allegations to MFCU and 79 allegations to other entities to be reviewed for further action.

In 2024, based on OMIG's analysis of the allegations received 1,179 investigations were opened for additional review.

MEDICAID INVESTIGATIONS

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 Clinical Reviews, Credential Verification Reviews (CVR), Pre-Payment Reviews (PPR), and Explanation of Medical (Medicaid) Benefits (EOMBs):

CLINICAL REVIEWS

OMIG staff includes Registered Professional Nurses (RNs) and dentists, who support investigations through their clinical insight and assist with identifying and/or planning additional investigative steps based on the claims data. These steps include Explanation of Medical (Medicaid) Benefits (EOMBs), analyzing allegations received, Credential Verification Reviews (CVR), interviewing and field assistance, claims data analysis, reviewing medical records, and assistance with identifying NYS Medicaid recipients for Medical Records Requests.

In 2024, RNs completed 55 comprehensive clinical reviews and consultations for 49 investigations, with eight leading to referrals to partner agencies, including MFCU and DOH Office of Professional Medical Conduct. OMIG dentists completed 23 clinical reviews for 23 investigations, leading to 11 referrals to external agencies.

OMIG also has a team of registered pharmacists and pharmacy subject matter experts who inform, support, and guide agency-wide pharmacy program integrity activities through regular collaboration and engagement with OMIG division partners and outside agency stakeholders. Activities include:

- Providing pharmacy subject matter expertise on OMIG pharmacy investigations and pharmacy enrollment reviews.
- Conducting pharmacy CVRs to assess a pharmacy provider's compliance with NYS pharmacy laws, rules, and regulations pertaining to the practice of pharmacy, operation of pharmacy establishments and NYS Medicaid program requirements.
- Analyzing drug trends for patterns of fraud, waste, and abuse.
- Identifying potential pharmacy program integrity vulnerabilities and work with stakeholders to implement solutions.
- Providing pharmacy subject matter expertise to MFCU as needed.

MEDICAID INVESTIGATIONS

CREDENTIAL VERIFICATION REVIEWS (CVRS)

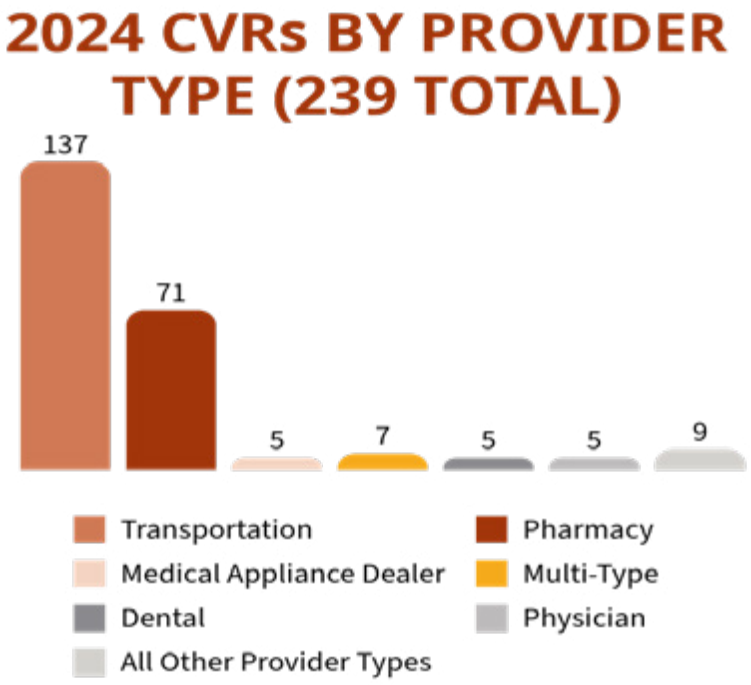
OMIG investigative staff routinely conduct CVRs to gather and verify information on Medicaid staff credentials and training requirements, service delivery, the storage of pharmaceuticals and medical supplies, the physical layout of the business, record keeping requirements, and Medicaid claiming practices, all of which is utilized to determine compliance with Medicaid requirements. This process facilitates provider education and improves provider compliance with the rules and regulations of the NYS Medicaid program. In 2024, OMIG performed 239 CVRs, a 15% increase from 2023.

OMIG performed 71 CVRs specific to pharmacy providers, with OMIG pharmacists assisting with 61 of these CVRs. OMIG identified 36 providers with prescriptions paid for by Medicaid that remained in the pharmacy pickup bin for more than 14 days and were not furnished to recipients. All Medicaid claims for drugs, over-the-counter products, or medical/surgical supplies that are not furnished (i.e., no proof of receipt) to the Medicaid recipient must be reversed within 14 days. These reviews found a total of 1,327 prescriptions that remained over 14 days, identifying $79,935 in claim payments. Of those claims, $45,248 have been recovered through the provider reversing the Medicaid claim.

In 2024, OMIG continued the pharmacy engagement initiative that began in 2023 following the NYRx transition. OMIG conducted 24 on-site CVRs in Queens, Brooklyn, and the Bronx over the course of three days. Findings included the following:

- 13 providers with 246 total prescriptions over 14 days, resulting in over $10,000 recovered through the provider reversing the Medicaid claim,
- pharmacies employing sanctioned individuals,
- no pharmacist on-duty at the time of the CVR,
- expired and adulterated drugs, and
- overfilled sharps containers.

As the project evolves, OMIG is exploring the appropriate action to take with the pharmacies that did not reverse their claims. Providers with more egregious findings are referred to NYSED OPD.



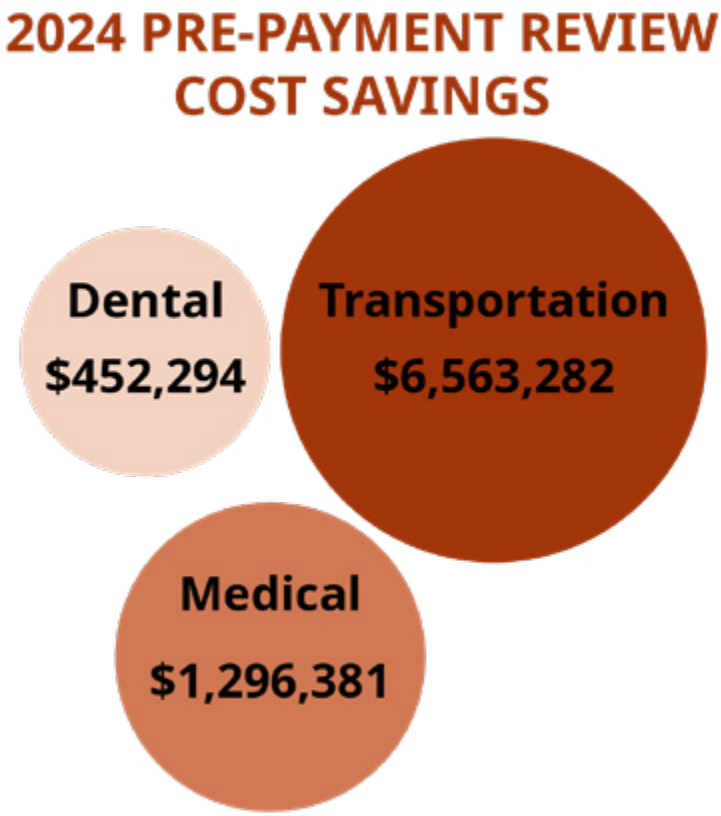
MEDICAID INVESTIGATIONS

PRE-PAYMENT REVIEW

Where OMIG identifies an unusual claiming pattern, OMIG may initiate a PPR process to both educate the provider on the procedural billing error and correct claiming on a prospective basis. This process pends claims for review to identify if they comply with Medicaid guidelines prior to payment and requires a close collaboration between OMIG and the impacted provider to ensure appropriate payments are made timely. OMIG provides support, guidance, and education to providers when inappropriate billing is identified. PPR is a particularly effective strategy for smaller providers or providers newly enrolled to the Medicaid program. Issues typically addressed though PPR include:

- Billing beyond the scope of enrollment
- Illegible, missing, or incorrect documentation
- Inappropriate combinations of procedures
- Billing for services that were not performed
- Excessive procedures per visit or treatment plan
- Duplication of services and upcoding

In 2024, OMIG initiated new PPRs on 192 providers, reviewing a total of 247 providers, including pharmacy, transportation, and durable medical equipment providers. As a result of these reviews 111,736 claims were ultimately denied with a total cost savings of $8,311,957.

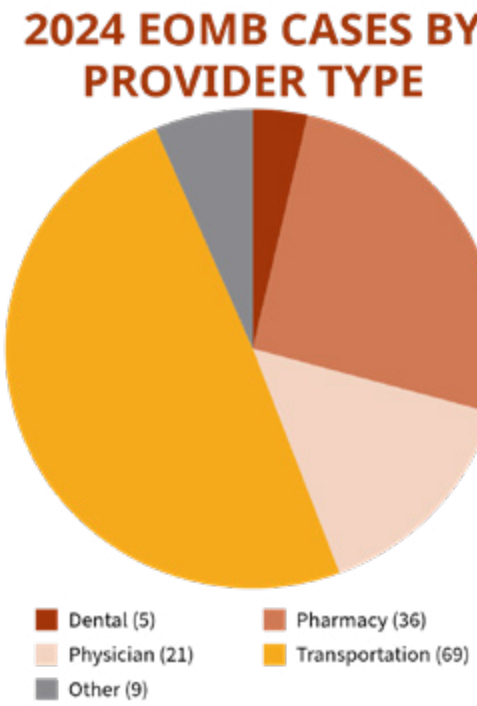


MEDICAID INVESTIGATIONS

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 a federal mandate under 42 CFR § 455.1(a)(2) and serve as a valuable tool to detect potential instances of fraud, waste, and abuse. OMIG uses data analytics to identify possible subjects who appear as outliers due to the number and types of claims they are submitting. OMIG generates EOMBs for recipients who may have obtained services from these providers.

In 2024, OMIG generated 60,000 EOMBs across multiple provider categories. Of the 3,253 EOMBs returned by recipients to OMIG, 687 recipients reported not receiving services, or had concerns with the services billed. These allegations led to OMIG initiating or supporting 140 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 identified by OMIG data analysis:

- Providers with a high number of telehealth services,
- Pharmacies billing high-cost medications, including antifungals and creams,
- Transportation services billed without any corresponding medical service,
- Patients of dentists identified as top billers in NYS, and
- Physical therapists billing impossible hours.

MEDICAID INVESTIGATIONS

COLLABORATIONS AND LAW ENFORCEMENT OUTREACH

Working in collaboration with other agencies is important for sharing resources and pooling knowledge on best practices and fraud trends. OMIG meets regularly with MCO SIU members to discuss and collaborate on matters of mutual interest including contractual requirements, program integrity concerns and referrals.

In 2024, staff attended meetings with several NYS law enforcement organizations including Local Department of Social Services (LDSS) staff, District Attorneys' office staff, Sheriffs office staff, representatives from NYS Department of Financial Services (DFS), and the Federal Bureau of Investigation (FBI). OMIG provides valuable investigative services to other entities, including fieldwork, data analysis, information on current fraud trends, and a range of subject matter experts in various issues related to medical billing and fraud. Further collaborative activities are planned for 2025, potentially increasing both the depth and breadth of resources available to support OMIG in its critical mission.

◊ In 2024, OMIG attended recurring meetings of the Orange County White Collar Crime Task Force to discuss crime trends, including money laundering, financial exploitation, and government benefit fraud. These task force meetings give OMIG an opportunity to collaborate with attendees including members of local law enforcement, NYS Tax and Finance, NYS DFS, MCOs, the FBI, and the US Secret Service. OMIG staff discussed the agency's investigative capabilities and resources available to collaborators investigating NYS Medicaid fraud. Future meetings will allow OMIG to further develop these external relationships and expand the agency's reach in combating fraud, waste, and abuse.

◊ On October 24, 2024, OMIG staff attended the Health and Human Services Office of the Inspector General (HHS-OIG) FBI Health Care Fraud Symposium. There were multiple city, state and federal law enforcement agencies in attendance. Meeting topics included:

- Artificial Intelligence (AI) in Health Care- Generative AI and Elder Based Health Care Fraud,
- Current Health Care Fraud Trends, and
- Best Practices for a Productive Partnership.

OMIG participated in a Transportation Task Force involving multiple state and federal agencies, including HHS/OIG, Department of Homeland Security, and Sullivan County DSS. The investigation targeted multiple transportation providers who were also NYS Medicaid recipients. On June 27, 2024, the NYS Attorney General announced the indictment and arrest of Muhammad Rizwan Khan, Muhammad Usman Khan, and Farhan Khan. The Khans and four of their related companies (Tristate Express NY, Inc., Meditrans NY, Inc., Empire Trans NY, Inc., and A1 Class Car, Inc.) were charged with stealing over $3.8 million in Medicaid funds and money laundering. The Khans allegedly established kickback schemes with Medicaid recipients, recruiting customers who they could then use to fraudulently bill Medicaid. They also gave recipients a weekly kickback to request rides from addresses that were further away so that a higher amount could be billed to Medicaid. OMIG provided support by conducting data analysis identifying additional individuals involved in the scheme. OMIG also excluded the Kahns, and an additional defendant, Richard Sehl, from participating in NYS Medicaid Attorney General Letitia James issued a press release announcing the indictment and thanking OMIG for their contributions.

MEDICAID INVESTIGATIONS

COLLABORATIONS AND LAW ENFORCEMENT OUTREACH

◊ In 2024, OMIG staff provided an overview of the agency and recipient investigation functions to Westchester County LDSS fraud and abuse managerial staff, to Dutchess County's LDSS SIU staff, Medicaid program director, assistant director and staff, District Attorney (DA), and Sheriff Office's Special Investigations, as well as Ulster County DA Special Investigations. These meetings were conducted to enhance the working relationship between OMIG and district agencies and assist with active investigations. Topics discussed included:

- Coordinating joint investigations between OMIG and the district to finalize administrative actions and prosecutions for NYS Medicaid beneficiary and public assistance fraud
- Guidance on the PHE Medicaid Winddown, the restart of program integrity functions by DOH, and OMIG's ability to secure and interpret NYS Medicaid applications for the LDSS
- The out-of-state residency initiative and how the project can assist with acting on recipients inappropriately receiving district administered welfare benefits
- Ongoing fraudulent billing and exploitation of the recipient population by NYS Medicaid Transportation and home health providers, kickback payments to recipients by transportation providers, and the successful prosecution of these providers throughout NYS by LDSS and OMIG joint investigations

◊ In March 2024, OMIG staff met with Oneida County staff including: LDSS SIU staff, their Restricted Recipient Program (RRP) representative, and their Deputy commissioners. OMIG gave a functional overview of how recipient investigations are performed and the RRP requirements. This overview was given with the intention of enhancing the relationship between OMIG and district agencies in addition to educating the district on OMIG's functions.

◊ OMIG, DOH, and pharmacy associations meet monthly to identify large scale forgery schemes and discuss changes that can be made. During one of these meetings, OMIG discussed an ongoing forgery scheme. The scheme consists of an individual calling in a forged prescription for high-cost medications such as Ozempic, Eliquis, Dexcom, or Trelegy. Attendees discussed ways to identify the scheme and steps to take if a forged prescription is received. OMIG and DOH are attempting to prevent this and other large scale forgery schemes by implementing changes such as improvements to the prior authorization process.

◊ On July 16, 2024, OMIG staff conducted an introductory meeting with Suffolk County DSS Fraud Unit supervisory staff to collaborate on current government benefit fraud trends. OMIG presented current trends in NYS Medicaid provider and recipient fraud and OMIG's investigative capabilities and resources.

◊ On March 27, 2024, OMIG hosted a roundtable discussion for OMIG and the MCOs in New York City (NYC), providing an overview of OMIG's referral process, an overview of the updated 2024 Provider Investigative Report guidelines and clarifications of OMIG's self-disclosure process.

MEDICAID INVESTIGATIONS

PROVIDER INVESTIGATIONS

CASE FILES: PHARMACY

◊ OMIG received an anonymous allegation stating a provider is billing Medicaid for medication that is not being dispensed to recipients. OMIG sent EOMBs to recipients to verify that they had received the medications that were billed. Ten recipients returned EOMBs with allegations including:

- not receiving the medications listed,
- the listed medications had not been prescribed,
- their identity had been stolen,
- they had received a lower cost drug than the one listed, and
- they had not picked up the medication.

Based on this information OMIG initiated an investigation which is ongoing.

◊ OMIG identified a provider billing for a large amount of Jublia 10% Topical Solution, a high-cost antifungal, and other high-cost medications. OMIG sent EOMBs to recipients to confirm the claims for these services were billed appropriately, and received EOMBs from 10 recipients with responses including:

- they had not received the medication,
- didn't recognize the pharmacy name,
- they used a different pharmacy and their identity was stolen, and
- receiving multiple medications that were not needed and/or requested.

Based on this information OMIG initiated an investigation which is ongoing.

CASE FILES: PHYSICIAN

◊ OMIG identified a doctor with a high percentage of claims with a telehealth modifier through data analysis and sent EOMBs to recipients to confirm that the services were provided. OMIG received EOMBs from 176 recipients, with responses including:

- not receiving the services,
- never seeing the provider,
- not recognizing the provider's name,
- not having an appointment on the date listed,
- never going the borough where the office is located, and
- receiving the services from a different provider at a different location on that date.

The high return of EOMBs supports OMIG's analysis in linking outliers identified in data with the actual experiences of the recipients purported to have received the services Medicaid was billed for. Based on the responses received, this case was assigned for further investigation at the end of 2024.

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 NY State of Health, as well as local, county, state, and federal law enforcement and regulatory agencies to advance the integrity of the Medicaid program.

RECIPIENT CASE CLOSURES

In 2024, OMIG continued working on identifying, investigating, and finalizing investigations of recipients who were found to be residing out-of-state and inappropriately receiving NYS Medicaid eligibility leading to MCOs receiving capitation payments. OMIG finalized 43 investigations as part of this initiative, resulting in 43 recipients referred to DOH for closure and a total cost savings for the program of more than $179,111.

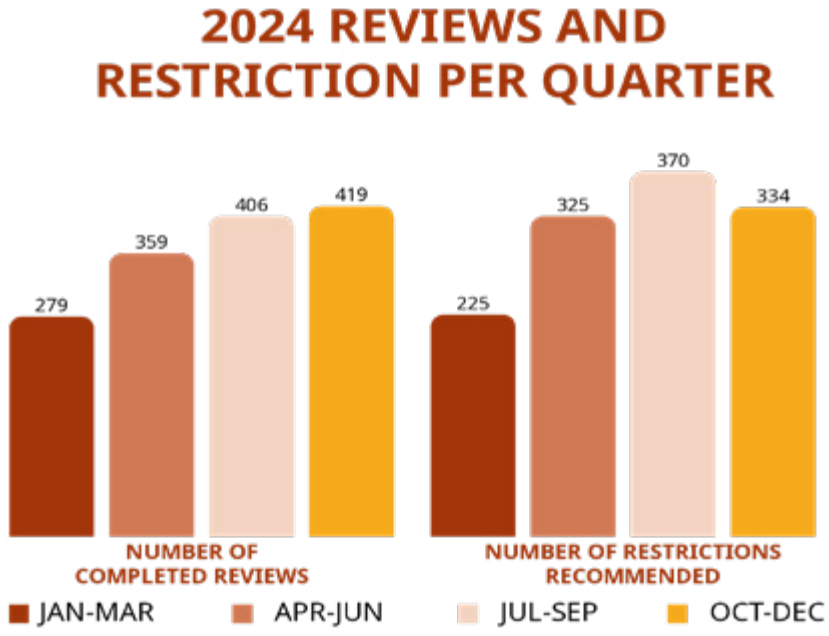
MEDICAID INVESTIGATIONS

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. 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.

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 (i.e., receiving duplicative, excessive, contraindicated, or conflicting health care services, drugs, or supplies), or committing potentially fraudulent acts with their Medicaid benefit card (i.e., 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 by 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. This is done to ensure that the primary care provider is aware and involved in the recipient's care. There are exceptions in place to ensure the recipient has access to necessary emergency and Opioid Treatment Program (OTP) services.



*These numbers represent FFS and MCO restrictions recommended. Reviews continued throughout 2024 in anticipation of the edits being restored.

MEDICAID INVESTIGATIONS

RECIPIENT RESTRICTION PROGRAM

Restriction edits were temporarily suspended on April 14, 2023, to accommodate the 2023 pharmacy benefit transition when all Medicaid recipients enrolled in Mainstream Managed Care transitioned to receiving their prescription drugs through NYRx, the Medicaid Pharmacy Program. Because the restriction edits were not operating, no cost savings is reported for 2024, as restoration of these edits did not occur until February 24, 2025. To avoid unintended recipient impacts and to facilitate restoration of the edits, OMIG worked in collaboration with DOH to create a bypass process for the pharmacy restriction to ensure recipients were not prohibited from receiving services in emergency situations. The bypass allows the pharmacy to request an override for reasons including primary pharmacy is closed, primary pharmacy is out-of-stock of desired medication, or unexpected travel, thereby ensuring recipients have access to needed prescriptions. This bypass was implemented July 25, 2024.

- OMIG RRP referred 20 cases of recipients with duplicate active Client Identification Numbers (CIN) to DOH. In 19 of the cases, the inactive CIN was closed due to our referral.

- On October 16, 2024, OMIG presented at the DOH Office of Health Insurance Programs Pharmacy Association Monthly Meeting. This event enabled OMIG RRP to engage with key participants involved in the billing of claims by educating and aiding pharmacy associations in the RRP process. This facilitated the training needed to restore the restriction edits.

MEDICAID INVESTIGATIONS

INVESTIGATION OUTCOMES

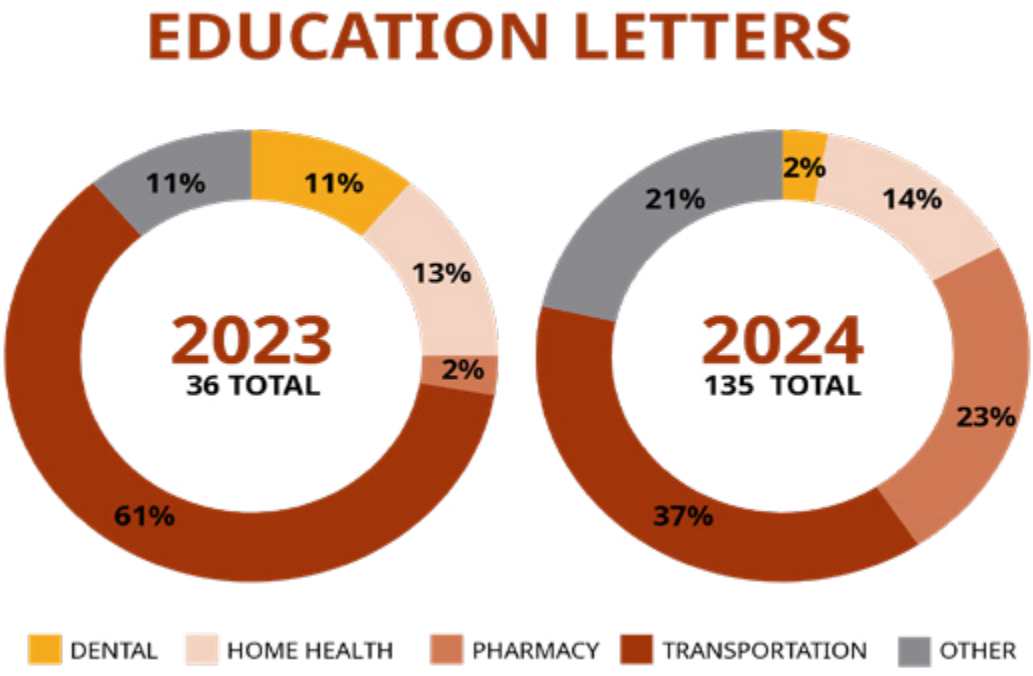
Investigations can result in a referral to other law enforcement partners or oversight agencies, criminal sanction, exclusion from the Medicaid program, a censure, recovery of Medicaid overpayment, or other administrative actions. In 2024, OMIG completed 1,828 investigations largely encompassing the following subject types: transportation, pharmacy, physician, home health, recipient, and dental; identifying overpayments of over $191,000. Investigation recoveries, including those finalized in prior years, were more than $308,000.

REFERRALS

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 to identify possible additional referrals, provide a comprehensive referral and provides additional support necessary to assist with the prosecution of the alleged fraud. MFCU can accept the referral for investigation or reject the referral. When the referral is accepted, OMIG receives regular updates on the referral. When the referral is rejected, the allegation is then analyzed to determine if OMIG will continue to actively investigate, and if any other law enforcement entity may be able to collaborate on the investigation. In 2024, OMIG issued 259 referrals for further investigation or prosecution to MFCU and 172 referrals to other governmental agencies and appropriate entities for further action.

EDUCATION LETTERS

OMIG issues education letters to providers when supported by investigative findings. After considering the facts and circumstances surrounding the case in connection with the guidelines for sanctioning, if the matter does not warrant imposition of a censure, or there are only minor billing issues, an education letter may be sent. This outreach provides details on Medicaid program requirements, emphasizes their obligations as a Medicaid provider and offers an appropriate contact for them to call to request assistance or answer any questions. In 2024, OMIG issued 135 education letters.



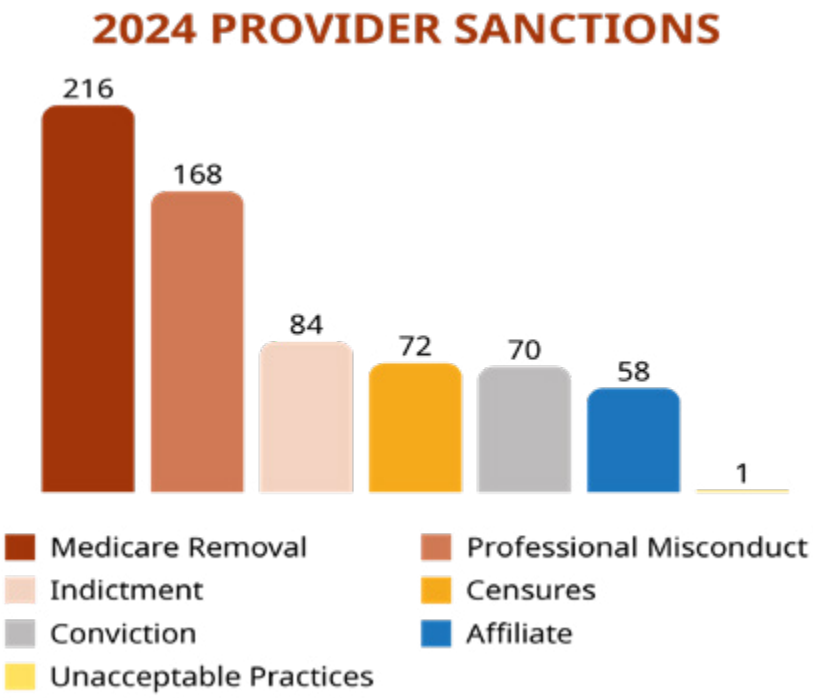
MEDICAID INVESTIGATIONS

ADMINISTRATIVE ACTIONS

OMIG is responsible for identifying providers whose behavior may necessitate immediate sanction under 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.

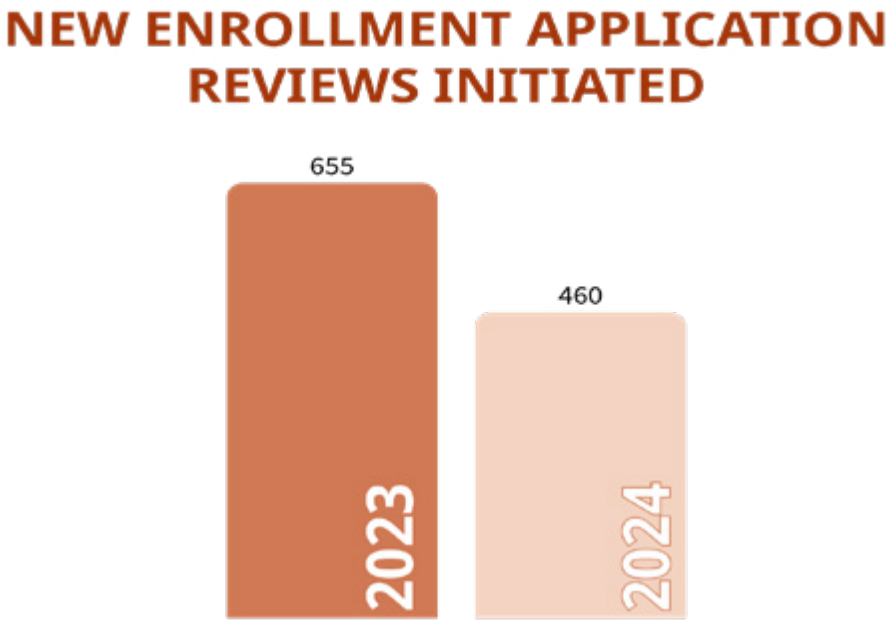
In 2024, OMIG issued 669 sanctions, including 72 censures and 597 exclusions from the Medicaid program. Of the sanctions issued, 662 of these were immediate actions, while seven were issued as a result of a completed investigation.

OMIG continues to provide feedback and education to the public, other state agencies, and stakeholders regarding OMIG's regulatory authority to sanction providers to protect the Medicaid program.



MEDICAID INVESTIGATIONS

PROVIDER ENROLLMENT AND REINSTATEMENT



OMIG assists DOH in reviewing enrollment applications for certain high-risk providers in the following categories: 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 2024, OMIG initiated 757 enrollment application reviews. 460 of these applications were new enrollment applications, a 29.77% decrease from 2023. The decrease in new enrollment applications is most likely due to a number of factors, including the completion of the pharmacy carve out in 2023, which required managed care enrolled pharmacies to apply for FFS enrollment which contributed to an increase in applications sent to OMIG for review. There was also the addition of the transportation broker, MAS.

MAS now determines which Medicaid transportation companies can apply for enrollment. Effective March 1, 2024, all Medicaid transportation applicants are required to submit a letter of support from MAS prior to submitting a Medicaid enrollment application. Applicants complete an MAS application, and a determination is made on whether the applicant will be given a letter of support. This new process has led a significant decrease in new enrollment transportation applications.

MEDICAID INVESTIGATIONS

OMIG completed 699 application reviews in 2024, of which 105 were denied, a 15.38% increase from 2023. These denials were a result of a fraud, waste, and abuse review by OMIG and a review by the respective policy unit within DOH. Out of the 105 denials only 25 were specific to fraud, waste, or abuse, the remaining denials were based upon determinations made by DOH of policy-related concerns.

Pharmacy on-site visits are a program integrity function available to Provider Enrollment. Enrollment can make a request to Pharmacy Program integrity Unit for an on-site inspection when there is unusual or questionable information in the enrollment application or for assistance from their specialists.

Pharmacy on-site visits in 2024 were completed in Nassau and Queens Counties. Some of the findings included, inadequate pharmacist identification and failure to post license/registration of the supervising pharmacist, expired medications amongst the drug inventory, high volume of no-fault insurance prescriptions with repetitive prescribers and drugs, incorrect Drug Enforcement Administration (DEA) number on prescriptions, inadequate drug refrigerator temperature, insanitary conditions, and employment of a sanctioned person. These findings resulted in denial of enrollment and in one case, referral to NYS OPD.

In 2024, OMIG received 68 requests for removal from the NYS Medicaid Exclusion List. This process allows rehabilitated providers to return to serve the Medicaid program and recipients, thereby increasing the number of available providers. OMIG's review resulted in 58 requests for removal approved and 13 denied.

CONTRACTOR RECOVERIES

$209M+

RECOVERY AUDIT CONTRACTOR RECOVERIES

$137M+

THIRD PARTY LIABILTY RECOVERIES

$136M+

CASUALTY & ESTATE RECOVERIES

$3M+

HOME HEALTH CARE MEDICARE MAXIMIZATION RECOVERIES

CONTRACTOR RECOVERIES

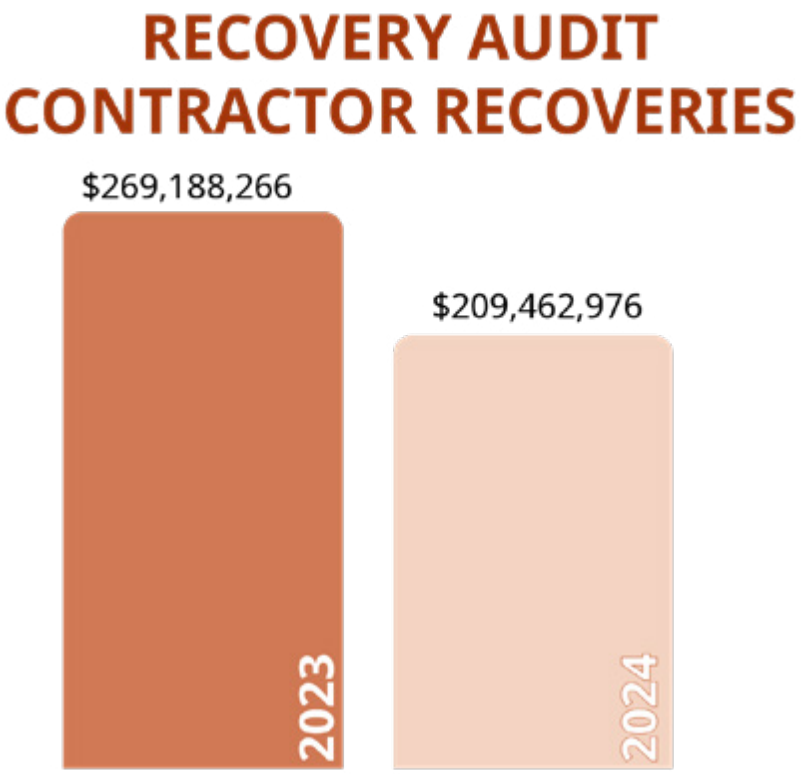
MEDICAID RECOVERY AUDIT CONTRACTOR

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 OMIG and the providers to recover identified overpayments.

The RAC continued an audit project where Medicaid capitation payments are recovered for recipients determined by DOH to be simultaneously enrolled or in receipt of Comprehensive Third-Party Health Insurance (TPHI) coverage through a different MCO.

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-only claims data.

Projects performed under the RAC resulted in recoveries of more than $209 million in 2024.



CONTRACTOR RECOVERIES

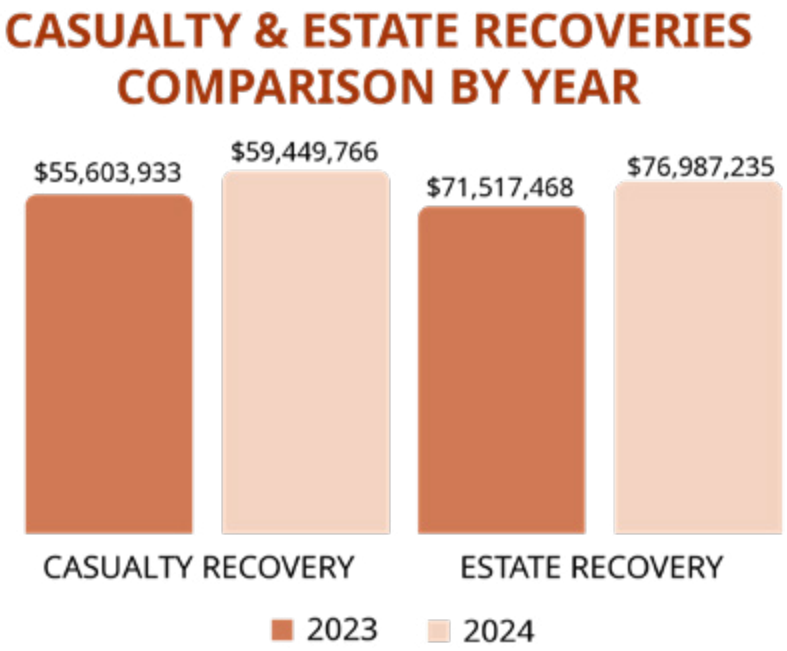
THIRD-PARTY LIABILITY MATCH AND RECOVERY SERVICES

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 and paid by Medicaid. OMIG contracts with HMS to identify and confirm other third-party insurance payment sources. When valid third-party coverage existed prior to this coverage being updated within 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 $137 million in recoveries in 2024.

CONTRACTOR RECOVERIES

CASUALTY & ESTATE RECOVERY

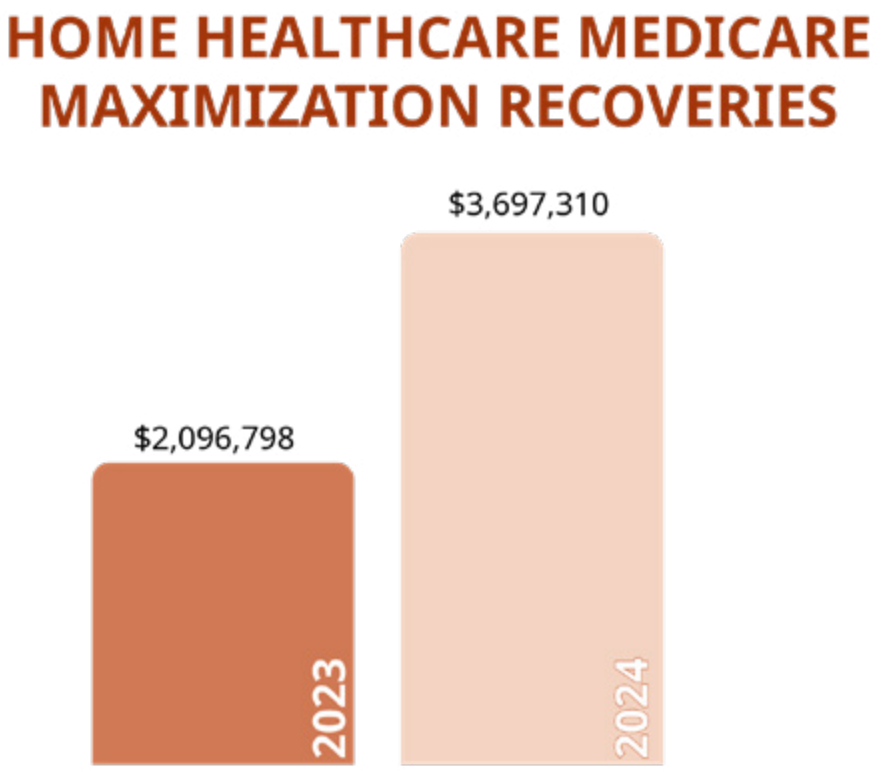
In circumstances where a Medicaid recipient passes away or receives a settlement due to a personal injury action, NYS is required by Federal law to recover certain amounts paid by Medicaid against settlement funds or estate assets. OMIG pursues these recoveries utilizing a contract vendor, HMS, and through collaboration with state and local government partners. In 2024, OMIG worked closely with HMS to identify opportunities for improvement both in established processes and in engagement with state and local government stakeholders, as well as opportunities for education to the general public regarding Medicaid recovery requirements and processes. Additionally, OMIG met with several county and county attorney representatives throughout the year to obtain feedback on existing processes and issues identified at the county level. As a result, recoveries in 2024 were more than $136 million, an increase of more than $9 million from 2023.



CONTRACTOR RECOVERIES

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 2024, these activities resulted in recoveries of more than $3.6 million.



OFFICE OF COUNSEL

MISSION

The mission of the Office of Counsel (OC) of OMIG is to interpret, support, and pursue the statutory and regulatory responsibilities of OMIG by providing the agency with quality legal representation and counsel.

To further this mission, OMIG employs attorneys and administrative staff who are located in OMIG's Albany, Buffalo, and NYC offices. OMIG attorneys serve a number of different roles on behalf of OMIG. These attorneys represent the interests of the agency whenever an administrative hearing is requested by a Medicaid provider following a final determination of OMIG, assist the Office of the Attorney General and county attorneys in litigation matters involving the OMIG, and provide legal support and guidance to agency staff in a variety of other matters.

DUE PROCESS PROTECTIONS

All providers that interact with OMIG in the audit and investigative activities are afforded "due process" throughout their engagement with OMIG. Due process is built into the laws and regulations that govern OMIG and is an integral and essential part of its activities.

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 provides notice through several mechanisms: audit notification letters and preliminary findings in Draft Audit Reports or Notices of Proposed Agency Action (NOPAA). Providers have the right to respond to OMIG's preliminary findings within 30 days of the Draft Audit Report or NOPAA. Providers may be given additional time to respond to OMIG's tentative findings where good cause for that additional time requested by the provider is shown. After the provider submits its response, OMIG considers that response before issuing a Final Audit Report or Notice of Agency Action (NOAA) (collectively referred to as a "Final Determination") to the provider. OMIG's Final Determination may identify Medicaid overpayments received by the provider and may also impose penalties and/or sanctions on a provider 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 to OMIG's General Counsel within 60 days of the date of the Final Determination. OC transmits the hearing request to the DOH Bureau of Adjudications which is responsible for assigning an Administrative Law Judge (ALJ) to preside over and conduct the hearing. Since March 2020, hearings have been held virtually via video conference which has allowed for more flexibility in scheduling and the cost and time for providers to travel to a location has been significantly reduced.

OFFICE OF COUNSEL

ADMINISTRATIVE HEARING PROCESS

OMIG attorneys defend the agency's Final Determination at the hearing and the provider has the burden to prove that OMIG's determination was incorrect. Pursuant to Medicaid regulations, prior to commencement of the hearing, OMIG is required to hold a pre-hearing conference with the provider. At the pre-hearing conference, the OMIG attorney and provider (or its representative) are required to exchange witness lists, documentation, and other information that may be presented at the hearing. At the hearing, OMIG attorneys provide the ALJ as well as the provider with a brief opening summary of the proceedings to date, including the names and relationships of people affected by the action of OMIG which prompted the request for the hearing, a brief description of the facts, evidence, and reasons supporting OMIG's actions and a copy of OMIG's Final Determination. The provider may also present an opening statement. The provider or its representative also has 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. Following the hearing, the parties may submit post hearing briefs summarizing their arguments for the ALJ's consideration. The ALJ then issues a decision in the matter. If that decision is favorable to OMIG, the provider has the right to appeal that decision through an Article 78 Proceeding in NYS Supreme Court.

DATA RELATED TO ADMINISTRATIVE HEARINGS

Throughout 2024, a total of 41 new requests for administrative hearings were received by OMIG. Also, a total of 21 administrative hearings were resolved in 2024, which includes 13 hearing decisions, two provider withdrawals of their hearing requests, and six stipulations of settlement. The number of hearings resolved included cases in which the request for a hearing was received prior to 2024. Additionally, not all hearing requests received in 2024 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. During 2024, OMIG attorneys appeared in hearings before ALJs on 22 separate days.

41
NEW REQUESTS RECEIVED

21
ADMINISTRATIVE HEARINGS RESOLVED

2
PROVIDER WITHDRAWLS

13
HEARING DECISIONS

6
STIPULATIONS

Hearing decisions issued during 2024 can be found at:
https://www.health.ny.gov/health_care/medicaid/decisions/decisions.htm

OFFICE OF COUNSEL

STIPULATIONS OF SETTLEMENT

Providers have the right to challenge the OMIG's final determination by requesting an administrative hearing. However, cases can be resolved (settled) before an administrative hearing and memorialized in a formal written document, or Stipulation of Settlement, which is negotiated by OMIG attorneys with the providers, and executed between the provider and the agency. The Stipulation of Settlement defines the terms of settlement, the review period in question, the overpayment amount owed, and the repayment terms. Stipulations of Settlement may result from a provider agreeing to resolve an audit or investigation, following or prior to the issuance of a Draft Audit Report or NOPAA, or after the issuance of a Final Audit Report or NOAA to resolve a request for hearing. Additionally, providers who self-disclose Medicaid overpayments may also request a Stipulation of Settlement. In 2024, OC finalized 15 Stipulations of Settlement, of which seven were in lieu of proceeding to an administrative hearing, and eight were for pre-final determinations and self-disclosure cases. The Stipulations of Settlement finalized by the OC facilitated the recovery of $12,200,346 in Medicaid overpayments.

NOPAAS/NOAAS REVIEWED: 89

NOPAAS/NOAAS CLOSED: 75

UNACCEPTABLE PRACTICES

OMIG's program integrity functions include investigating providers to determine if they engaged in unacceptable practices pursuant to the Medicaid regulations. The OMIG may issue NOPAAs and NOAAs to providers engaged in such practices. In 2024, OMIG attorneys reviewed 89 new NOPAAs and NOAAs, and closed 75 of these matters that same year.

NOTICE OF IMMEDIATE AGENCY ACTION

Pursuant to Medicaid regulations, upon notice to a person, OMIG may take immediate action to sanction a person and any affiliate. The sanction may include an immediate exclusion from the Medicaid program for a number of reasons, including but not limited to receiving notice an indictment charging a person with committing a felony under New York law which relates to or results from the furnishing or billing for medical care, services, or supplies, notice that a person has been convicted of a crime relating to or resulting from such matters, or notice that the person is excluded or terminated from participation in the Federal Medicare program. A person notified of an immediate sanction is not entitled to an administrative hearing, but may, within 30 days of the date of the Notice of Immediate Agency Action, submit written arguments and documentation to appeal the immediate sanction.
In 2024, 33 new appeals were received by the OC challenging such a Notice; 28 of these appeals were closed in 2024. With respect to those appeals closed in 2024, in 11 appeals the determinations were reversed and in 17 appeals, the determinations were affirmed.

FREEDOM OF INFORMATION LAW

The OMIG's public website contains a link with information to the Freedom of Information Law (FOIL) which outlines the public's right to access agency records. OMIG responded to 131 FOIL requests throughout 2024 in which members of the public sought records from OMIG. Each of these requests required OMIG attorneys to review, research, and respond to the request submitted by a member of the general public. Common FOIL requests in 2024 sought information relating to Requests for Proposals, Medicaid lien information, New York's HWB program, and the Medicaid exclusion list.

The public may submit FOIL requests to the OMIG in a variety of ways. Requests may be submitted via email, in person, or sent to the OMIG through regular mail. In addition, implementation by OMIG of the GovQA FOIL platform in 2024 has afforded the public another option to submit a FOIL request. This platform not only provides the public with a way to conveniently make such a request, it also affords the requesting party with a simple way of accessing the requested information through a secure portal. GovQA also allows OMIG to track the progress of FOIL requests using the built-in functionality of the platform. OMIG continues to implement additional features available through GovQA to further enhance public access to information and increase transparency.

OFFICE OF COUNSEL

LEGISLATIVE AND REGULATORY MATTERS

OMIG attorneys regularly review New York laws that may impact the Medicaid program and OMIG's program integrity activities (i.e., audit, compliance, investigations). As a result of this review, OMIG attorneys may recommend changes to existing laws, regulations and policies and procedures. In addition, OMIG program area staff may recommend such changes to further the agency's mission. As part of the legislative and regulatory process OMIG attorneys and program staff collaborate in drafting proposed legislation and/or regulations and related policies and procedures. OMIG attorneys continue providing legal assistance and guidance to division staff regarding those proposed changes throughout this process, including implementation as necessary.

PROJECT PROCESSING REQUESTS

OMIG attorneys also completed numerous project requests submitted to the OC by the program divisions of OMIG. These are generally requests by an OMIG division for OC to review a document or consider a certain fact pattern and then provide the division with a legal opinion or interpretation based upon the research the attorney performed in analyzing the project request. In 2024, OMIG attorneys received 216 project processing requests. These requests included but were not limited to:

- preparing and filing judgment liens,
- reviewing audit protocols,
- reviewing and drafting data use agreements, contracts, and contract amendments, and
- drafting stipulations of settlement.

MEDICAID LIENS

Because the Medicaid program should be the payor of last resort, the Medicaid Program must take reasonable steps to determine the legal liability of other parties (insurance coverage, tortfeasors, etc.) to pay for a Medicaid recipient's health care and services. Pursuant to federal and state law, Medicaid expenses may be recovered from personal injury settlements and estate assets. To that end, OMIG's third party contractor files liens in casualty/personal injury and estate cases on behalf of the Medicaid program. In those cases where OMIG has been named as a defendant, OC staff contacts and may request representation by the County Attorney to defend the Medicaid Lien. OC staff works regularly with the County Attorneys and County Departments of Social Services to answer questions, provide records, and assist and coordinate with DOH to resolve issues. In 2024, 628 new Medicaid lien cases were received and reviewed by OMIG OC staff. Of those 628 cases, 346 Medicaid lien matters were closed in 2024.

UNIFIED PROGRAM INTEGRITY CONTRACTOR

PURPOSE

Unified Program Integrity Contractors (UPICs) are contracted by CMS to perform program integrity functions that include the detection, deterrence, and prevention of fraud, waste, and abuse (FWA) in Medicare and Medicaid programs. They operate across five geographical jurisdictions in the United States and are responsible for integrity-related activities associated with Medicare Parts A, B, DME, Home Health and Hospice (HH+H), Medicaid, and the Medicare-Medicaid data match program (Medi-Medi). The NE UPIC uses multiple sources to identify different data projects. These project ideas are based on a variety of sources such as, the NE UPIC's experience, state and CMS initiatives, state and OIG Work Plans, collaboration with other UPICs, national reports, and or other state's initiatives.

KEY RESPONSIBILITIES

According to CMS's Medicare Program Integrity Manual, the primary tasks of UPICs include:

Investigating allegations of fraud made by beneficiaries, providers/suppliers, CMS, the HHS-OIG, social media, and other sources.

Conducting post-payment reviews of claims/claim lines as part of their investigative activities.

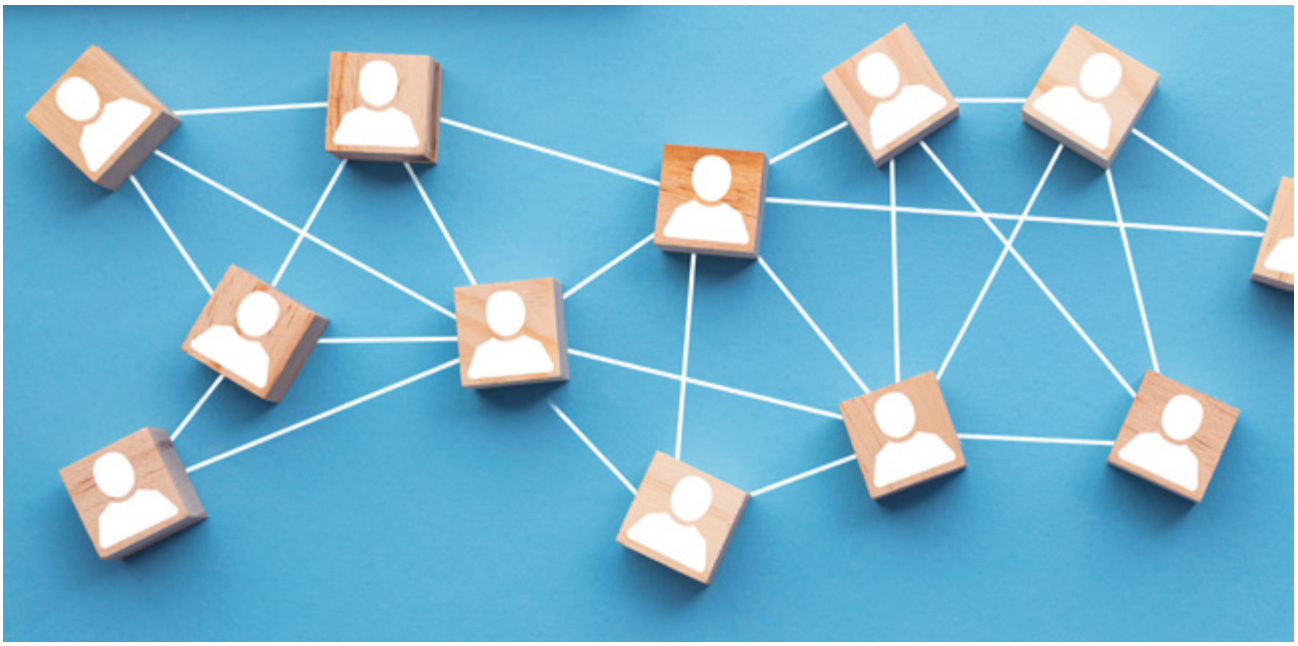
- In 2024, four investigations were completed with identified overpayments of $39,552.
- The UPIC currently has forty-six open investigations at different stages of review.

Referring cases that align with the Medicaid Major Case Coordination process to the HHS-OIG/Office of Investigations for consideration of civil and criminal prosecution and/or application of administrative sanctions.

- Four providers were presented as law enforcement referrals in 2024, three were accepted by HHS-OIG and one referral was declined.

Collaborating with State Medicaid Agencies (SMAs) to identify potential fraud, waste, and abuse across the Medicaid and Medicare programs, incorporating data matching, coordination, and information sharing to detect fraudulent or wasteful billing behavior.

- In 2024 the UPIC had nine open dental audits in different stages of review.
- OMIG and the UPIC are in discussions to expand their audit activity in NYS.



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 2024. In 2024, EAU received a total of 37 audit reports/reviews containing millions of claims and managed care encounters. Addressing these audits involve OMIG staff from all divisions across the agency. 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.

OSC

OSC performs audits pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law. Examples of audit areas include:

- Compliance with Electronic Visit Verification
- Outpatient Services Billed as Inpatient Claims in Managed Care (OMIG's review identified more than $142 million of OSC findings as low risk)
- Recipients in the Restricted Recipient Program
- Payments to Unenrolled Providers

FEDERAL SINGLE AUDIT

Pursuant to the requirements of Section 8(9) of the State Finance Law, the Office of the State Comptroller engages a certified public accounting firm to perform an independent audit of the State of New York's financial statements as prepared by the State Comptroller. In 2024, KPMG performed the audit of the State's financial statements for the year ended March 31, 2024.

HHS-OIG

As a recipient of U.S. Department of Health and Human Services (HHS) grant funds, the State agency is subject to Office of Inspector General (OIG) audits and other reviews. An example of an audit area includes:

- Multiple Identification Numbers

CMS

In 2024 Centers for Medicare and Medicaid Services performed a Medicaid RAC Desk Review. As part of the program integrity review process, CMS followed up with states to review compliance with federal regulations at 42 CFR 455 Subpart F - Medicaid Recovery Audit Contractor Program.

PROBLEMS & CONCERNS

As the Annual Report illustrates, OMIG accomplished a wide range of objectives and implemented a number of new initiatives in support of its mission to protect the integrity of New York State's Medicaid program. From delivering billions in cost savings and recoveries to vast expansion of its provider outreach activities, OMIG accomplished much in 2024.

Going forward, OMIG will remain dedicated to addressing and resolving ongoing issues and challenges facing the agency, which are detailed below.

Staffing- Similar to other state agencies and private-sector employers, OMIG continues to address ongoing challenges related to employee recruitment and retention. While the agency has successfully employed numerous strategies - participation in career fair events, enhanced use of online-based recruiting solutions and the like, OMIG will continue its focus on and dedicate resources to address this concern.

Early Intervention - Some data fields captured in the Early Intervention billing system, such as rendering Provider and time in/time out, are not captured in claims pulled from the MDW. OMIG is able to obtain this data for sampled claims after a sample is pulled, so it does not affect the actual performance of the audits, but this data would be helpful in audit selection. To date OMIG has issued nine summations and finalized one audit. OMIG is actively engaged with DOH to implement a solution.

PARIS Match - OMIG conducts a regular audit to identify capitation payments for Medicaid managed care enrollees who are receiving benefits in another state based on data contained in the Public Assistance Reporting Information System (PARIS) Match file. OMIG has sought to expand the findings of these audits by incorporating additional data sources, including Transformed Medicaid Statistical Information System (T-MSIS) data and Electronic Benefit Transaction/Supplemental Nutrition Assistance Program (EBT/SNAP) data. T-MSIS data can provide Medicaid eligibility and claim data from other states, and historical EBT/SNAP data shows where individuals were purchasing food. OMIG believes these data points could provide clarity for some overlap periods where the PARIS Match data is ambiguous about when the enrollee's residence in another state began and/or ended. As both of these data sets involve member-specific information provided by or governed by data sharing agreements with the federal government, it has been challenging to gain access to this data despite cooperative partners at fellow state agencies. OMIG continues to work to gain access to these additional data sources, but was unable to do so in 2024.

PROBLEMS & CONCERNS

Death Match - OMIG conducts an annual audit to recover capitation payments paid for Medicaid managed care enrollees after their date of death. To identify these inappropriate capitation payments, OMIG uses dates of death provided by the Bureau of Vital Statistics through a data sharing agreement. This agreement, which is subject to periodic renewal, expired before being extended, which resulted in OMIG's audit being delayed. OMIG worked collaboratively with DOH and a new data sharing agreement has now been executed, allowing OMIG's audits to resume. This new agreement was revised to reduce the risk of such delays in the future.

Shifting Federal Landscape

- ◊ Increased complexity of MA Administration
  - Federal policy changes continue to expand Medicaid's scope, especially in the areas of managed care and home-based services. In calendar year 2024 the NYS Medicaid program processed over 1 billion FFS claims and MCO encounter transactions in the Medicaid Data Warehouse (MDW).
  - The proliferation of specialized services (e.g. telehealth, behavioral health, personal care) demands tailored audit protocols and compliance reviews, stretching OMIG's capacity.
- ◊ Accountability Gaps
  - Federal shifts in eligibility and reimbursement can obscure responsibility across state and federal lines, complicating enforcement actions.
  - OMIG's referrals to MFCU are substantial, but federal reporting delays and procedural gaps can weaken case outcomes.

2025 WORK PLAN

OMIG's 2025 Work Plan provides a comprehensive roadmap for citizens, policymakers, providers, MCOs, and other stakeholders to follow as a guide to the agency's program integrity initiatives planned for the year. This plan should not be viewed as an exclusive list of all activities that OMIG will conduct over the course of the year, and the agency reserves the right to conduct all activities under its regulatory authority necessary to meet its program integrity responsibilities.

OMIG works closely with the NYS Department of Health (DOH) and other state and local agencies responsible for administering Medicaid services to enforce their respective requirements. Additionally, OMIG works cooperatively and in a coordinated manner with other federal and state agencies, as well as the special investigative units maintained by each Medicaid Managed Care Organization (MCO) operating within the state. In conducting these program integrity activities, OMIG promotes the delivery of appropriate and high-quality patient care to Medicaid recipients.

OMIG will continue its commitment to engage and enhance transparency with the provider community through a comprehensive range of education, information, and outreach activities.

2025 OMIG MEDICAID PROGRAM INTEGRITY KEY FOCUS AREAS:

These efforts are intended to promote open communication and enable the agency to incorporate stakeholder input and evaluate the operational impacts of its program integrity activities. OMIG encourages providers and stakeholders to share information and feedback, which can be submitted to the agency via email at information@omig.ny.gov.

POWERS & DUTIES

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, OMH, OASAS, the Office of Temporary and Disability Assistance, the Office of Children and Family Services, and the OPWDD.
- Coordinate, to the greatest extent possible, activities to prevent, detect and investigate MA program fraud and abuse amongst State agencies, local governments, and entities; and to work in a coordinated and cooperative manner with, to the greatest extent possible, the deputy attorney general for Medicaid fraud control; other law enforcement entities, 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

POWERS & DUTIES

- 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
BOC	OMIG's Bureau of Compliance
CDPA	Consumer Directed Personal Assistance
CMS	Centers for Medicare and Medicaid Services
CVR	Credential Verification Reviews
D&TC	Diagnostic and Treatment Center
DFS	Department of Financial Services
DME	Durable Medical Equipment
DOH	Department of Health
EAU	External Audit Unit
EOMB	Explanation of Medical Benefits
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
HMS	Health Management Systems, Inc.
HWB	Health Care and Mental Hygiene Worker Bonus
LDSS	Local Departments of Social Services
MA	Medical Assistance
MAS	Medical Answering Service
MC	Managed Care
MCO	Managed Care Organization
MDW	Medicaid Data Warehouse
MFCU	New York State Attorney General's Medicaid Fraud and Control Unit
MLTC	Managed Long-Term Care Plans
MMCOR	Medicaid Managed Care Operating Report
NOAA	Notice of Agency Action
NOPAA	Notice of Proposed Agency Action
NYC	New York City
NYCRR	New York Codes, Rules and Regulations
NYS	New York State
OASAS	Office of Addiction Services and Support

ACRONYM	TERM
OC	OMIG's Office of Counsel
OMH	Office of Mental Health
OMIG	Office of the Medicaid Inspector General
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
PHE	Public Health Emergency
PERM	Payment Error Rate Measurement
PPR	Pre-Payment Review
RAC	Recovery Audit Contractor
RN	Registered Nurse
RRP	Recipient Restriction Program
SIU	Special Investigative Units
UMass	University of Massachusetts Chan Medical School

DATA TABLES

2024 Initiated Audits by Region				
Region	**County Demo**	**Managed Care**	**Provider**	**Total**
Capital Region	0	48	69	**117**
Central NY	0	43	25	**68**
Finger Lakes	0	16	45	**61**
Long Island	0	26	87	**113**
Mid-Hudson	0	28	85	**113**
Mohawk Valley	0	16	30	**46**
New York City	5	260	182	**447**
North Country	0	0	24	**24**
Out of State	0	0	2	**2**
Southern Tier	0	17	25	**42**
Western NY	4	65	88	**157**
Grand Total	**9**	**519**	**662**	**1,190**

2024 Finalized Audits by Region				
Region	**County Demo**	**Managed Care**	**Provider**	**Total**
Capital Region	0	24	16	**40**
Central NY	0	27	17	**44**
Finger Lakes	0	9	40	**49**
Long Island	0	16	43	**59**
Mid-Hudson	0	16	44	**60**
Mohawk Valley	0	6	15	**21**
New York City	3	170	142	**315**
North Country	0	0	6	**6**
Out of State	0	0	1	**1**
Southern Tier	0	12	12	**24**
Western NY	0	49	34	**83**
Grand Total	**3**	**329**	**370**	**702**

2024 Overpayments Identified by Region				
Region	**County Demo**	**Managed Care**	**Provider**	**Total**
Capital Region	$0	$15,003,474	$997,851	**$16,001,326**
Central NY	$0	$14,459,430	$1,745,852	**$16,205,282**
Finger Lakes	$0	$2,911,162	$3,544,412	**$6,455,574**
Long Island	$0	$197,578	$5,280,811	**$5,478,389**
Mid-Hudson	$0	$2,610,145	$4,207,335	**$6,817,480**
Mohawk Valley	$0	$1,282,127	$1,089,855	**$2,371,982**
New York City	($3,797,609)	$121,856,927	$12,454,819	**$130,514,138**
North Country	$0	$0	$1,989,199	**$1,989,199**
Out of State	$0	$0	$5,588	**$5,588**
Southern Tier	$0	$1,470,044	$298,022	**$1,768,066**
Western NY	$0	$2,905,573	$2,698,099	**$5,603,672**
Grand Total	**($3,797,609)**	**$162,696,460**	**$34,311,844**	**$193,210,696**

DATA TABLES

2024 Penalties Issued by Region				
Region	**County Demo**	**Managed Care**	**Provider**	**Total**
Capital Region	$0	$0	$0	**$0**
Central NY	$0	$0	$0	**$0**
Finger Lakes	$0	$0	$0	**$0**
Long Island	$0	$0	$0	**$0**
Mid-Hudson	$0	$0	$0	**$0**
Mohawk Valley	$0	$0	$0	**$0**
New York City	$0	$14,133,324	$0	**$14,133,324**
North Country	$0	$0	$0	**$0**
Out of State	$0	$0	$0	**$0**
Southern Tier	$0	$0	$0	**$0**
Western NY	$0	$0	$0	**$0**
Grand Total	**$0**	**$14,133,324**	**$0**	**$14,133,324**

2024 Recoveries by Region				
Region	**County Demo**	**Managed Care**	**Provider**	**Total**
Capital Region	$0	$15,262,831	$2,119,986	**$17,382,817**
Central NY	$0	$15,977,283	$1,948,652	**$17,925,934**
Finger Lakes	$0	$1,421,632	$3,081,186	**$4,502,818**
Long Island	$0	$277,381	$11,442,982	**$11,720,363**
Mid-Hudson	$107,590	$3,123,667	$3,268,918	**$6,500,174**
Mohawk Valley	$0	$1,187,086	$1,371,164	**$2,558,250**
New York City	$3,364,661	$130,693,783	$14,807,893	**$148,866,338**
North Country	$0	$0	$2,431,742	**$2,431,742**
Out of State	$0	$0	$15,748	**$15,748**
Southern Tier	$0	$1,145,028	$658,694	**$1,803,722**
Western NY	$0	$2,900,356	$3,519,921	**$6,420,276**
Grand Total	**$3,472,251**	**$171,989,046**	**$44,666,887**	**$220,128,184**

Audit Summations	
Audit Department	**Amount**
County Demonstration Program	2
Managed Care	3
Provider	24
Rates/AM&D	104
Healthcare Worker Bonus	29
Grand Total	**162**

DATA TABLES

2024 Self-Disclosures				
Region	**Initiated**	**Finalized**	**Findings**	**Recoveries**
Capital Region	56	53	$761,214	$797,900
Central NY	54	62	$341,511	$465,316
Finger Lakes	61	56	$439,367	$904,981
Long Island	60	65	$5,935,338	$6,005,004
Mid-Hudson	65	61	$699,601	$760,807
Mohawk Valley	30	25	$686,505	$909,166
New York City	177	184	$14,922,765	$12,043,706
North Country	32	30	$333,147	$319,766
Out of State	8	7	$1,079,398	$1,081,012
Southern Tier	53	46	$258,250	$257,151
Western NY	54	46	$1,708,156	$1,764,480
Grand Total	**650**	**635**	**$27,165,251**	**$25,309,289**

2024 Healthcare Worker Bonus				
Type	**Initiated**	**Finalized**	**Findings**	**Recovery**
HWB Audit	380	30	$71,000	$20,851
HWB Self-Disclosure/Payment to Employee	1,311	1,299	$16,965,937	$19,762,274
Grand Total:	**1,691**	**1,329**	**$17,036,937**	**$19,783,126**

2024 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	90	116	98	101	3	2	191	219
District Attorney	2	2	0	0	0	0	2	2
Enrolled Recipient	10	27	17	17	4	3	31	47
Federal Agencies	4	23	9	7	0	0	13	30
General Public (Non Enrolled)	91	110	109	122	2	3	202	235
Law Enforcement	0	5	2	5	0	0	2	10
Local Departments of Social Services	14	5	25	25	0	0	39	30
Managed Care Plans	63	238	10	25	0	14	73	277
Managed Long Term Care Plans-MLTC	21	39	2	6	0	0	23	45
OMIG	159	370	146	199	5	11	310	580
Provider	16	38	53	42	0	0	69	80
State and City Agencies	60	114	133	124	3	2	196	240
Transportation Manager	19	20	9	13	0	0	28	33
Total	**549**	**1,107**	**613**	**686**	**17**	**35**	**1,179**	**1,828**

DATA TABLES

2024 Referrals to MFCU		
Provider Type	**Analysis Referrals**	**Investigative Referrals**
Capitation Provider	6	2
Child Care Institution	1	0
Chiropractor/Port-XRAY-SVC-QMB Services	0	1
Consumer Directed Aide	9	3
Dental Groups	0	4
Dentist	0	6
Diagnostic and Treatment Center	3	3
Enrolled Recipient	23	33
Home Health Agency	12	9
Home Health Aide	4	3
Hospital	0	4
Laboratory	3	5
Long Term Care Facility	2	0
Medical Appliance Dealer	5	1
Multi-Type	11	6
Multi-Type Group	0	2
Non-Enrolled Individual	1	3
Non-Enrolled Provider	5	6
Nurse	0	2
Personal Care Aide	0	1
Pharmacy	3	18
Physician	2	27
Physicians Group	3	15
Service Bureau	1	2
Social Adult Day Care	32	12
Therapist	0	1
Therapy Group	0	1
Transportation	69	89
Total	**195**	**259**

DATA TABLES

2024 Referrals to Other Agencies		
Agency	**Analysis Referrals**	**Investigative Referrals**
AG - Not MFCU	49	1
Bureau of Narcotic Enforcement	1	1
Centers for Medicare and Medicaid Services (CMS)	2	0
Delaware County DSS Adult Protective Services	0	2
Joint Commission	0	1
Local Department of Social Services	0	2
Local District Attorney	0	2
NYC Department for the Aging	1	0
NYC Department of Buildings	0	1
NYC HRA Bureau of Client Fraud Investigations	0	2
NYS Department of Health	3	58
NYS DOH Office of Professional Med Conduct	2	26
NYS Education Department- Office of Professional Discipline	0	51
NYS Justice Center	4	2
NYS Office for People with Dev Disabilities (OPWDD)	4	3
NYS Office of Alcoholism and Subs Abuse Services (OASAS)	3	1
NYS Office of Mental Health	5	0
Onondaga County DSS Adult Protective Services	3	0
U.S. Attorney	0	1
U.S. Department of Justice	2	16
U.S. Health and Human Services (HHS-OIG)	0	1
U.S. Social Security Administration (SSA/OIG)	0	1
Total	**79**	**172**

2024 Exclusions	
Reasons for Exclusions	**Number of Actions**
18 NYCRR 504.1(d)(1)- Affiliations	58
18 NYCRR 515.2- Unacceptable Practices	1
18 NYCRR 515.7(b)- Indictments	84
18 NYCRR 515.7(c)- Convictions	70
18 NYCRR 515.7(e)- Professional Misconduct	168
18 NYCRR 515.8- Mandatory Exclusion	216
Total	**597**

DATA TABLES

2024 Contractor Recoveries	
Activity Area	**Amount**
Recovery Audit Contractor	$209,462,976
Casualty & Estate	$136,437,000
Third-Party Liability	$137,271,370
Home Health Care Medicare Maximization Project	$3,697,310
Total	**$486,868,656**

2024 Recoveries (All Sources)	
Activity Area	**Amount**
Recovery Audit Contractor	$209,462,976
Managed Care	$171,989,046
Third-Party Liability	$137,271,370
Casualty & Estate	$136,437,000
Fee-for-Service	$27,305,744
Self-Disclosure	$25,309,289
Healthcare Worker Bonus	$19,783,126
Rate	$16,693,999
Home Health Care Medicare Maximization Project	$3,697,310
County Demo	$3,472,251
Systems Match	$667,144
Investigative Financial Recoveries	$308,876
Total	**$752,398,131**

2024 Cost Savings Activities	
Activity Area	**Amount**
Pre-Payment Insurance Verification Commercial	$3,444,324,525
Pre-Payment Insurance Verification Medicare	$288,673,119
Enrollment and Reinstatement Denials	$47,028,737
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	$10,305,846
Exclusions/Terminations – External	$8,996,373
Medical Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	$7,859,662
Exclusions/Terminations – Internal	$3,425,426
Dental Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	$452,294
Recipient Medicaid MC Benefits – Case Closures for False Information	$224,432
Total	**$3,811,290,415**

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OMIG'S REPAYMENT OPTIONS

https://omig.ny.gov/information-resources/omig-repayment-options

OMIG'S SELF-DISCLOSURE PROGRAM

https://omig.ny.gov/provider-resources/self-disclosure

COMPLIANCE PROGRAM REQUIREMENTS

https://omig.ny.gov/compliance/compliance-library

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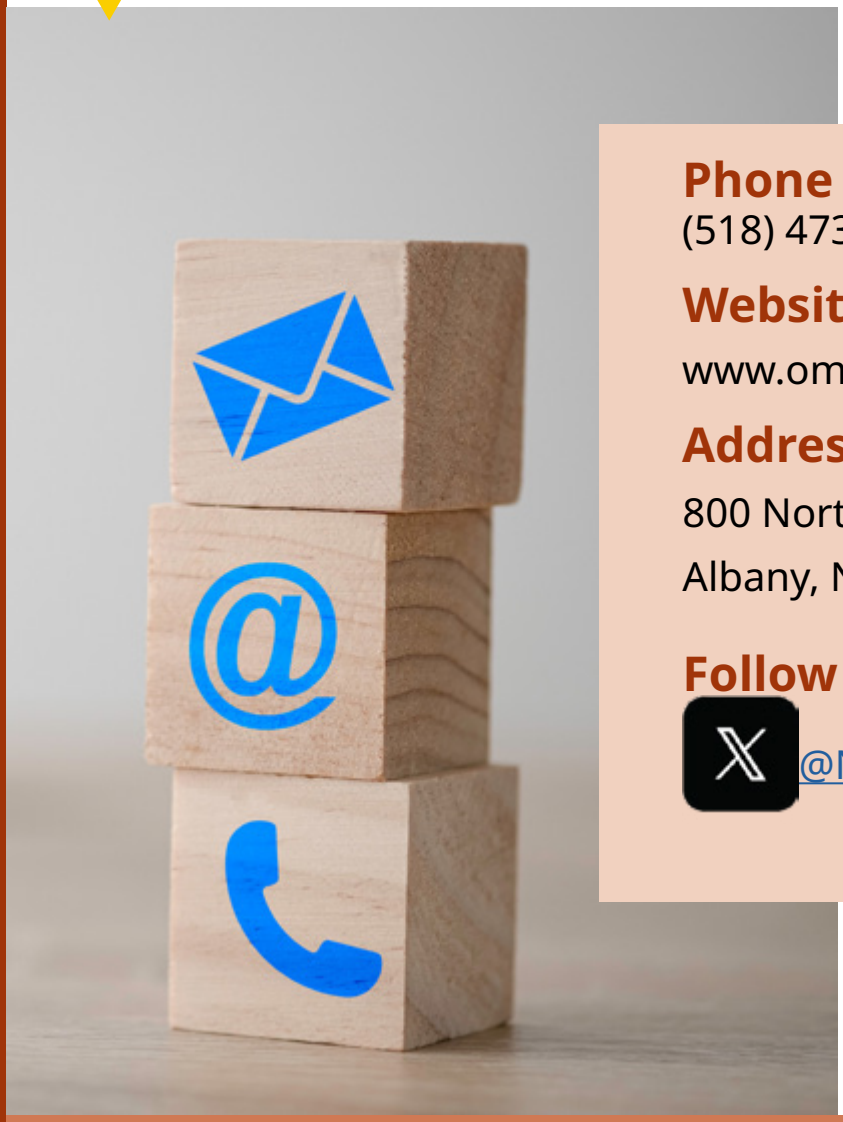

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