Health Care Fraud Enforcement and Compliance; Trends and Developments

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Health Care Fraud Enforcement and Compliance: Trends and Developments

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U.S. Department of Justice

Health Care Fraud Unit: Overview

- **DOJ Criminal Division, Fraud Section**
  - Health Care Fraud Unit
  - Securities and Financial Fraud Unit
  - Foreign Corrupt Practices Act Unit
- **Fraud Section Senior Management**
  - Sandra Moser, Acting Chief
  - Robert Zink, Acting Principal Deputy Chief
  - Joseph Beemsterboer, Chief, Health Care Fraud Unit
- **10+ Fraud Strike Force locations**
  - 50+ attorneys
  - Data Analytics Team

Health Care Fraud Unit: Mission

- **Focus solely on the prosecution of health care fraud cases**
  - **Emphasis:** cases involving patient harm & large loss to public
- **Identify**, **respond to**, and **prosecute** emerging fraud trends across the U.S.
- **Train** AUSAs and agents on best practices for investigating and prosecuting HCF cases
- **Analyze** data to:
  - Identify aberrant billing levels in health care fraud hot spots; and
  - Target suspicious billing patterns and schemes that migrate from one community to another

Health Care Fraud Unit: Locations

- **Strike Force Locations:**
  - Brooklyn
  - Chicago
  - Corporate
  - Detroit
  - Los Angeles
  - Miami
  - Newark/Philadelphia
  - New Orleans/Baton Rouge
  - Tampa
  - Texas (Houston, Dallas, McAllen)

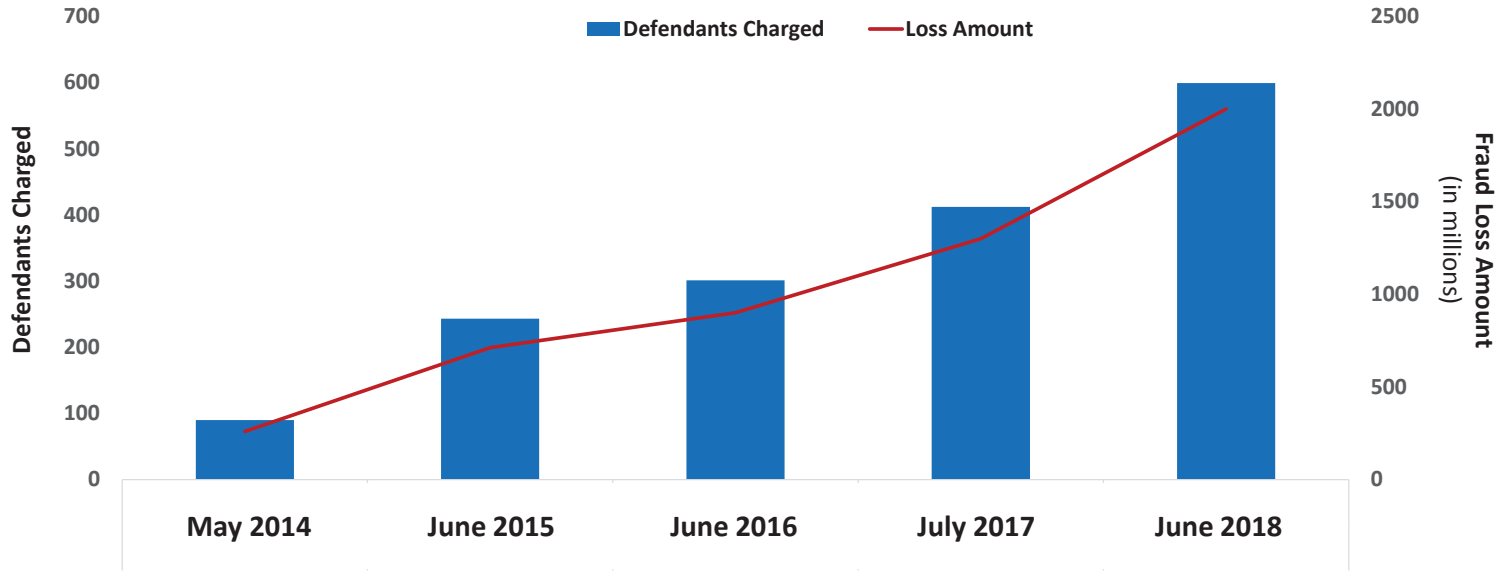
Signature Program: National HCF Takedown

June 2018 National HCF Takedown:

- 601 Defendants Charged, including:
  - 165 Medical Professionals
- $2 Billion in Losses
- 58 Federal Districts
- 30 Medicaid Fraud Control Units

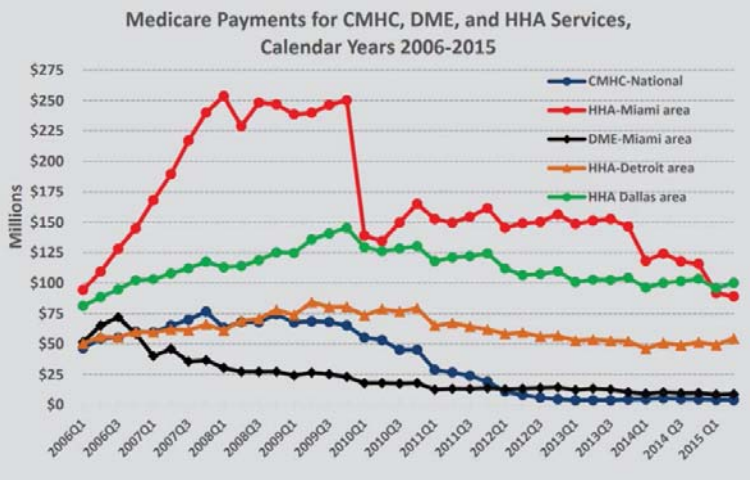
National Health Care Fraud and Opioid Takedown Trends

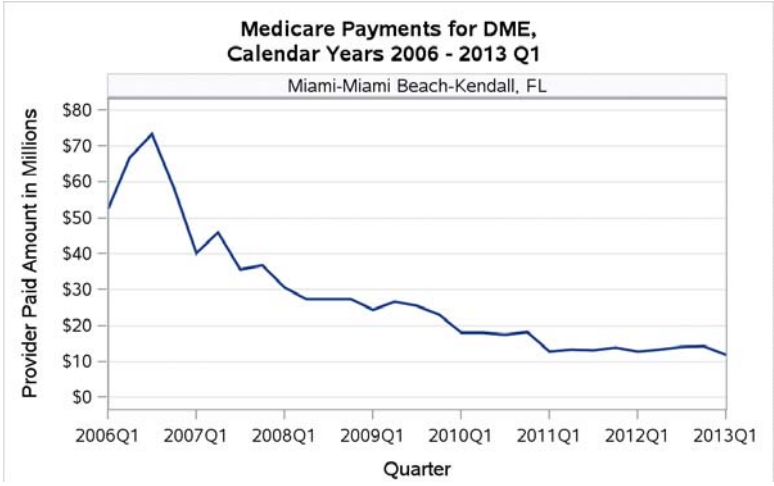
FY 2014 - FY2018



	May 2014	June 2015	June 2016	July 2017	June 2018
Defendants Charged	90	243	301	412	601
Loss Amount	$260M	$712M	$900M	$1.3B	$2.0B

Strike Force: Success Metrics





Strike Force: Team Approach

- HHS-OIG
- FBI
- DEA
- Internal Revenue Service, Criminal Investigations
- Homeland Security Investigations
- U.S. Secret Service
- Medicaid Fraud Control Units (MFCUs)
- Postal Inspection Service

Strike Force: Primary Statutes

- 18 U.S.C. §§ 1347, 1349 (health care fraud, conspiracy)
- 42 U.S.C. § 1320a-7b (federal anti-kickback statute)
- 18 U.S.C. § 1035 (false statements relating to health care matters)
- 18 U.S.C. § 371 (conspiracy to defraud, commit offense against U.S.)
- 18 U.S.C. § 287 (false claims)
- 18 U.S.C. §§ 1956, 1957 (money laundering)
- 18 U.S.C. § 1343 (wire fraud)
- 26 U.S.C. § 7206 (false tax statements)
- Title 21 drug offenses

Data Analytics Team: Overview

- Internally, the team is a hub for training, consultation, data management, and data analysis
  - Enables “smarter” investigations and prosecutions
- Externally, the team serves as a liaison with data teams at agencies performing work relevant to the HCF Unit’s efforts
- Addresses analytical weaknesses to improve identification of health care fraud, waste, and abuse across the U.S. health care system

Data Analytics: "Smarter" Investigations and Prosecutions

- Prioritization of health care fraud prevention has:
  - **Significantly improved data analytic resources** allowing for increased data mining and quicker identification and action in fraud, waste, and abuse cases
  - **Strengthened collaboration** between Federal, State, and local agencies, allowing them to better coordinate data analytic resources
  - **Capitalized on the power of data** to improve the effectiveness of the Health Care Fraud and Abuse Control (HCFAC) program

Data Analytics: Advantages

- Proactively set our own prosecutorial agenda
  - Reduce reliance on cooperators and relators
  - Apply resources efficiently in top health care fraud threat areas
- Proactively identify where fraud is occurring
  - Efficiently identify potential witnesses and subjects
  - Shrink the time between the fraudulent acts and detection
  - Permit UC operations and possible seizure of assets

NEW YORK STATE OF OPPORTUNITY. | Office of the Medicaid Inspector General

Protecting the Integrity of New York State's Medicaid Program

January 16, 2019

OMIG's Mission

To enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high-quality patient care.

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A Statewide Presence

Regional Offices:

- Albany
- Buffalo
- Hauppauge
- New York City
- Rochester
- Syracuse
- White Plains

OMIG Reports

Work Plan & Annual Report

- **2018-19 Work Plan** posted on the OMIG website at: https://omig.ny.gov/index.php/information/work-plan
  - Offers guidance, direction and information regarding OMIG's focus areas, review plans and new initiatives
  - Released annually in April; updated throughout the year
- **2017 OMIG Annual Report** posted at: https://omig.ny.gov/index.php/information/annual-reports
  - Released annually in October

2018-19 Work Plan: Key Focus Areas

Enhancing Compliance Outreach and Education Efforts

- Promote provider outreach and education
  - Hits to the Compliance tab on OMIG's website in 2017: 100,000+
  - Phone calls to dedicated call line in 2017: 1,150+
  - Emails to Compliance dedicated email address in 2017: 325
- Generate policy based on provider collaboration efforts

Mandatory Compliance Program Certification

- Certification is only available electronically on OMIG's website
- OMIG's webinar series provides statutory and regulatory background on the compliance and certification obligations

  See: https://www.omig.ny.gov/resources/webinars
- Effective December 2018: compliance certification is based on Provider Identification Number

Promoting Innovative Analytics

- Enhance multidisciplinary activities, including improved data access, storage and mining capabilities
- Apply technology to aggregate & analyze continuously updated data to enhance accuracy, timeliness, etc.

Fighting Fraud, Waste, and Abuse

- Refer and support prosecution of cases related to suspected or confirmed allegations of fraud to Attorney General's Medicaid Fraud Control Unit (MFCU)
- Utilize multidisciplinary activities to improve audit and investigation efforts to recover and save Medicaid funds
- Develop efficient and effective managed care auditing processes through OMIG's Project Team Initiative

Fighting Fraud, Waste, and Abuse

- OMIG Project Teams
  - Data
  - Managed Care Contract and Policy/Relationship Management (MCCPRM)
  - Managed Care Plan Review
  - Managed Care Network Provider Review
  - Pharmacy
  - Value Based Payments

Prescription Drug & Opioid Abuse

The Current Landscape:

- **Drug Diversion –** Schemes to sell prescription drugs for profit involving high-cost, highly abused drugs like narcotics, antidepressants, antipsychotics, and antiretrovirals
- **Prescription Forgeries –** Electronic prescribing now accounts for 89% of all prescriptions; yet over 1.5 million out of more than 41 million Medicaid prescriptions last year were written as paper scripts; 17% of those were for controlled substances

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OMIG's Response:

- **Investigate Outliers** – Launched a new project with the Unified Program Integrity Contractor (SGS) to assist in identifying and investigating providers and recipients whose prescribing or utilization is outside normal parameters
- **Recipient Restriction Program (RRP)**
  - Restrict access to a single designated provider, pharmacy, or both to prevent doctor shopping
  - Delivered cost savings of more than $94M with 2,300 reviews conducted in 2017

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Home Health & Community-Based Services

Current Landscape

- **Expanding Universe** - Home and community-based care sector continues to grow
- **Abuse Alert by HHS OIG to all states**
  - Significant and persistent fraud risk in home care
  - Home care aides have the highest number of fraud convictions nationwide of any provider type
  - New York City identified as one of 27 “hotspots” for characteristics common to home health fraud

OIG Findings

- Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases
- More than 350 criminal and civil actions; over $975 million in receivables for fiscal years 2011-2015
- Major concerns pertain to questionable billing patterns, compliance problems, and improper payments in home health
  - "Impossible Days"
  - Failure to have effective compliance program in place

Home Health & Community-Based Services

- **OMIG home health working group**: auditors, investigators work collaboratively – triage cases, referral matters, etc.
- **Certified Home Health Agency**
  - Conduct fee-for-service audits to validate payments
  - Conduct Episodic Payment System (EPS) audits
- **Personal Care Services (PCS)**
  - Audit and investigate PCS FFS Medicaid claims and services provided through MCOs
  - Audit and investigate CDPAP providers to ensure compliance with rules and regulations

Home Health & Community-Based Services

- **Long-Term Home Health Care Program (LTHHCP)**
  - Continue to audit LTHHCP fee-for-service (FFS) Medicaid claims to verify per-visit and hourly rates calculated for the various ancillary services provided; focus on LTHHCPs with both high Medicaid utilization and rate capitations.
  - Review rate add-ons, including funds dedicated to worker recruitment, training, and retention.

Home Health & Community-Based Services

- **Wage Parity**
  - OMIG continues to conduct reviews and work closely with DOH and DOL to ensure that home care providers are providing wage and fringe benefit compensation in compliance with wage parity laws
- **Minimum Wage/Fair Labor Standards Act**
  - OMIG, in collaboration with DOH, continues to conduct reviews to ensure MCOs are appropriately passing on supplemental Medicaid payments to home care providers, in compliance with DOH directives

Managed Care

Current Landscape

- **Select Mainstream Model Contract Amendments**
  - MCOs now required to submit quarterly provider investigative reports
  - OMIG can audit both MCOs (data submitted to the State) and their network providers (data submitted to the MCOs)

Current Landscape

- **Model Contract Changes (Required by CMS 2016 Final Rule)**
  - MCOs must refer all “potential” fraud, waste, or abuse
  - MCOs must report enrollee change of address or death
  - MCOs must report overpaid capitation rates or other contract payments within 60 calendar days
  - MCOs must suspend payments to network providers under investigation by the State for credible allegation of fraud

OMIG Activities

- **Multi-disciplinary Project Teams** – Six specialized project teams work in concert to investigate, audit, and review providers in the managed care environment
- **MCO Visits** – OMIG is conducting on-site visits with MCOs to educate, inform, and clarify expectations, processes, and regulations regarding program integrity
- **Network Provider Reviews**

Managed Long-Term Care

- Investigate – independently and with partner agencies - Social Adult Day Care (SADC) Centers
  - In concert with DOH and NYSOFA, launched SADC Certification process
- Conduct bimonthly meetings with MLTC plans, DOH, New York City Department for the Aging (DFTA),and NYS Office for the Aging (NYSOFA)
- Audit MLTC plans to ensure enrollees are program eligible and appropriate care management is provided
  - Includes the MLTC Partial Capitation program

Transportation

Current Landscape

- **Mobility** - The “portable” nature of this business makes it easy for fraudulent providers to close up shop in one place and open elsewhere under a different name when being investigated or reviewed by OMIG
- **High Billing** - Medicaid transportation services claims in 2017 totaled more than $937 million

OMIG’s Response

- **Transportation Task Force –** working together with state and local partners, OMIG identifies non-licensed or uninsured operators, as well as those with pending or adjudicated criminal allegations
- **Statewide CVR effort –** onsite reviews conducted to ensure transportation providers are in full compliance with all local, state, and federal regulations

Self-Disclosure

Self-Disclosure Background

- Providers who identify Medicaid overpayments are obligated to return those funds
- Failure to timely report and return any overpayment can have severe consequences, including but not limited to:
  - Potential liability under the False Claims Act
  - The imposition of civil monetary penalties
  - Fines and treble damages
  - Possible exclusion from the Medicare and Medicaid programs

Regulatory Authority

- New York State Public Health Law (NYS PHL) §32(18)
  OMIG shall, in conjunction with the commissioner, develop protocols to facilitate the efficient self-disclosure and collection of overpayments and monitor such collections, including those that are self-disclosed by providers. The provider's good faith self-disclosure of overpayments may be considered as a mitigating factor in the determination of an administrative enforcement action.

Regulatory Authority

- Affordable Care Act (ACA) of 2010 §6402
  Medicaid and Medicare overpayments must be returned within 60 days of identification, or by the date any correspondence cost report was due, whichever is later.

- Title 18 of the New York Code of Rules and Regulations (NYCRR) §521 (7)
  Requires the refunding of overpayments as part of provider's compliance program.

Regulatory Authority

- Title 42 of the United States Code (USC) §1320a-7k(d)(1) & (2)
  Requires a person who has received an overpayment to report the overpayment, the reason for the overpayment, and to return the overpayment within 60 days of identification or by the date the correspondence cost report is due, if applicable.

Benefits of Self-Disclosure

- Promotes an environment of compliance and integrity within an organization
- Avoids the potential for treble damages by the federal government
- Can result in OMIG making accommodations regarding interest and payment period

Method of Submission

- Self-Disclosure website recently enhanced to include a new combined submission and data form as well as updated FAQs
- Self-Disclosure site: https://www.omig.ny.gov/self-disclosure

Contact Us

OMIG Contact Information:

- OMIG: 518-473-3782
- Website: www.omig.ny.gov
- Medicaid Fraud Hotline: 877-873-7283
- Join our Listserv: https://omig.ny.gov/omig-email-list-subscriptions
- Follow us on Twitter: @NYSOMIG
- Like us on Facebook
- Dedicated e-mail: information@omig.ny.gov
- Bureau of Medicaid Fraud Allegations: bmfa@omig.ny.gov

NEW YORK STATE OF OPPORTUNITY. Office of the Medicaid Inspector General

A Message from the Medicaid Inspector General

The OMIG Work Plan for State Fiscal Year (SFY) 2019 (April 1, 2018 to March 31, 2019) outlines the framework for the agency's multi-faceted program integrity initiatives. It is OMIG's intention that its Work Plan will be dynamic and adjustments will be made throughout the year as new priorities arise and issues emerge.

Where previous Work Plans were updated annually, going forward OMIG will update its Work Plan throughout the year to adapt to the changing Medicaid landscape and our approach to conducting and coordinating fraud, waste, and abuse control activities for all Medicaid-funded services. These updates will be posted on this webpage as they are initiated, and update alerts will be sent out via OMIG's listserv.

2018-2019 OMIG Work Plan

Fiscal Year 2018-2019 Work Plan: Introduction

In fulfilling its mission, OMIG prioritizes work and allocates resources accordingly. In addition to the mandatory requirements set forth in laws and regulations, OMIG evaluates projects for the potential for positive impact on the Medicaid program and Medicaid recipients.

OMIG outlined three over-arching goals in its 2018-2020 Strategic Plan (see graphic). It is important to note that the goals are not presented in order of priority - each goal has equal significance and weight in helping OMIG achieve its mission.

The first goal focuses on provider compliance and the work OMIG does to monitor compliance programs in the Medicaid program.

The second goal focuses on identifying and addressing fraud, waste, and abuse in the Medicaid program. To achieve this goal, OMIG will direct its efforts in areas including, but not limited to: prescription drug and opioid abuse; home health and community-based care services; transportation; long-term care services; and Medicaid managed care (MMC). This is in addition to ongoing program integrity activities.

The third goal focuses on OMIG's efforts to develop innovative analytic capabilities to detect fraudulent or wasteful activities. This includes data mining and analysis, cost-savings measures, and pre-payment reviews.

Finally, as noted in the Message from the Inspector General, OMIG's Work Plan will now be dynamic and updated throughout the year as new priorities and issues arise.

- Work Plans for previous years

Work Plan Updates

Current Action Items

- Compliance Activities
- Combatting Prescription and Opioid Abuse
- Home Health and Community-Based Care Services
- Long-Term Care Services
- Medicaid Managed Care
- Transportation
- Ongoing Program Integrity Activities
- Data Analytics Activities

(Click image to enlarge.)

Goal #1: Collaborate with providers to enhance compliance

Effective compliance programs create a control structure to reduce the potential for fraud, waste, and abuse through self-correction and/or self-reporting of errors by providers.

Compliance Program General Guidance and Assistance

OMIG will continue to maintain a dedicated telephone line and email address to respond to and address questions related to the implementation and operation of Medicaid providers' compliance programs required by Social Services Law (SSL) § 363-d and 18 New York Codes, Rules and Regulations (NYCRR) Part 521.

OMIG will also continue to update and publish procedures and forms to assist providers in meeting compliance obligations.

Compliance Certifications

Providers subject to the mandatory compliance program obligation are required to complete an annual certification on OMIG's website. Providers who fail to fulfill their mandatory compliance certification obligations may be identified for potential administrative action.

Compliance Certification Change: To make the annual compliance certification process more efficient, OMIG is transitioning from a system that utilizes the Federal Employer Identification Numbers (FEIN) to a system based on Provider Identification Numbers.

Compliance Program Reviews

OMIG will conduct compliance program reviews of providers and Managed Care Organizations (MCO) to analyze whether a Medicaid provider's compliance program is implemented and operating as required by SSL § 363-d and NYCRR Part 521 and issue censures as needed.

Corporate Integrity Agreement Monitoring and Enforcement

OMIG will continue to implement, monitor, and enforce corporate integrity agreements (CIA) when terminating or excluding a provider found to have committed fraud, waste, or abuse would have significant impact on recipient access to care.

Goal #2: Coordinate with stakeholders to identify and address fraud, waste, and abuse in the Medicaid program

In addition to ongoing program integrity endeavors, the activities in this section are centered on several priority areas: fighting prescription drug and opioid abuse; home health and community-based care; long-term care; transportation; and managed care.

In pursuing cases of Medicaid fraud, OMIG will continue to engage in collaborative efforts with federal, state, and local law enforcement agencies; and with local Departments of Social Services (LDSS). OMIG will continue to participate in the Federal Bureau of Investigation-directed Health Care Fraud Strike Forces throughout the state. OMIG will continue to participate in the U.S. Department of Justice (DOJ) Medicare Fraud Strike Force, based in the Eastern District of New York, and will assist in health care fraud investigations they conduct. OMIG will continue to work with the New York State Attorney General's Medicaid Fraud Control Unit (MFCU) and will also work collaboratively with District Attorneys across the state to identify and prosecute those individuals attempting to defraud New York State taxpayers and the Medicaid program.

Combatting Prescription Drug and Opioid Abuse

To help fight opioid abuse, OMIG will continue to dedicate resources to a variety of activities to reduce drug misuse, prescription opioid abuse, and drug diversion.

Prescription Monitoring

OMIG will work in tandem with the DOH Bureau of Narcotics Enforcement (BNE) to ensure provider compliance with the Internet System for Tracking Over-Prescribing (I-STOP), NYS's Prescription Monitoring Program (PMP) registry. OMIG monitors provider compliance with mandated electronic prescribing and identifies fraudulent prescriptions being billed to Medicaid.

Utilization Alerts

OMIG is working to proactively educate providers where a substance utilization review indicates that a recipient may have an accumulation of a controlled substance although they did not meet the criteria for restriction under OMIG's Recipient Restriction Program. A "Controlled Substance Accumulation" notice will be sent to alert providers of the potential overutilization and abuse.

Similarly, OMIG developed Medication Therapy Review Form to alert prescribers to instances of apparent therapeutic duplication. This will allow the prescriber to reconcile the recipient's medication list and identify potential forgeries or overutilization.

Recipient and Provider Investigations

OMIG will review recipient data to identify and investigate physicians prescribing excessive amounts of controlled substances or providing unnecessary services, and refer them to MFCU, if appropriate, for prosecution.

Recipient Restriction Program

OMIG will use the Recipient Restriction Program (RRP) to limit a recipient's access to Medicaid care and services if it is found that they have received duplicative, excessive, contraindicated or conflicting health care services, drugs, or supplies. This addresses a Medicaid recipient's ability to obtain duplicate prescription fills through doctor or pharmacy shopping. It

also may be utilized where recipients have engaged in fraudulent or abusive practices such as forgery, selling drugs obtained through Medicaid, or providing their Medicaid card to another person.

OMIG will monitor MCO compliance in: administering their RRP programs, providing monthly data on current restriction information; sharing new OMIG-initiated restrictions on enrollees; monitoring enrollees who change plans and sending the appropriate restriction information to the new plan; and coordinating provider changes with the MCO by acting as a conduit of the plan to the local district or the Health Benefit Exchange (HBE), as appropriate, to make changes in eMedNY.

Collaborative Partnerships

OMIG will continue to work closely with the Centers for Medicare and Medicaid Services (CMS), the Department of Justice, the FBI, and national health insurance companies, as well as state and local law enforcement agencies, and continue to participate on the Governor's Task Force to Combat Heroin and Opioid Addiction.

Home Health and Community-Based Care Services

Home and community-based care services continue to grow as the population ages and the Medicaid program moves away from hospitalization and long-term care placements under the value-based payment system. The need for oversight of the home care services workers providing services to vulnerable home-bound recipients is critical.

Long-Term Home Health Care Program (LTHHCP)

OMIG will continue to audit LTHHCP fee-for-service (FFS) Medicaid claims to verify per-visit and hourly rates calculated for the various ancillary services provided, with a focus on LTHHCPs with both high Medicaid utilization and rate capitations. OMIG will also review rate add-ons, including funds dedicated to worker recruitment, training, and retention.

Certified Home Health Agencies (CHHA)

OMIG will continue to conduct both CHHA FFS audits and CHHA Episodic Payment System (EPS) audits.

Personal Care Services (PCS)

OMIG will continue to audit and investigate PCS FFS Medicaid claims, as well as PCS services provided through MCOs. MCOs are responsible for assessing Medicaid recipients and making service determinations. OMIG convenes a monthly meeting with a cross section of team representatives to discuss initiatives relating to personal care services. When auditing or investigating matters related to personal care assistants, OMIG also assesses the responsibilities of any entity associated with the personal caregiver and takes appropriate actions when those responsibilities are not being met.

The Consumer Directed Personal Assistance Program (CDPAP) continues to expand. OMIG will audit and investigate CDPAP providers to ensure compliance with rules and regulations. Audit activities will include services reimbursed through fee-for-service and MCOs.

Traumatic Brain Injury (TBI) Waiver Services

OMIG will continue to examine TBI FFS claims to determine compliance with program requirements.

Nursing Home Transition and Diversion Waiver

OMIG will continue to examine NHTD FFS claims to determine compliance with program requirements.

Wage Parity

OMIG will continue to conduct reviews and work collaboratively with DOH and the Department of Labor to ensure that home care providers are providing wage and fringe benefit compensation to employees in compliance with wage parity laws.

Minimum Wage/Fair Labor Standards Act

OMIG will continue to conduct reviews and work collaboratively with DOH to ensure that MCOs are appropriately passing on supplemental Medicaid payments to home care providers, in compliance with DOH directives.

Long-Term Care Services

Assisted Living Program (ALP)

Resident Care Audits

OMIG will conduct field audits to validate payments for services and ensure the documented needs of patients are being met. OMIG will also provide oversight of ALP resident care audits that are conducted as part of the County Demonstration program.

OMIG and DOH Division of Adult Care Facilities and Assisted Living Surveillance will continue to coordinate efforts to monitor ALP provider's compliance with Medicaid regulations. In the event OMIG identifies a potential quality of care or patient endangerment issue, DOH will be contacted immediately and remedial activities will be coordinated. Quality of service and fiscal issues of entities will be addressed to ensure that the population serviced by the program is safe and adequately served while maintaining claiming accuracy.

Nursing Home Audits

Rate Audits

OMIG will continue to work with DOH's Bureau of Long-Term Care Reimbursement (BLTCR) to ensure facilities conform to BLTCR's policy and reimbursement regulations and will audit submitted pertinent costs and data related to the capital calculations.

Minimum Data Set

OMIG will continue to coordinate with BLTCR to review the accuracy of nursing home Minimum Data Set (MDS) submissions.

Managed Long-Term Care

Social Adult Day Care (SADC) Centers

OMIG will continue to independently investigate SADCs, and work jointly with MFCU, DOH, the New York City Buildings Department, the New York City Department for the Aging (DFTA) and the State Office for the Aging (SOFA). OMIG will also continue to have bimonthly discussions regarding complaints and new initiatives with MLTC plans, DOH, DFTA, and SOFA to review complaints, and discuss investigations and new initiatives.

Partial Capitation

OMIG will audit MLTCs to ensure enrollees are eligible to qualify for the program and that appropriate care management is being provided by the MLTC plans.

Enrollment and Eligibility Reviews

OMIG will review the enrollment records, recipient Plans of Care and claims data to determine if the MLTC plans are providing the specific services deemed medically necessary by those MLTC plans for their recipients. Additionally, OMIG will examine Case/Care Management system notations to confirm that appropriate care management is also being rendered to its members. OMIG will continue to assess MLTC plans to ensure that their contractual obligations in serving their recipient population are being met.

Medicaid Managed Care

OMIG's ongoing efforts include performance of various match-based targeted reviews and other audits identified through data mining, analysis, and other sources. These audits lead to the recovery of overpayments and implementation of corrective actions that address system and programmatic concerns. As more service areas are transitioned into managed care, OMIG will continue to pursue initiatives that significantly enhance the detection of fraud, waste, and abuse in the MMC environment.

Managed Care Contract and Policy Relationship Management Project Team

OMIG's Managed Care Contract and Policy Relationship Management Project Team will work to develop and advance new MCO contract amendments to address current and future Medicaid program integrity challenges and support the work of the other project teams, as well as work with DOH to continue implementation of provisions included in prior contract amendments.

Managed Care Plan Review Project Team

OMIG's Managed Care Plan Review Project Team will conduct audits of Medicaid managed care operating reports (MMCOR). Audits will focus on the review of reported pertinent medical and administrative costs for accuracy and allowability to ensure only proper costs were utilized in the development of respective rate components.

Network Provider Review Project Team

OMIG's Network Provider Review Project Team will perform audits of providers within MCOs' networks to ensure the accuracy of encounter claim submissions and confirm that provider records are in regulatory and contractual compliance. OMIG will identify improper encounter claims that contribute to inflated capitation payments. OMIG will coordinate with MCOs and their Special Investigation Units (SIU) in its audit efforts.

Pharmacy Review Project Team

OMIG's Pharmacy Review Project Team will conduct managed care network pharmacy audits to ensure pharmacy compliance with federal and state regulations, contract requirements, and the pharmacy benefit component of MMC.

The team will also audit pharmacy encounter data to verify accuracy in billing and payment of encounter claims.

Value-Based Payments Project Team

OMIG's Value-Based Payments (VBP) Project Team will continue to work with DOH to: gain an understanding of how value-based payments will be reflected in the Medicaid data; to discuss ways of ensuring integrity within the data; and to ensure access to information is readily available to OMIG to be able to audit and investigate in a VBP environment.

Managed Care/Family Planning Chargeback

OMIG will audit claims for family planning and health reproductive services paid by MCOs for enrollees who go to non-network providers when family planning services are included in the managed care organization's benefit package.

MC Capitation Payment Audits

OMIG will audit instances where MC plans receive a capitation payment from Medicaid subsequent to an enrollee's month of death.

OMIG will audit instances where MC plans receive a capitation payment from Medicaid when the enrollee was incarcerated for the entire payment month.

MC Investigations

OMIG will continue to strengthen the MCO referral process and work with MCO SIUs to coordinate activities related to fraud investigations. Each MCO has been assigned a designated OMIG liaison to work with their SIU representative. OMIG liaisons meet regularly with the MCOs' SIU representative to discuss fraud, waste, and abuse-related referrals and general fraud trends. The liaison process was implemented to improve communications and increase referrals so that appropriate action can be taken to address overall program integrity.

Retroactive Disenrollment Monitoring/Recovery

OMIG will continue to maintain and update the database file used to monitor the retroactive disenrollment of enrollees by MCOs and to perform a secondary review of retroactive disenrollment activities by other agencies.

Transportation

OMIG will continue to work with the New York State Department of Motor Vehicles, MFCU, DOH, and New York State Department of Transportation, as well as individual counties, to conduct reviews of Medicaid ambulette and taxi services providers. Reviews will determine if services were properly ordered, if paid services were provided, if Medicaid claims were accurately submitted to eMedNY, and if drivers were qualified to drive the vehicles used to provide the service.

Transportation Review

OMIG is conducting Credential Verification Reviews (CVR) throughout New York State to ensure Medicaid transportation providers are adhering to all of the requirements outlined within the Department of Health Transportation Manual policy guidelines.

Ongoing Program Integrity Activities

County Demonstration Program

OMIG will continue to work with LDSSs and the New York City Human Resources Administration (NYC-HRA) to conduct reviews of pharmacy, durable medical equipment, transportation (ambulette, taxi and livery), long-term home healthcare and ALPs.

Enrollment, Reinstatement, and Removal from the Excluded Provider List

OMIG will continue to provide a secondary review of provider enrollment applications in certain high-risk categories such as pharmacies, durable medical equipment suppliers, physicial therapists, and transportation providers to determine if applicants should be enrolled in the Medicaid program. OMIG will also review all reinstatement applications and requests for removal from the OMIG Exclusion List.

External Audits

OMIG will respond to external audits from other government entities such as the Office of the New York State Comptroller, the federal Health and Human Services Office of Inspector General, and CMS. OMIG will analyze the external audit data, searching for and providing documentation not found during the course of the audit, researching applicable regulations, contract language and policy, and working with OMIG staff to recover inappropriately paid claims.

Fee-for-Service Audits

OMIG will conduct audits of various FFS providers in areas of concern or to meet federal waiver requirements. Programs that will be audited include, but will not be limited to:

- Diagnostic and Treatment Centers
- Durable Medical Equipment
- Health Homes
- Office of Alcoholism and Substance Abuse Services
    - Outpatient Services
    - Inpatient Rehabilitation Services
    - Opioid Treatment Program

- Office of Mental Health
    - Clinic Treatment
    - Continuing Day Treatment
    - Children's Day Treatment
    - Partial Hospitalization
    - Intensive Psychiatric Rehabilitation Program
    - Children with Serious Emotional Disturbances
- Office for Persons With Developmental Disabilities
    - Clinical and Medical Services
    - Day and Residential Habilitation
- Pre-School and School Supportive Health Services
- Private Duty Nursing Agencies

Investigations

OMIG will continue to investigate both providers and recipients to identify those who abuse the Medicaid program.

Medicaid Electronic Health Records (EHR) Incentive Payment Program

OMIG will continue to provide oversight and conduct reviews to ensure that the CMS eligibility requirements of the Medicaid EHR Incentive program are met. In addition, the post-payment audit team will continue to conduct knowledge-sharing and collaboration sessions with stakeholders throughout the state in an effort to keep providers informed of changes in audit requirements and provide updates to the post-payment audit section of the program website as necessary.

Self-Disclosure

OMIG staff will continue to work closely with providers through the self-disclosure process and will be available to address any questions or concerns that they may have.

Goal #3: Develop innovative analytic capabilities to detect fraudulent or wasteful activities

Data Review Project Team

The Data Review Project Team will continue to ensure OMIG has reliable and usable data from a wide variety of sources, including the Medicaid Data Warehouse (MDW), Salient Data Mining Solution, All Payer Database, Data Mart, and Encounter Intake System. The Team represents OMIG on the Encounters Steering Committee, a committee that is accountable for governance of Encounter Intake System changes with the goal of promoting transparency, stakeholder communication and shared decision-making.

Encounter Analysis

OMIG will continue to analyze and evaluate the integrity of encounter data, performing comparative analyses of encounters and other plan-submitted data to evaluate the consistency and completeness of MCO encounter reporting. OMIG will also

collaborate with DOH to improve data reporting by plans and facilitate data availability in the MDW.

Innovative Analytics

OMIG and DOH will be partnering with a data analytics firm to recover erroneous payments made on behalf of incarcerated and/or deceased recipients.

System Match Recovery

OMIG will continue to use analytical tools and techniques, as well as knowledge of Medicaid program rules, to data mine Medicaid claims and identify improper claim conditions for potential recoveries of inappropriate Medicaid expenditures.

Recovery Audit Contractor (RAC)

OMIG will continue to collaborate and coordinate recovery initiatives with its Recovery Audit Contractor (RAC), Health Management Systems Inc. (HMS). During FY19, HMS will focus reviews on the following:

- Credit Balance Audit FFS and Encounter
- Graduated Medical Education and Indirection Medical Education
- MCO/FFS/Same Plan Overlap
- Long-Term Care - Bed Hold Days/Net Available Monthly Income/Correct Co-insurance/Coordination of Benefit Errors/Rate Code Errors
- Duplicate Payment of Professional Services Included in Ambulatory Patient Group Rate Code
- Alternate Level of Care Days
- Medicare - Inpatient Part B/Crossover Overpayment/Incorrect Reimbursement for Medicare Part C Claims (NY RAC 033)
- Medicare Medicaid Duplicate Payment/Crossover Overpayments
- Medicaid Payment Exceeds Billed Charge
- Intensity Modulated Radiation Therapy Plan Unbundling
- Duplicate Comprehensive Psychiatric Emergency Program Case Rates/Inpatient Overlap/Brief vs. Full
- Intensive Rehab Add On
- Ordered Ambulatory Services
- JCode Incorrect Reimbursement
- Home Health

Unified Program Integrity Contract

OMIG will continue its collaboration with Safeguard Services (SGS) under CMS's Unified Program Integrity Contract (UPIC). OMIG and SGS have multiple projects in process involving data analysis, audits, investigations, and pre-payment reviews covering the following program areas: dental providers; home health; consumer-directed assistance program; and opioids. OMIG is looking to expand UPIC review areas to hospice and transportation providers.

Third Party Liability (TPL) Match and Recovery Services

OMIG's contractor, HMS, will continue to conduct pre-payment insurance verification to identify and utilize third-party coverage for Medicaid recipients, to conduct third-party retroactive recoveries, and engage in estate and casualty recoveries.

Medicare Home Health Maximization

OMIG will continue to work collaboratively with its contractor, the University of Massachusetts Medical School (UMass), to maximize Medicare coverage for dual-eligible Medicare/Medicaid recipients who have received home health care services paid by Medicaid. OMIG will continue to work with CMS and the Office of Medicare Hearings and Appeals to achieve favorable outcomes of hearings and appeals for Medicaid cases.

Medi-Medi Crossover

OMIG is collaborating with both UPIC and RAC contractors to identify duplicative payments occurring between Medicare and Medicaid. By utilizing Medicare data supplied by SGS and having our RAC contractor, HMS, match this data to the Medicaid paid claims, providers who are not properly using the Medicare crossover process and, therefore, obtaining duplicative payments will be identified and repayment of Medicaid claims will be sought.

Previous OMIG Work Plans

- 2017 - 2018 Work Plan
- 2016 - 2017 Work Plan
- 2015 - 2016 Work Plan
- 2014 - 2015 Work Plan
- 2013 - 2014 Work Plan
- 2012 - 2013 Work Plan
- 2011 - 2012 Work Plan
- 2009 - 2010 Work Plan

Work Plan Acronyms and Abbreviations

ALP	Assisted Living Program
BLTCR	Bureau of Long-Term Care Reimbursement
BNE	New York State Bureau of Narcotic Enforcement
CHHA	Certified Home Health Agency
CIA	Corporate Integrity Agreement
CMS	Centers for Medicare and Medicaid Services
DFTA	New York City Dept. for the Aging
DOH	New York State Department of Health
DOJ	U.S. Department of Justice
EHR	Electronic Health Record
eMedNY	Electronic Medicaid of New York
EPS	Episodic Payment System
FFS	Fee-For-Service
HBE	Health Benefit Exchange
HMS	Health Management Systems, Inc.
LDSS	Local Department of Social Services
LTHHCP	Long-Term Home Health Care Program
MCO	Managed Care Organization
MDS	Minimum Data Set
MDW	Medicaid Data Warehouse
MFCU	New York State Attorney General Medicaid Fraud Control Unit

MLTC	Managed Long-Term Care
MMC	Medicaid Managed Care
MMCOR	Medicaid Managed Care Operating Report
MRT	Medicaid Redesign Team
NHTD	Nursing Home Transition and Diversion Waiver
NYC-HRA	New York City Human Resources Administration
NYCRR	New York Codes, Rules and Regulations
NYSoH	New York State of Health
OIG	Health and Human Services Office of the Inspector General
OMIG	New York State Office of the Medicaid Inspector General
PCS	Personal Care Services
RAC	Recovery Audit Contractor
RRP	Recipient Restriction Program
SADC	Social Adult Day Care
SGS	Safeguard Services
SIU	Special Investigation Unit
SOFA	New York State Office for the Aging
SSL	Social Services Law
TBI	Traumatic Brain Injury
TPL	Third-Party Liability
UMass	University of Massachusetts
UPIC	Unified Program Integrity Contact
VBP	Value-Based Payment

OMIG Strategic Plan

Mission

To enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high-quality patient care.

Vision

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

Goal 1

Collaborate with Providers to Enhance Compliance

Objectives

- Promote provider outreach and education through engagement and participation efforts
- Generate policy based on provider collaboration efforts

Goal 2

Coordinate with partners, including law enforcement and managed care SIUs, to identify and address fraud, waste, and abuse in the Medicaid program

Objectives

- Referring and supporting prosecution of cases related to suspected or confirmed allegations of fraud in program integrity partnership with the Attorney General's Medicaid Fraud Control Unit
- The Managed Care Plan Review, Network Provider Review and the Pharmacy Project Teams will focus on developing efficient and effective audit processes to enhance the integrity of the managed care environment.

Goal 3

Develop innovative analytic capabilities to extract high-level data on fraudulent or wasteful Medicaid activities

Objectives

- Enhance multidisciplinary activities, including improved data access, storage and mining capabilities
- Utilize multidisciplinary activities to improve upon audit and investigation efforts to recover and save Medicaid funds

2017 ANNUAL REPORT

ANDREW M. CUOMO
GOVERNOR

DENNIS ROSEN
MEDICAID INSPECTOR GENERAL

Contents

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Message from the Medicaid Inspector General

It is my pleasure to submit the Office of the Medicaid Inspector General's (OMIG) 2017 Annual Report.

New York continues to lead the nation in identifying and preventing Medicaid fraud, waste, and abuse.

OMIG's comprehensive investigative, auditing and cost-avoidance efforts, extensive partnerships with law enforcement agencies, and wide range of compliance initiatives and provider education efforts, resulted in more than $2.6 billion in Medicaid recoveries and cost savings in calendar year 2017. The report that follows details the agency's efforts across all divisions and bureaus.

Going forward, as the health care landscape and the Medicaid program continues to evolve and change, OMIG will continue to aggressively protect the integrity of the program, which is a key component in sustaining New York State's (NYS) high-quality health care delivery system.

Sincerely,

Dennis Rosen
Medicaid Inspector General

OMIG's main office is in Albany with regional offices in New York City (NYC), White Plains, Hauppauge, Syracuse, Rochester, and Buffalo.

General Overview

History and Authority

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

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

Mission Statement

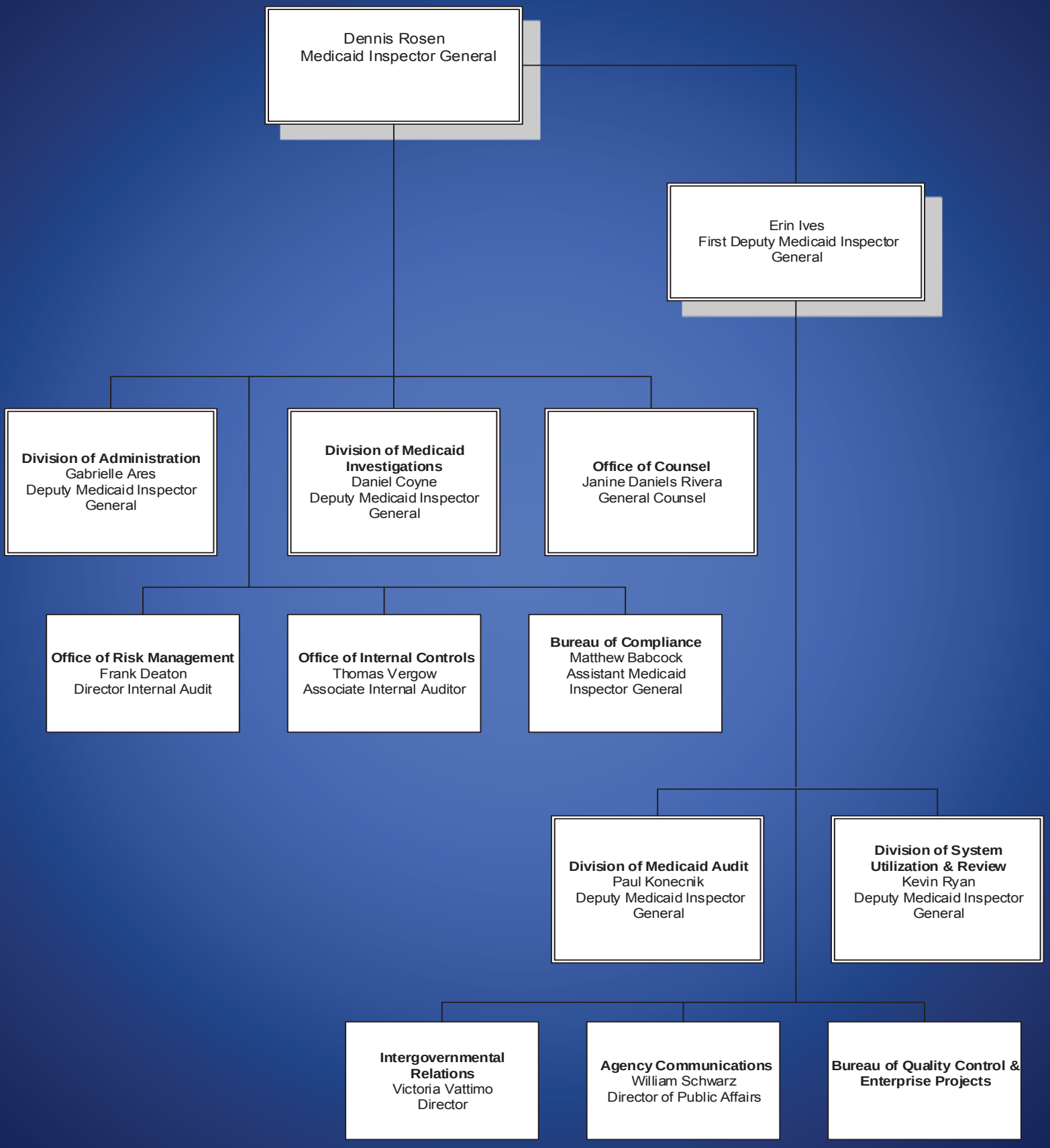
The mission of OMIG is to enhance the integrity of the NYS Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds, while promoting a high quality of patient care.

Annual Reporting

As required by NYS Public Health Law §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 exemplify OMIG's program integrity efforts.

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

OMIG Organizational Chart



2017 Program Integrity Activities

OMIG conducts and oversees Medicaid program integrity activities that prevent, detect, and investigate instances of Medicaid fraud, waste, and abuse. OMIG coordinates such activities with a range of NYS agencies such as DOH, the Office for People with Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH), the Office of Temporary Disability Assistance, the Office of Children and Family Services, the Justice Center for the Protection of People with Special Needs (Justice Center), the NYS Education Department (NYSED), the fiscal agent employed to operate the Medicaid Management Information System, as well as local governments and entities.

OMIG receives and processes complaints of alleged Medicaid fraud, waste, and abuse. All allegations are reviewed and investigated, and if fraud is suspected, OMIG refers such cases to the NYS Attorney General's Medicaid Fraud Control Unit (MFCU), pursuant to applicable regulations and laws. The agency also works closely with local, state, and federal law enforcement entities as part of its efforts to protect the integrity of the state's Medicaid program.

Executive Initiatives

OMIG's Response to the Opioid Epidemic

The cost in lives and dollars due to the opioid epidemic - throughout New York State and the nation - is a recognized public health crisis. To combat opioid abuse, OMIG continues to collaborate across its divisions and with federal, state, and local law enforcement and other state regulatory agencies. OMIG staff meet monthly to discuss ongoing drug diversion investigations, findings, and future program integrity projects related to opioid abuse. OMIG's Division of Medicaid Investigations (DMI) and its Recipient Restriction Program (RRP) play major roles in the agency's efforts to address the crisis, and each continues to pursue additional avenues to fight the opioid epidemic. The RRP is an administrative mechanism whereby selected recipients with a demonstrated pattern of abusive utilization of Medicaid services are restricted to one primary medical provider, one primary pharmacy, and one designated inpatient hospital or clinic.

- Gabapentin, also known as Neurontin, is often used as an alternative for narcotics in pain treatment. Lack of controlled substance scheduling and generic availability of Gabapentin makes the drug more easily available and susceptible to overutilization, and this drug can be misused and abused alone or in combination with other legal or illicit drugs. To address this overutilization, OMIG's RRP pharmacy team performed additional exception processing. This resulted in RRP identifying recipients who appeared to be overutilizing pharmacy services to obtain an excess of this drug, and RRP uses this process to identify recipients for restriction.

Opioid Surveillance Task Force

OMIG participates in the Statewide Opioid Task Force created by the Governor's Office of Employee Relations (GOER). Multiple agencies collaborate to share ideas in the effort to combat the opioid

epidemic. Other agencies involved include OASAS, Bureau of Narcotic Enforcement, Division of Criminal Justice Services, and DOH's AIDS Institute.

OMIG Initiative to Combat Fraud in Home Health

In NYS, services provided by personal care aides (PCA) and home healthcare agencies (HHA) continues to increase as the population ages and as the managed care program moves away from hospitalization and long-term care placements. The need for oversight of the PCAs and HHAs providing these services to this vulnerable population is critical. This population often does not have the personal ability or family members available to advocate or to monitor and ensure that the services are necessary, are provided by qualified individuals, are provided as ordered, are provided at all, that the caregivers show up as assigned, and that the beneficiary is not at any risk.

OMIG is addressing the issue of fraud, waste, and abuse in the home health care sector by coordinating efforts statewide, and meeting monthly to discuss allegations and trends. However, a significant challenge to combating home health care fraud is the lack of an identifier for home health aides, personal care assistants, or individuals providing services under the Consumer Directed Assistance Program (CDPAP). While most providers receiving funds from the NYS Medicaid program have a National Provider Identifier (NPI), there is no such "unique" identifier to track the history and performance of individuals providing services. OMIG is reviewing solutions to address this issue, including requiring all home health caregivers to obtain an NPI, thereby enhancing OMIG's program integrity efforts through the ability to review individual caregiver services across all home health care providers.

OMIG staff collaborated with a Managed Care Organization (MCO) Special Investigation Unit (SIU) to identify consumer directed personal care aides who may be abusing the CDPAP by submitting timesheets for services not rendered or for services inappropriately billed during a recipient's inpatient admission. As a result of this collaboration, OMIG decided to review all allegations received since January 2016 that involved CDPAP aides and then used this information to create a watchlist. The watchlist has proven instrumental in identifying aides for whom OMIG has received more than one complaint and potentially colluding recipients. A required unique identifier would make it possible to systematically identify possible fraud, waste, and abuse by both PCAs and recipients.

Managed Care

In NYS, several different types of MCOs participate in Medicaid managed care, including mainstream managed care plans, health maintenance organizations, prepaid health service plans, managed long-term care (MLTC) plans, and Human Immunodeficiency Virus (HIV) Special Needs Plans. OMIG's program integrity initiatives in managed care include audits of MCOs' cost reports and related data, investigations of providers and enrollees, and regular meetings with the MCOs' SIU to identify targets and discuss cases.

Managed Care Audit Activities

OMIG's audit efforts include performing various match-based reviews utilizing data mining and analysis to identity potential audits. These audits lead to the recovery of inappropriate premium payments and identification of actions to address systemic and programmatic concerns. During 2017, these efforts resulted in 543 finalized audits with over $131 million in identified overpayments. Highlights of managed care audit activities are described below.

Foster Care

When a child is placed in agency-based foster care, that child loses eligibility for Medicaid Managed Care, and a per diem rate is paid to the foster care agency responsible for the child's care. Currently, there are separate upstate and downstate Welfare Management Systems. Due to the separate systems, a child may be issued a duplicate client identification number (CIN) which creates the possibility of duplicate payments being made.

After the child is placed in foster care, the New York State of Health (NYSoH), Local Departments of Social Services (LDSS), and New York City Human Resources Administration (NYC HRA) are responsible for retroactively adjusting the enrollee eligibility file, notifying OMIG of the retroactive disenrollment, and notifying the MCO to void the premium payments for any month where the MCO was not at risk to provide services for the foster care child.

During 2017, OMIG identified more than $17.1 million in inappropriate payments to MCOs for foster care children whose services were provided by the foster care agencies. This project was enhanced by a collaborative effort among OMIG and DOH's Office of Health Insurance Programs (OHIP) and NYS Office of Information Technology Services (ITS). OMIG utilizes information obtained from OHIP and ITS monthly reports (i.e., lack of social security numbers on eMedNY data files) to confirm instances where multiple CINs were created for a foster care child. OMIG continues to collaborate with the MCOs, NYSoH, LDSS, and NYC HRA to identify and resolve issues concerning timely eligibility updates for foster care children.

Retroactive Disenrollment

In most cases, when a member's Medicaid managed care eligibility changes, the adjustment is prospective. However, in some cases, the eligibility change is retroactive and may render one

or more capitation payments paid on behalf of the member inappropriate. OMIG recovers these inappropriate capitation payments from the MCO through the retroactive disenrollment process. This process requires a collaboration among OMIG, NYSoH, LDSS, and NYC HRA.

OMIG assists DOH in the development of new retroactive disenrollment reason codes, consults on MCO contract development, provides education and outreach to the LDSS, conducts analyses of retroactive disenrollment submissions, and distributes a semi-annual report to the MCOs of all LDSS-reported retroactively disenrolled individuals. Through the audit process, OMIG recovers any capitation payments the MCOs fail to void after receiving the semi-annual report. In 2017, more than $51 million in overpayments was identified due to retroactive disenrollments.

Managed Care Annual Deceased Enrollee Audit

OMIG continues to audit enrollment issues in several project areas, including Medicaid managed care monthly capitation payments made on behalf of deceased enrollees. OMIG compares data provided by NYS's Bureau of Vital Statistics and the NYC Bureau of Vital Statistics and individuals who are indicated as deceased on eMedNY against the monthly capitation payments paid to MCOs. OMIG's review identifies monthly capitation payments paid to the MCOs for months subsequent to the enrollee's month of death, that were not voided by the MCOs as part of the first-level enrollment reviews conducted by LDSS, NYC HRA, or NYSoH. OMIG's audit of deceased Medicaid managed care enrollees identified more than $23 million in overpayments.

OMIG Strengthens Partnerships with Managed Care Organizations

Throughout 2017, OMIG staff, including representatives from DMI, Division of Medicaid Audit (DMA), and Bureau of Business Intelligence (BBI), have visited several MCOs to discuss their program integrity operations. Topics include but are not limited to: SIU operations, claims processing and encounter validation, and subcontractor/vendor relations and oversight. Through its MCO on-site review process, OMIG continues to identify MCO best practices in an effort to enhance program integrity consistency throughout the industry. An example of a best practice identified through the on-site process, is one MCO's daily manual review of 15% of its paid claims, concurrent with its auto-adjudicated process. OMIG also noted that several plans conduct annual on-sites of contracted vendors in order to ensure Medicaid and contractual requirements are being met. It is processes such as these that OMIG is identifying and analyzing for potential inclusion in future contractual arrangements with MCOs.

OMIG has also undertaken an MCO liaison initiative to strengthen its working relationships with MCO SIUs. Each MCO has been assigned a designated OMIG liaison to work with their SIU representative. The appointed liaison meets with the SIU representative monthly to discuss fraud, waste, and abuse related referrals and general fraud trends. The liaison process was implemented in an effort to improve communication and increase referrals, so appropriate action can be taken to address overall program integrity. As a result of this initiative, OMIG has received positive feedback from the MCOs, and the agency has several ongoing investigations.

Managed Care Project Teams

OMIG has six project teams, each with a goal towards improving and expanding the agency's program integrity work in Medicaid managed care. OMIG staff across all divisions and offices participate on these teams and coordinate their efforts through the project management office.

OMIG's six project teams oversee the following focus areas:

- Data
- Managed Care Contract and Policy/Relationship Management (MCCPRM)
- Managed Care Plan Review
- Managed Care Network Provider Review
- Pharmacy
- Value Based Payments

Data

The Data Team assisted with creating a SharePoint tool entitled, "Report a Data Issue." This tool enables OMIG staff to submit issues and/or questions regarding any Medicaid processing system or database that is used in OMIG business operations. Another project identified all data elements that are available on the Medicaid Data Warehouse (MDW) for managed care encounters. This information was used to create a crosswalk between fields submitted on the post adjudicated claims data reporting (PACDR), the national encounter reporting standard adopted by DOH in September 2015, to those delivered to the MDW. Analysis of the crosswalk helped to identify fields being submitted on the PACDR encounter that are useful to OMIG program integrity efforts, but that are not currently populated in the MDW.

Managed Care Contract and Policy/Relationship Management

In 2017, the MCCPRM Team focused on developing model contract amendments to address new federal regulatory requirements. As part of this effort, MCCPRM proposed and negotiated amendments to the January 1, 2017 Managed Long-Term Care Partial Capitation Contract (Partial Capitation Contract). These amendments include updated fraud and abuse referral requirements, compliance programs, and the requirement that MCOs withhold payments from network providers who are the subject of a pending investigation of a credible allegation of fraud. In addition, program integrity changes made to the October 1, 2015 Medicaid Managed Care Model Contract were incorporated into the Partial Capitation Contract. All of these amendments will serve to strengthen OMIG's program integrity and oversight role in the managed long-term care program. In anticipation of the October 1, 2015 Model Contract being approved by Centers for Medicare and Medicaid Services (CMS), MCCPRM continued to coordinate the development of instructions and guidance for new program integrity requirements.

Managed Care Plan Review

The Managed Care Plan Review Team conducted Medicaid Managed Care Operating Report (MMCOR) audits utilizing detailed audit plans and processes. MMCORs are used by DOH to develop the capitation rates paid to MCOs. Costs and utilization reported on these MMCORs are reviewed to ensure accuracy of the reported data.

In addition, team members participated in on-site visits with seven MCOs to discuss program integrity related processes and procedures. These visits are part of a coordinated effort to gain a greater understanding of MCO business processes and to analyze their fraud, waste, and abuse activities.

Managed Care Network Provider Review

The Managed Care Network Provider Team finalized four audits of services provided by physicians who contracted with various MCOs. While conducting these reviews, OMIG auditors gained understanding of the complexities of reviewing network providers and ensuring the validity of encounter data. Team members are working on understanding data issues related to previously non-enrolled providers. Development has started on new audit plans and processes in the areas of outpatient chemical dependence services, opioid treatment programs, personal care services, and consumer directed personal care assistance. As these are developed the team will train audit staff throughout the agency to increase participation in program integrity efforts.

Pharmacy

While reviewing encounter data for pharmacy audits, the Pharmacy Team discovered that the encounter amounts paid were inconsistent with actual pharmacy reimbursements. Team members verified the submitted encounter field information directly with the MCOs, and by utilizing the Program Integrity Reports. The audit process was adjusted to obtain pharmacy reimbursement amounts directly from the pharmacies, and to use those amounts in the calculation of any recoveries. The Pharmacy Team continues to develop the practical application of audit processes to a managed care network pharmacy audit.

Value Based Payments

OMIG established a Value Based Payment (VBP) Team in August 2017. The team's mission is to determine how value based payment systems are being implemented, and to identify the rules and regulations that govern these payment structures. The team will identify potential program integrity weaknesses and make recommendations to help strengthen value based payment systems. Since its inception, VBP Team members have participated on the VBP Workgroup; a stakeholder group that meets regularly to support the development of the VBP Roadmap. The Workgroup is hosted by DOH and includes representatives from various regulatory oversight agencies and healthcare associations. VBP Team members have also participated on the VBP Program Integrity Workgroup and contributed to VBP program recommendations. Additionally, the team has expanded OMIG's knowledge base to prepare existing processes for the transition to the VBP system.

Audits

OMIG conducts audits of Medicaid services provided to beneficiaries. The objective of the audit is to assess providers' compliance with applicable federal and state laws, rules, and policies governing the NYS Medicaid program, and to verify that:

- Medicaid-reimbursable services were rendered for the dates billed;
- Appropriate rate or procedure codes were billed for services rendered;
- Patient-related records are maintained and contain the documentation required by regulations; and,
- Claims for payment were submitted in accordance with DOH regulations and the appropriate provider manuals.

In 2017, OMIG finalized 585 fee-for-service (FFS) audits which resulted in identified overpayments of more than $21 million. The most common audit findings identified by OMIG's FFS auditors were missing, late, or improperly authorized plan of care documentation. These care plans may have different titles across all categories of service which utilize them, however they form the fundamental basis for authorized Medicaid services. Errors of this nature resulted in identified overpayments and reinforced the importance of maintaining proper documentation. Auditors evaluate the required document set for accuracy in support of payment. The provider's ability to render services by licensed, certified, trained, and qualified caregivers is also evaluated via a review of the supporting documentation, which is required to be maintained. Health screenings, vaccinations, and lab test results documentation are reviewed to ensure that caregivers are providing service in a manner that will not endanger the patients. OMIG also performed audits in the following areas: rate-based providers, county demonstration, school districts and county preschools as required by the State Plan Amendment, and provider self-disclosures.

Personal Care

Throughout 2017, OMIG continued to audit various areas of personal care. OMIG finalized 21 audits with identified overpayments of more than $9 million. These audits reviewed certified home health agencies, personal care, and traumatic brain injury providers. The most common findings included:

- Billing Medicaid before services were authorized;
- Supervision visits not performed within the required timeframe;
- Failure to maximize third-party or Medicare benefits;
- Failure to document tasks;
- Personal care aide not present at nursing supervision visit;
- Missing plan of care;
- Missing documentation of service;
- Failure to complete health requirements; and,
- Failure to complete required training.

Minimum Data Set Reviews

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

OMIG, in collaboration with BLTCR, reviews the MDS submissions to verify that the data submitted by the nursing home was an accurate representation of each resident's medical condition. These reviews have identified upcoding errors in the activities of daily living (i.e., bed mobility, transferring, eating, toileting) and the number of physician orders and visits. In addition, these reviews have identified instances where skilled therapy, including speech, occupational, and physical therapy, were not medically necessary. In 2017, OMIG finalized 364 reviews resulting in identified overpayments of more than $31.7 million.

Rate-Based Audit Activities

Certain Medicaid providers are reimbursed for covered services to eligible beneficiaries based on prospectively determined rates. These rates are calculated based on cost reports that are submitted annually by the provider to BLTCR. BLTCR uses these cost reports as the basis to promulgate a daily rate for each provider. An example of a rate-based provider reimbursed using this method is a residential health care facility (RHCF).

Base Year and Notice of Rate Change Audits

OMIG examines the costs reported in a nursing facility's base year. The reported base year costs are trended forward by an inflation factor and used by BLTCR to calculate the operating portion of the rate for subsequent years until a new base year is established. Examples of the base year audit findings are as follows:

- Expense not related to patient care;
- Undocumented expense;
- Duplicated expense; and
- Non-allowable expense.

When a base year audit has resulted in adjustments to the base year's operating costs, these audit findings need to be integrated and carried forward into the rate calculation for subsequent rate years that use those base year costs as its basis. These projects are referred to as notice of rate changes because they carry forward the audit findings from a base year audit. During 2017, 46 base year and notice of rate change audits were finalized, with identified overpayments of more than $9 million.

Capital

The reported capital costs for RHCFs are used as a basis for the capital component of a nursing facility's Medicaid rate. OMIG audits the capital costs to examine the underlying costs that determine the capital component of the rate. Some examples of findings from capital audits where improper expenses were included in the rate calculation are:

- Working capital interest expense disallowances;
- Sales tax disallowances;
- Mortgage expense disallowances; and
- Depreciation disallowances.

During 2017, 52 capital audits were finalized, resulting in identified overpayments of more than $18 million.

System Match and Recovery Projects

OMIG uses analytical tools and techniques to data mine Medicaid claims and identify improper claim conditions. The System Match and Recovery Unit finalized 144 reviews with identified overpayments of more than $3.1 million. The following reviews contributed to these findings:

Physician Services in OMH Clinics

This project sought recovery of paid claims for physician's services provided under an OMH Article 31 Licensed Outpatient Program for which only the licensed outpatient program is eligible for Medicaid reimbursement. Physicians engaged by the licensed OMH program may not seek separate Medicaid reimbursement for services provided by the OMH-licensed program. OMIG finalized 45 audits with identified overpayments of more than $750 thousand for this project.

CHHA – Improper Episodic Payments

Certified Home Health Agencies (CHHA) bill Episodic Payment System (EPS) claims, which are based on 60-day episodes of care, rather than fee-for-service claims, to reimburse CHHA's for home care services provided to Medicaid recipients. The EPS was designed to address the rapid growth in CHHA costs per patient by better aligning payments with needed services. By receiving services in the home, patients can avoid unnecessary and more costly placement in medical facilities, such as hospitals or rehabilitative centers. This project sought recovery of claims where Medicaid was inappropriately billed for:

- Improper episodic payments for recipients who were transferred into MLTC during a 60-day episode of care;
- Multiple episodic payments within 60 days; and

- Overpayments to a CHHA that improperly received full 60-day payments for recipients who subsequently obtained services from a different CHHA within 60 days of an episode of care.

This project finalized 54 audits with identified overpayments of more than $2 million.

Self-Disclosure

OMIG operates the statewide mandatory self-disclosure program, which is a way for all Medicaid providers to return self-identified overpayments, regardless of the types of services provided to beneficiaries. OMIG encourages providers to investigate and identify possible fraud, waste, abuse, or inappropriate payments through self-review, compliance programs, and internal controls. Section 6402(a) of the Federal Affordable Care Act and New York's Compliance Program obligations under Title 18 of the New York Codes, Rules and Regulations (NYCRR), require Medicare and Medicaid providers to self-disclose any overpayments within 60 days of identification by the provider. In 2017, OMIG's self-disclosure unit finalized 327 audits with identified overpayments of more than $26.9 million.

2017 Initiated Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	12	1	9	0	22
Managed Care	350	91	109	0	550
Medicaid in Education	3	4	3	0	10
Provider	479	110	121	8	718
Rate	50	100	218	0	368
Self-Disclosure	92	68	72	1	233
System Match Recovery	84	48	39	52	223
Total	1,070	422	571	61	2,124

2017 Finalized Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	9	2	2	0	13
Managed Care	349	98	94	2	543
Medicaid in Education	1	0	1	0	2
Provider	341	100	140	4	585
Rate	249	80	134	0	463
Self-Disclosure	135	104	85	3	327
System Match Recovery	73	30	26	15	144
Total	1,157	414	482	24	2,077

2017 Overpayments Identified for Recovery by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program*	$ 7,962,269	$ (59,686)	$ 53,160	$ 0	$ 7,955,744
Managed Care	93,720,744	28,886,742	7,853,353	1,486,135	131,946,975
Medicaid in Education	20,877	0	3,080	0	23,957
Provider	11,955,974	6,797,560	3,183,750	4,870	21,942,153
Rate	40,850,960	4,776,035	11,996,144	0	57,623,139
Self-Disclosure	21,508,469	2,408,099	2,656,173	392,089	26,964,830
System Match Recovery	2,082,219	454,368	333,176	259,874	3,129,637
Total	$ 178,101,512	$43,263,118	$26,078,836	$ 2,142,968	$249,586,435

2017 Overpayments Recovered by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	$ 2,373,646	$ 170,900	$ 183,655	$ 0	$ 2,728,202
Managed Care	90,939,579	28,846,628	7,788,257	1,486,135	129,060,599
Medicaid in Education	20,877	0	49,387	0	70,264
Provider	73,010,815	6,617,728	5,052,772	1,349,546	86,030,861
Rate	30,070,175	6,091,774	12,876,637	0	49,038,586
Self-Disclosure	19,192,800	2,444,201	2,439,992	433,625	24,510,618
System Match Recovery	2,794,330	412,193	365,089	214,305	3,785,916
Total	$218,402,222	$44,583,424	$28,755,789	$3,483,611	$295,225,046

*Audit Overpayments identified for recovery were lowered due to stipulations issued in 2017 related to final audit reports issued in prior reporting periods.

Data Mining and Technological Support

OMIG's BBI provides a comprehensive range of services and functions that drive agency initiatives through the optimum use of data.

BBI utilizes resources such as eMedNY, Salient, and MDW, to extract, organize, analyze, and report data. The data analyses cover a wide range of provider types and program areas, and support the operation of the other divisions within OMIG. In addition, BBI frequently processes data requests from several federal, state, and county government organizations.

In 2017, BBI processed the following requests:

1,520 data requests which consisted of Medicaid FFS and managed care data extraction and analysis in support of:

- DMA and DMI activities;
- System Match audits;
- CMS Payment Error Rate Measurement audit;
- CMS Healthcare Fraud Prevention Partnership Data Analysis and Review Committee (DARC);
- Office of the State Comptroller audits;
- U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) audits;
- Unified Program Integrity Contractor (UPIC) Audits;
- United States Department of Justice;
- District Attorney's Offices;
- Federal Bureau of Investigations (FBI); and
- Self-disclosure reviews.

163 statistical samples created for DMA audits and DMI investigations, including:

- County Demonstration audits;
- UPIC audits;
- Self-disclosure reviews;
- Medicaid Electronic Health Record Incentive Program audits; and
- Dental Provider reviews.

Positive Provider Reports

During the audit process, there are instances when OMIG determines that, for the audit period and objective reviewed, the provider has generally adhered to applicable Medicaid billing rules and regulations. In these cases, OMIG will issue an Audit Summation Letter advising the provider that pursuant to 18 NYCRR § 517.3(h) the audit was concluded and no further action is required on their part. These reports are also listed on the OMIG website as "Positive Reports."

Audit Summations	
Audit Department	2017
County Demonstration Program	10
Managed Care	5
Medicaid in Education	7
Provider	239
Rate	224
Total	485

Third-Party Liability

Medicaid is the payor of last resort; however, there are instances when Medicaid payments are made on claims for which third-party liability was not known at the time of service or Medicaid billing. OMIG recovered Medicaid overpayments for both FFS and managed care encounter claims. Recoveries were made from various third parties, including providers, commercial insurance carriers, Medicare, casualty settlements, and the estates of deceased Medicaid beneficiaries.

Medicaid Recovery Audit Contractor

Health Management Systems (HMS), the NYS Medicaid Recovery Audit Contractor (RAC), reviews claims that providers submit for services rendered to Medicaid beneficiaries, either through FFS or managed care, and identifies overpayments. HMS continued its reviews of long-term care facilities, assuring that proper patient liability amounts were used in Medicaid payment calculations, that other payor responsibilities were exhausted, and that service days reimbursed were appropriate. Throughout 2017, HMS had several successful reviews that utilized reverse engineering reviews. In reverse engineering, the cause of an overpayment is identified and then applied to a statewide algorithm based on policy and data to additional providers who may have made the same error. Examples include the duplicate comprehensive psychiatric emergency program (CPEP), CPEP inpatient overlap, intensive rehabilitation add-on, and intensity modulated radiotherapy unbundling. OMIG continues to facilitate the exchange of Medicare data with the CMS UPIC contractor to enhance the RAC's ability to identify potential overpayments that would likely not be identified by reviewing Medicaid claims data alone. In 2017, the RAC recovered more than $23.8 million in Medicaid overpayments.

2017 Third-Party Liability and RAC Recoveries		
Activity Area	**Amount**	
Third-Party Liability	$	80,050,348
Casualty & Estate		97,015,027
Recovery Audit Contractor		23,897,090
Home Health Care Demonstration Project		3,644,274
Self-Disclosed TP Health Insurance		909,494
Total	$	205,516,233

Investigations

OMIG investigates allegations of fraud and abuse within the Medicaid program. Enrolled and non-enrolled providers, entities, and recipients can all potentially be subjects of an investigation. Allegations are analyzed utilizing a variety of methods, including but not limited to, data mining, undercover operations, analyses of returned Explanation of Medicaid Benefits (EOMB) letters, and interviews of complainants and subjects. Investigations can lead to administrative actions, sanctions, and cash recoveries. Below are examples of OMIG's investigative activities.

Summary of Investigations by Source of Allegation and Region

	Downstate		Upstate		Out of State		Totals	
Initial Source	Opened	Completed	Opened	Completed	Opened	Completed	Opened	Completed
Anonymous	278	325	151	157	2	1	431	483
Enrolled Recipient	70	74	31	29	7	5	108	108
Federal Agencies	91	89	6	8	1	3	98	100
Fiscal Agent Fraud Unit	9	6	1	0	0	0	10	6
General Public	228	239	154	154	3	3	385	396
Law Enforcement	0	3	0	0	0	0	0	3
Local Departments of Social Services	36	19	86	72	0	0	122	91
Managed Care Plans	317	315	180	109	34	35	531	459
Managed Long Term Care Plans	25	4	11	0	0	0	36	4
Non-Enrolled Provider	4	9	2	9	0	1	6	19
Non-Enrolled Recipient	9	7	8	6	0	0	17	13
Provider	69	92	64	68	3	6	136	166
State Agencies (including OMIG)	922	930	377	265	94	47	1,393	1,242
Total	2,058	2,112	1,071	877	144	101	3,273	3,090

OMIG Plays Critical Role in Multi-Agency Takedown of Massive $146M Health Care Fraud Scheme

OMIG assisted its partners in law enforcement to uncover a massive $146 million Medicaid and Medicare fraud, corruption, and money-laundering scheme that had been operating for more than three years out of Brooklyn. The details of the case and related arrests were announced at a December 5, 2017 joint press conference at the Brooklyn District Attorney's (DA's) office.

OMIG's investigative team in NYC assisted investigators and prosecutors from the Brooklyn DA's Office as well as HHS-OIG, NYC HRA's Office of Medicaid Provider Fraud and Abuse Investigation, DOH, NYS Department of Financial Services, the NYS Police, and the NYC Police Department (NYPD).

The multi-agency effort exposed an extensive, highly sophisticated network of physicians, clinic managers, recruiters, and others who are alleged to have conspired to fraudulently bill Medicare and Medicaid for thousands of unnecessary medical tests and services. Ultimately, 34 defendants – 20 individuals and 14 corporations, including four doctors (one, an NYPD surgeon) – were named in an 878-count indictment.

* Investigations completed may represent cases opened in prior periods.

At the press conference Medicaid Inspector General Dennis Rosen said, "This collaborative investigation and resulting indictment send an unmistakable message to those who seek personal gain by preying upon vulnerable New Yorkers and exploiting the Medicaid program: 'you will be identified and held fully accountable.' My office will continue to work closely with our partners in the Brooklyn District Attorney's Office, U.S. Health and Human Services Office of the Inspector General, NYC Human Resources Administration, NYS Department of Health, and other state and federal agencies to protect Medicaid recipients and save taxpayer dollars by rooting out fraud, waste and abuse in the Medicaid program."

Key elements of OMIG's support in this case included real-time, language-translation assistance during wiretapped phone conversations, as well as the use of data analytics and analyses to help identify fraudulent billing practices.

National Health Care Fraud Takedown

As a result of a Medicare Fraud Strike Force takedown in July 2017, ten individuals - including three doctors, a chiropractor, three licensed physical therapists, an occupational therapist, and two medical company owners - were charged for their alleged participation in multiple schemes that fraudulently billed the Medicare and Medicaid programs more than $125 million. These schemes, which took place in multiple NYC boroughs, included money laundering, falsifying millions of Medicaid claims for services that were not medically necessary or not rendered, and paying illegal bribes and kickbacks to patients to receive medically unnecessary services and diagnostic tests. OMIG provided claim and payment data as well as analysis that showed a network of Medicaid providers engaging in an extensive scheme that involved the payment of kickbacks for referrals of patients to their clinics who, in turn, subjected themselves to purported physical and occupational therapy and other services. Several of the indicted subjects, patients, and witnesses spoke Russian, OMIG staff assisted with interviews and language-translation.

OMIG Assists in $2.1 Million Medicaid and Medicare Fraud Scheme Takedown

Two managers of a Brooklyn-based occupational therapy medical clinic were charged in an indictment unsealed February 15, 2017 with allegedly partaking in a $2.1 million Medicaid and Medicare fraud and kickback scheme. OMIG's investigative team worked closely with the Department of Justice, HHS-OIG and the Internal Revenue Service Criminal Investigation (IRS-CI) throughout the investigation.

One manager was charged with one count of conspiracy to commit health care fraud, one count of conspiracy to commit money laundering, and three counts of money laundering. The second manager was charged with one count of conspiracy to commit money laundering and three counts of money laundering. Both indictments were filed in the Eastern District of New York.

Federal prosecutors charge in the indictment that through the Brooklyn-based occupational therapy services medical clinic the defendants paid patients to submit themselves to medically unnecessary therapy services provided by unlicensed aides. Prosecutors also allege that in order to conceal their

scheme the owners laundered the profits through shell companies using a skeleton crew of licensed occupational therapists that fabricated medical charts. The pair used ill-gotten cash to enrich themselves and to pay kickbacks to the beneficiaries.

OMIG assisted HHS-OIG and IRS-CI to investigate the case, which was brought as part of the Medicare Fraud Strike Force, under the supervision of the Criminal Division's Fraud Section and the U.S. Attorney's Office for the Eastern District of New York.

Patient Recruiting Investigation

On December 3, 2014, arrests and search warrants were executed pursuant to the unsealing of a Federal indictment obtained in the Southern District of New York. The indictment charged the ten individuals, involved in a $70 million health scheme, with conspiracy to commit health care fraud, wire fraud, and mail fraud, in addition to charging three of the ten with counts of Money Laundering. The scheme involved the operation of three clinics in Brooklyn and Queens where disadvantaged and homeless people insured by Medicaid and/or Medicare were recruited to undergo unnecessary medical tests, frequently performed by unlicensed personnel, in exchange for cash. Patient recruiters would locate these individuals in soup kitchens and local welfare offices, and then coach them on what to say on various medical forms, to make the procedures appear medically necessary. Medicaid and Medicare were then billed for these procedures. The clinic owners also enlisted a licensed physician to act as the nominal owner and/or physician to conceal their ownership, which goes against NYS law. Throughout the course of this investigation, OMIG assisted the law enforcement agencies by conducting surveillance, assisting in witness interviews, providing Medicaid data, and participating in the execution of search warrants.

The former owner of one of the three clinics implicated in this scheme, was sentenced to a prison term of 60 months and ordered to pay approximately $8 million in forfeiture and restitution. On August 13, 2016, the owner pleaded guilty to conspiracy to commit wire fraud, mail fraud, and health care fraud.

After pleading guilty to one count of conspiracy to commit wire fraud, mail fraud, and health care fraud, two other owners were sentenced. One owner was sentenced to imprisonment for 60 months, and supervised release for three years. The other owner was sentenced on May 19, 2017 to imprisonment for 40 months and supervised release for three years. They were both ordered to pay restitution of more than $13.7 million.

The physician of record for the health care clinics located in Queens and Brooklyn, falsely represented that he personally screened and conducted medical tests on patients at the three clinics, when in fact he was not present at two of them. The physician was sentenced to one month’s imprisonment and ordered to pay approximately $26 million in restitution, of which more than $15 million is to be paid to Medicaid.

The manager of the health care clinics located in Queens, involved in the payment of kickbacks to underprivileged individuals in exchange for their receipt of medically unnecessary services, was sentenced to 34 months imprisonment and ordered to pay approximately $13 million in restitution, of which more than $9.9 million is to be paid to Medicaid.

A nuclear medical technician at a diagnostic medical clinic in Jackson Heights, Queens, one of three clinics implicated in the scheme, was sentenced to a prison term of 18 months and ordered to pay approximately $3.6 million in restitution, of which more than $2.6 million is to be paid to Medicaid.

One of the patient recruiters was sentenced to a prison term of 24 months and ordered to pay approximately $5.6 million in restitution, of which more than $2.7 million is to be paid to Medicaid. Another patient recruiter, who had been remanded, was sentenced to time served, and ordered to attend an outpatient drug treatment program and pay approximately $3.9 million in restitution, of which more than $2.9 is to be paid to Medicaid. A third patient recruiter was sentenced to three years of probation with six months of home detention, and ordered to pay approximately $3.3 million in restitution, of which more than $2.4 million is to be paid to Medicaid.

All the individuals who were sentenced as a result of this investigation were excluded by OMIG from the NYS Medicaid program.

Home Care Referrals to MFCU

OMIG investigated allegations of fraud relating to home care. In one case, it was alleged a home health aide was providing CDPAP services and submitting documents stating she provided home health care to her mother, while her mother was out of the country. OMIG obtained passport documents, and the investigation verified that the home health aide did submit time sheets for a time period when the recipient was out of the country. OMIG referred the subject to MFCU for prosecution. The home health aide pleaded guilty in Orange County Court on March 9, 2017 to Grand Larceny in the 4th Degree, a class E Felony. On May 19, 2017, the home health aide was sentenced to five years of probation and 300 hours of community service, and had already repaid $75,812 in restitution to the Medicaid program.

In another case, OMIG received an anonymous complaint indicating that the mother of a recipient had enlisted her boyfriend as a PCA through Maxim of New York (Maxim) for her son, who is a Medicaid recipient. The anonymous complainant further indicated that the mother and her boyfriend were submitting false times sheets to Maxim indicating that her boyfriend was providing PCA services to her son when in fact he was not.

After OMIG determined that the recipient was participating in the CDPAP, and Maxim was billing the Medicaid program for PCA services, OMIG referred the matter to MFCU. MFCU ascertained that the PCA, who was a parolee, was wearing a GPS ankle monitoring device in accordance with his parole restrictions. Times and locations from the tracking device were compared against timesheets submitted to Maxim, showing that the PCA was not at the recipient's home providing services as reported, causing Maxim to inappropriately bill the Medicaid program for 251 hours of PCA services. On November 9, 2017, the Attorney General's office announced the sentencing of the PCA to one and a half to three years in state prison for stealing from and defrauding the Medicaid program.

Recipient Investigations

OMIG referred and coordinated the investigation with the Westchester County Police Department relating to a complaint alleging that a recipient's Medicaid card was presented to fill a forged prescription for Oxycodone. OMIG obtained a copy of the forged prescription and received verification documentation from the prescriber that the prescription was a forgery. On May 16, 2017, the Westchester County Police Department charged the recipient with three counts of Criminal Possession of a Forged Instrument in the 2nd degree in violation of NYS Penal Law 170.25, a class D felony.

Program Integrity Referrals to MFCU and Other Agencies

OMIG is required by law to refer suspected fraud and criminality to MFCU. OMIG also refers its findings to numerous other agencies including those responsible for oversight of professional licensure, specifically, the NYSED's Office of Professional Discipline (OPD) and DOH's Office of Professional Medical Conduct (OPMC). OPD and OPMC may take administrative action on individuals who hold professional licenses.

Referrals to MFCU	
Provider Type	2017
Billing Service Group/EMEVS	2
Capitation Provider	3
Consumer Directed Aide	2
Diagnostic and Treatment Center	5
Enrolled Provider	5
Enrolled Recipient	10
Home Health Agency	13
Home Health Aide	2
Hospital	1
Laboratory	1
Managed Long Term Care	2
Medical Appliance Dealer	1
Multi-Type	4
Multi-Type Group	10
Non-Enrolled Provider	68
Nurse	7
Optician	5
Optometrist	3
Personal Care Aide	1
Pharmacy	50
Physician	48
Physicians Group	17
Podiatrist	1
Service Bureau	4
Social Adult Day Care	3
Therapist	3
Therapist Group	2
Transportation	14
Total	287

Referrals to Other Agencies	
Agency	2017
AG - Not MFCU	3
CMS - UPIC	34
Law Enforcement Agency	114
Local Departments of Social Services	47
Local District Attorney	4
NYC Department of Buildings	1
NYC Department of Health	2
NYC HRA Bureau of Client Fraud Investigations	154
NYC Office of the Special Narcotics Prosecutor	8
NYS Bureau of Narcotic Enforcement	12
NYS Department of Environmental Conservation	4
NYS Department of Financial Services	1
NYS Department of Health	99
NYS Department of Justice	4
NYS DOH Office of Professional Medical Conduct	12
NYS Education Department – Not Professional Discipline	23
NYS Education Department – Office of Professional Discipline	89
Office for People with Developmental Disabilities	3
Out of State	1
US Health and Human Services (HHS-OIG)	14
Total	629

2017 Recoveries

The recoveries outlined in the chart below include OMIG's audits and investigations, third-party payments recovered from other insurers, Medicaid RAC activities, and estate and casualty recovery projects. The recoveries represent both the Federal and State share of funds and equal the actual dollars recouped by OMIG. The recoveries reflect cash deposits and voids resulting from OMIG and contractor audits, less any refunds paid to providers.

2017 Recoveries		
Activity Area	**Amount**	
Third-Party Liability	$	80,050,348
Managed Care		129,060,599
Casualty & Estate		97,015,027
Provider		86,030,861
Recovery Audit Contractor		23,897,090
Rate		49,038,586
Home Health Care Demonstration Project		3,644,274
Self-Disclosure		24,510,618
System Match Recovery		3,785,916
Investigation Financial Activities		761,342
County Demonstration Program		2,728,202
Self-Disclosed TP Health Insurance		909,494
Medicaid in Education		70,264
Total	$	501,502,621

Cost Savings

Cost savings activities prevent inappropriate, duplicate, or erroneous Medicaid payments from being made. OMIG's cost savings are calculated as estimates based on historical and current Medicaid claims data. Cost savings amounts are not monetary recoveries. Cost savings initiatives are intended to save taxpayer dollars proactively and protect the integrity of the Medicaid program. Each OMIG action or initiative has its own methodology for calculating program costs that are avoided. For example, OMIG utilizes program edits in the Medicaid billing system that deny provider claims, thereby preventing improper Medicaid payments from being made; those denied claims represent cost savings. In another example, when OMIG has an interaction with a provider, the agency will subsequently compare billing patterns prior to the interaction with those after to determine the cost savings attributable to OMIG's actions.

OMIG utilizes an internal workgroup of cross-divisional staff to develop, review, and approve its cost savings methodologies. This team reviews all cost savings initiatives on an ongoing basis to identify and assess variations in the savings amounts reported. Variations can occur naturally over time for any of OMIG's initiatives, and the workgroup ensures that methodologies are being reviewed on a timely basis, and updated as needed.

Throughout 2017, OMIG saved NYS taxpayers more than $2.1 billion as a result of these proactive efforts. Some examples of these activities are outlined below.

Pre-Payment Insurance Verification

OMIG's third-party liability vendor, HMS, obtains rosters of insured individuals from insurance carriers across the country. HMS matches this identified coverage against Medicaid beneficiaries enrolled in NYS to identify those beneficiaries who have additional insurance coverage. Once identified, this information is added to eMedNY so that medical services are first billed to the other insurance, establishing Medicaid as the payor of last resort. This pre-payment insurance verification resulted in cost savings of over $1.9 billion in 2017.

Enrollment Screening Activities

In coordination with OHIP's Provider Enrollment Unit, OMIG performs secondary reviews of enrollment applications determined to require additional evaluation based on specific categories of service, or high-risk providers that require additional scrutiny, and determines an appropriate course of action. OMIG's Enrollment and Reinstatement Unit (EAR) also assists OHIP in coordinating and conducting on-site visits of enrolled Medicaid providers that are in the process of revalidating their enrollment.

In 2017, EAR reviewed 1,394 new enrollment and reinstatement applications. These reviews resulted in 256 applications being denied, the cost savings associated with these denials was more than $34 million. Below are examples of enrollment denials:

Pharmacy Enrollment Denials

OMIG staff conducted an on-site inspection of a pharmacy located in the Bronx, that applied for enrollment in the NYS Medicaid program, and found eleven expired medications in the inventory. The pharmacy also did not have hot running water in the dispensing area and was not equipped with the proper graduates as required by the Board of Pharmacy. Violations of Board of Pharmacy regulations are cause for denial of Medicaid enrollment, and the pharmacy's application for enrollment was denied.

During an on-site inspection of a different pharmacy seeking to enroll in the NYS Medicaid program, OMIG staff found that the pharmacy had ten expired medications on the shelves and had a refrigerator with temperatures that were warmer than those required by Board of Pharmacy regulations. Due to these violations and the pharmacy's inability to provide safe, high-quality care to recipients, the pharmacy's application for enrollment was denied.

Dental Group Enrollment Denial

During the on-site inspection of a dental group located in Queens, that applied for enrollment in the NYS Medicaid program, OMIG staff found that the group failed to have proper spore testing conducted to assure that the autoclave was properly sterilizing dental instruments. The failure by the group to conduct testing required by state regulations is a potential safety hazard, and was cause for denial.

2017 Cost Savings Activities	
Activity Area	**Amount**
Clinic License Verification	$ 1,680,779
Corporate Integrity Agreement Sentinel Effect	2,025,090
Dental Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	1,144,495
Duplicate Claim included in Inpatient Coverage – Edit 760	272,705
Enrollment and Reinstatement Denials	34,381,847
Exclusions/Terminations – Internal	7,511,831
Exclusions/Terminations – External	7,791,732
Managed Care Locator Code	8,867,281
Medical Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	1,110,738
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	26,809,139
Ordering Provider Excluded Prior to Order Date – Edit 939	1,303,300
Ordering/Referring Provider Number Missing – Edit 903	790,125
Order/Servicing/Referring Provider Number Verification – Edit 1236/1238	1,022,436
Pharmacies License Verification	2,467,443
Pre-Payment Insurance Verification Commercial	1,494,323,892
Pre-Payment Insurance Verification Medicare	418,344,948
Pre-Payment Review Sentinel Effect – Edit 1141	2,758,916
Prescription Serial Number Missing, Lost, Stolen, Altered	10,182,954
Provider ID/Service ID are the same – Edit 1357	306,444
Recipient Medicaid MC Benefits - Case Closures for False Information	339,843
Recipient Restriction	94,038,001
Service Date prior to Birth Date – Edit 102	261,969
Transportations Claims-Modifier Invalid for Submitted Procedure Code – Edit 927	970,899
Transportation Claims-Procedure Code Modifier Missing – Edit 1344	4,125
Transportation Service Billed for During Inpatient Stay – Edit 02062	11,094
Total	**$ 2,118,722,025**

Compliance Initiatives

Medicaid providers with compliance programs are better positioned to identify, correct, and prevent billing mistakes and fraud. NYS Social Services Law §363-d and 18 NYCRR Part 521 (Part 521) establish New York's requirements for what must be included in compliance programs. Medicaid providers who must maintain an effective compliance program are those who are subject to the provisions of Public Health Law Article 28 or 36; or those who are subject to the provisions of Mental Hygiene Law Article 16 or 31; or those for whom Medicaid is a substantial portion of their business operations. What constitutes a substantial portion of business operations is if the Medicaid provider claims, orders, receives payment, or submits bills for others for Medicaid care, services, or supplies in an amount of at least $500,000 in any consecutive 12-month period.

The Deficit Reduction Act of 2005 (DRA) instituted a requirement for health care entities receiving or making $5 million or more in direct Medicaid payments during any FFY to establish written policies and procedures informing their employees, contractors, and agents about federal and state False Claims Acts and whistleblower protections. If an entity furnishes items or services at more than a single location, under more than one contractual or other payment arrangement, or uses more than one provider or tax identification number, the aggregate of all payments to that entity is used to determine if the entity reached the $5 million annual threshold. Direct Medicaid payments involve payment directly by New York's Medicaid program to the payee.

Certification and Review

Part 521 requires Medicaid providers subject to NYS's mandatory compliance program obligation to certify that they have a compliance program in place that meets the requirements of Part 521. The certification is required at the time of enrollment into the Medicaid program and a subsequent annual certification is required each December. The certification is a self-reporting requirement that is used by OMIG to help identify Medicaid providers who may not be meeting the mandatory compliance program obligation.

Annually OMIG develops a universe of providers who are subject to the mandatory compliance program obligation. The universe includes FFS and MCO supplied encounter data. It should be noted that the mandatory compliance program and the certification obligations apply to MCOs, as well as those that are direct providers of Medicaid care, services, or supplies. In 2017, OMIG issued two notices of agency action for failure to meet the compliance certification obligation. This was the first time an enforcement action was taken for such failures.

There is also an annual certification requirement for those providers who are subject to the DRA obligation. The DRA certification is to be completed in December each year and it applies based upon payments received by the Medicaid provider during the FFY that ended immediately prior to December. OMIG manages the DRA certification process by making a DRA Certification form available on OMIG's website. Medicaid direct payment data is used to establish the universe of providers who must annually complete a DRA Certification.

Compliance Program Reviews

OMIG conducts compliance program reviews of Medicaid providers subject to the mandatory compliance program obligation. These reviews include compliance program assessments of MCOs, as well as providers of Medicaid care, services, or supplies. The desk review and on-site review process gives providers and OMIG an opportunity to discuss what specific

requirements are not being met, and guidance is provided either through direct conversations or through reference to resources posted on OMIG's website. OMIG conducts follow-up reviews of providers' compliance programs when OMIG determines, on an initial review, that providers' compliance programs fail to meet a significant number of requirements. The compliance unit referred six providers to DMI due to significant insufficiencies identified during the compliance program review process.

Corporate Integrity Agreements

Corporate Integrity Agreements (CIA) are monitoring agreements entered into with Medicaid providers who have been determined to have engaged in one or more unacceptable practices that would otherwise warrant exclusion as a provider in New York's Medicaid program. CIAs are for a five-year term and involve a heightened level of monitoring by OMIG. A large part of the monitoring of providers under a CIA is conducted by an Independent Review Organization (IRO). The IRO is engaged by the provider, at the provider's expense, and with OMIG's approval, to report on specific areas related to the unacceptable practice that gave rise to the need for a CIA, as well as other issues specified in the CIA. Additionally, the CIA establishes significant additional reporting requirements for a provider beyond the typical reporting required of all Medicaid providers.

Failure to meet any term of the CIA, including a reporting requirement, can result in OMIG determining that a breach of the CIA has occurred for which OMIG can assess penalties. In 2017, OMIG received $25,000 in payments for penalties assessed due to breaches of CIAs. If OMIG determines that the provider materially breached the CIA, the CIA can be terminated and the provider can be excluded.

Education and Outreach

Since 2010, OMIG has taken extensive steps to educate and provide tools to providers subject to the mandatory compliance program and certification obligations so that they know what is expected and can develop effective compliance programs. In 2017, OMIG provided 14 compliance-related presentations and webinars that addressed specific questions raised by those subject to the compliance obligation, and focused much attention on the *Compliance Program Review Guidance* that was published by OMIG in 2016. The education programs were supplemented by compliance publications on OMIG's website and in the *Medicaid Updates* posted on DOH's website.

OMIG's outreach activities went beyond presentations at educational programs and conferences. OMIG received over 1,150 telephone calls and 325 email contacts to its dedicated compliance phone lines and compliance email box, respectively, where providers asked more specific questions about the compliance requirements and how they may relate to their compliance programs.

In an attempt to accomplish provider specific notice and reminders of their compliance and certification requirements, OMIG mailed more than 1,100 letters and sent more than 9,500 email reminding providers of the December 2017 certification obligation. All outreach was initiated to maximize notice of the compliance and certification obligations and to provide notice of compliance resources that are available to help providers meet those obligations. OMIG's website includes a compliance tab that includes links to forms, guidance, alerts, and other resources. During 2017, there were nearly 100,000 hits on the compliance tab.

Collaborative Activities

Collaboration with St. Lawrence County Drug Task Force

While OMIG has extensive administrative powers, investigators work collaboratively with local, state, and federal law enforcement to seek punitive action against recipients who have committed fraud against the Medicaid program. On May 31, 2017, OMIG staff met with the St. Lawrence County Drug Task Force to discuss ongoing investigations. The task force consists of law enforcement from multiple city police departments in the county, the County Sheriff's Office, State Police, Drug Enforcement Administration, and Homeland Security. OMIG began working with the task force following the arrests of Medicaid recipients for illegal distribution of prescription medications that involved Medicaid recipients.

OMIG discussed their findings related to upstate recipients travelling to NYC to obtain Buprenorphine prescriptions, a drug used to treat opioid addiction, and discussed OMIG's investigative efforts related to opioid prescriptions and the prescribers. Specific recipient targets were also discussed and investigative plans were coordinated to prevent duplication. OMIG and the St. Lawrence County Task Force continue to work together on this initiative.

Pre-Payment Reviews Lead to Investigation Referrals

Medical and dental pre-payment review (PPR) staff continue to have several successful collaborations within OMIG, including an ongoing transportation project with DMI. Staff meet periodically to discuss joint cases and providers of concern for transportation services. As a result of these meetings, DMI referred nine transportation providers for pre-payment claims review. PPR staff referred eight private duty nursing providers to DMI for further investigation. PPR and DMI also collaborate to monitor providers with limited enrollments to ensure providers submit only those claims allowed under the limited enrollment agreement, and monitor billings for providers slated for exclusion until the enrollment status change is processed. This was initiated to prevent payments from being made to excluded providers. PPR staff referred four individual dentists along with two dental groups to DMI for further investigation. PPR staff also assisted DMI staff on multiple site visits. Additionally, PPR staff works joint cases with external entities including MFCU, CMS, SGS, General Dynamics Information Technology, and OHIP. PPR staff also work closely with DOH policy staff and statewide stakeholder associations as needed.

Encounter Reimbursement Process

In recent years, several situations of duplicate or overlapping Medicaid payments made on behalf of Medicaid managed care enrollees had been identified during audits. This includes situations where the enrollee is in foster care, has multiple CINs, is retroactively enrolled, or where the enrollee has permanent residency in an institution and is not eligible for managed care. In these scenarios, OMIG would not be able to recover the capitation payment due to encounter payments made by the MCO. OMIG and DOH worked jointly to address the issue; and in May 2017, OMIG and DOH finalized and announced the CMS approved Encounter Reimbursement Process. This new process gives OMIG the ability to recover capitation payments that were paid for an enrollee in specific scenarios, inclusive of months with encounters. DOH will then reimburse the MCO for the cost of services rendered. The announcement of the finalized process allowed OMIG to issue a number of final audit reports that had been on hold.

OMIG Collaboration Regarding Transportation

Claims for Medicaid ambulette services require a driver's license to be entered on the Medicaid claim for the driver who transported the Medicaid recipient on the date of service. For transportation providers to receive payment, drivers must be authorized and certified by the NYS Department of Motor Vehicles (DMV) under 19-A of the NYS Vehicle and Traffic Law, which requires a special class license, a clean driving record, an annual physical, and an annual road test to maintain the 19-A qualification. OMIG staff collaborated with DMV to gain access to the data for 19-A qualified driver records. OMIG staff used the information from DMV and created a database of 19-A qualified/disqualified driver information. This database is used to match against paid Medicaid claims data for ambulette services and will be used for future transportation projects.

Healthcare Fraud Prevention Partnership

In April 2017, OMIG staff attended the Healthcare Fraud Prevention Partnership (HFPP) information sharing meeting at the Medicaid Integrity Institute in South Carolina. The HFPP is a voluntary, public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations to identify and reduce fraud, waste, and abuse across the healthcare sector. HFPP partners regularly collaborate, share information and data, and conduct cross-payer studies to achieve these objectives. Much of the April sharing session focused on current investigations being conducted by health plans. However, HHS-OIG gave a presentation related to their efforts to investigate opioid related cases followed by a presentation by the FBI. This presentation consisted of a briefing on an opioid conviction from start to finish and what is needed to prove the crime for prosecution. The HFPP also conducts in-depth studies using data from other states and insurance companies to identify trends and patterns that should be investigated. This information was also shared at this session. In attendance were Federal and State program integrity representatives, as well as representatives from some of the major managed care plans from across the country. The HHS-OIG as well as the FBI gave presentations related to healthcare fraud investigations and initiatives. After the presentations, small breakout groups discussed ongoing investigations, trends, and ideas with the whole group. Other states and OMIG shared best practices relating to opioid investigations and identifying targets through recipient data and RRP successes. Many of the trends had been identified by other managed care plans, and the breakout groups facilitated the sharing of the various methods used to achieve positive outcomes in investigations.

New York Welfare Fraud Investigators Association Conference

In June 2017, OMIG staff attended the 34th Annual New York Welfare Fraud Investigators Association Training Conference. The conference had 240 participants representing LDSS staff, law enforcement agencies, district attorney offices, and other state agencies that oversee benefit programs. Breakout and general sessions were conducted, covering regulatory changes, current fraud trends, and techniques designed to detect and investigate welfare fraud. OMIG staff spoke about its efforts in investigating Medicaid eligibility fraud and discussed trends that had been discovered through investigations.

Recipient Investigations Unit Collaboration with LDSS Offices

During 2017, the Recipient Investigations Unit facilitated meetings with LDSS offices to discuss ongoing investigative activities and the RRP. The meetings included the investigations units and Medicaid personnel to discuss and review the referral process, and resolve outstanding OMIG fraud allegation complaints. The meetings also provided LDSS staff with a RRP overview and administrative training to those assigned to RRP functions. An updated RRP resource file is used that identifies and describes each step of the local district implementation process. Specific cases for each RRP district function (FFS, Managed Care, and NYSoH) were used to demonstrate the step-by-step enrollee and provider notification process.

2017 visits were as follows:

- January - Broome County
- February - Erie County, Cayuga County, and Westchester County
- March - Onondaga County
- May - Greene County
- June - Clinton County
- August - Franklin County and Hamilton County
- September - Albany County and Steuben County
- October - NYC HRA, Courtland County, Wayne County, Orleans County, Chautauqua County, and Allegany County
- November - St. Lawrence County

Administrative Actions

Sanctions – Exclusions

Sanctions that can be imposed on a provider by OMIG include censure, exclusion, or conditional or limited participation in the Medicaid program (18 NYCRR §515). In 2017, OMIG conducted investigations and imposed administrative actions based upon:

- Investigations, audits, or reviews that identified unacceptable practices as defined by 18 NYCRR § 515.2 and/or determined that the provider represented an imminent danger to the public health or welfare;
- NYSED actions, such as license surrender, suspension, or revocation, for Medicaid and non-Medicaid providers;
- Actions taken by DOH's OPMC involving professional misconduct and physician disciplinary actions, including suspensions, revocations, surrenders, and consent agreements;
- Felony indictments and convictions of crimes relating to the furnishing or billing for medical care, services, or supplies;
- Federal HHS-OIG exclusion actions; and/or
- Ownership information and affiliations of excluded providers.

OMIG issued 990 exclusions and 175 censures in 2017. The NYS Medicaid Exclusion List contains 6,681 Medicaid and non-Medicaid provider exclusions. This list is updated daily (except holidays and weekends) and is available to the public on OMIG's website, www.omig.ny.gov.

Exclusions	
Reasons for Exclusions	Number of Actions
Affiliations – 18 NYCRR 504.1(d)(1)	90
Unacceptable Practice – 18 NYCRR 515.2	16
Indictments – 18 NYCRR 515.7(b)	163
Convictions – 18 NYCRR 515.7(c)	232
Imminent Danger – 18 NYCRR 515.7(d)	4
Professional Misconduct – 18 NYCRR 515.7(e)	155
Mandatory Exclusion – 18 NYCRR 515.8	330
Grand Total	990

Conclusion

OMIG appreciates the opportunity to share the results of its Medicaid program integrity activities for 2017. Across all sectors of the Medicaid program, OMIG's provider education and outreach programs, coupled with its comprehensive investigative efforts and success in identifying and recovering inappropriate Medicaid payments, play a vital role in preventing and detecting Medicaid fraud and abuse, while promoting the delivery of high-quality care to millions of New Yorkers. OMIG's commitment to preventing, detecting, and rooting out fraud and abuse in the Medicaid program remains unwavering.

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

A Message from the Medicaid Inspector General

The OMIG Work Plan for State Fiscal Year (SFY) 2019 (April 1, 2018 to March 31, 2019) outlines the framework for the agency's multi-faceted program integrity initiatives. It is OMIG's intention that its Work Plan will be dynamic and adjustments will be made throughout the year as new priorities arise and issues emerge.

Where previous Work Plans were updated annually, going forward OMIG will update its Work Plan throughout the year to adapt to the changing Medicaid landscape and our approach to conducting and coordinating fraud, waste, and abuse control activities for all Medicaid-funded services. These updates will be posted on this webpage as they are initiated, and update alerts will be sent out via OMIG's listserv.

2018-2019 OMIG Work Plan

Fiscal Year 2018-2019 Work Plan: Introduction

In fulfilling its mission, OMIG prioritizes work and allocates resources accordingly. In addition to the mandatory requirements set forth in laws and regulations, OMIG evaluates projects for the potential for positive impact on the Medicaid program and Medicaid recipients.

OMIG outlined three over-arching goals in its 2018-2020 Strategic Plan (see graphic). It is important to note that the goals are not presented in order of priority - each goal has equal significance and weight in helping OMIG achieve its mission.

The first goal focuses on provider compliance and the work OMIG does to monitor compliance programs in the Medicaid program.

The second goal focuses on identifying and addressing fraud, waste, and abuse in the Medicaid program. To achieve this goal, OMIG will direct its efforts in areas including, but not limited to: prescription drug and opioid abuse; home health and community-based care services; transportation; long-term care services; and Medicaid managed care (MMC). This is in addition to ongoing program integrity activities.

The third goal focuses on OMIG's efforts to develop innovative analytic capabilities to detect fraudulent or wasteful activities. This includes data mining and analysis, cost-savings measures, and pre-payment reviews.

Finally, as noted in the Message from the Inspector General, OMIG's Work Plan will now be dynamic and updated throughout the year as new priorities and issues arise.

- Work Plans for previous years

Work Plan Updates

Current Action Items

- Compliance Activities
- Combatting Prescription and Opioid Abuse
- Home Health and Community-Based Care Services
- Long-Term Care Services
- Medicaid Managed Care
- Transportation
- Ongoing Program Integrity Activities
- Data Analytics Activities

(Click image to enlarge.)

Goal #1: Collaborate with providers to enhance compliance

Effective compliance programs create a control structure to reduce the potential for fraud, waste, and abuse through self-correction and/or self-reporting of errors by providers.

Compliance Program General Guidance and Assistance

OMIG will continue to maintain a dedicated telephone line and email address to respond to and address questions related to the implementation and operation of Medicaid providers' compliance programs required by Social Services Law (SSL) § 363-d and 18 New York Codes, Rules and Regulations (NYCRR) Part 521.

OMIG will also continue to update and publish procedures and forms to assist providers in meeting compliance obligations.

Compliance Certifications

Providers subject to the mandatory compliance program obligation are required to complete an annual certification on OMIG's website. Providers who fail to fulfill their mandatory compliance certification obligations may be identified for potential administrative action.

Compliance Certification Change: To make the annual compliance certification process more efficient, OMIG is transitioning from a system that utilizes the Federal Employer Identification Numbers (FEIN) to a system based on Provider Identification Numbers.

Compliance Program Reviews

OMIG will conduct compliance program reviews of providers and Managed Care Organizations (MCO) to analyze whether a Medicaid provider's compliance program is implemented and operating as required by SSL § 363-d and NYCRR Part 521 and issue censures as needed.

Corporate Integrity Agreement Monitoring and Enforcement

OMIG will continue to implement, monitor, and enforce corporate integrity agreements (CIA) when terminating or excluding a provider found to have committed fraud, waste, or abuse would have significant impact on recipient access to care.

Goal #2: Coordinate with stakeholders to identify and address fraud, waste, and abuse in the Medicaid program

In addition to ongoing program integrity endeavors, the activities in this section are centered on several priority areas: fighting prescription drug and opioid abuse; home health and community-based care; long-term care; transportation; and managed care.

In pursuing cases of Medicaid fraud, OMIG will continue to engage in collaborative efforts with federal, state, and local law enforcement agencies; and with local Departments of Social Services (LDSS). OMIG will continue to participate in the Federal Bureau of Investigation-directed Health Care Fraud Strike Forces throughout the state. OMIG will continue to participate in the U.S. Department of Justice (DOJ) Medicare Fraud Strike Force, based in the Eastern District of New York, and will assist in health care fraud investigations they conduct. OMIG will continue to work with the New York State Attorney General's Medicaid Fraud Control Unit (MFCU) and will also work collaboratively with District Attorneys across the state to identify and prosecute those individuals attempting to defraud New York State taxpayers and the Medicaid program.

Combatting Prescription Drug and Opioid Abuse

To help fight opioid abuse, OMIG will continue to dedicate resources to a variety of activities to reduce drug misuse, prescription opioid abuse, and drug diversion.

Prescription Monitoring

OMIG will work in tandem with the DOH Bureau of Narcotics Enforcement (BNE) to ensure provider compliance with the Internet System for Tracking Over-Prescribing (I-STOP), NYS's Prescription Monitoring Program (PMP) registry. OMIG monitors provider compliance with mandated electronic prescribing and identifies fraudulent prescriptions being billed to Medicaid.

Utilization Alerts

OMIG is working to proactively educate providers where a substance utilization review indicates that a recipient may have an accumulation of a controlled substance although they did not meet the criteria for restriction under OMIG's Recipient Restriction Program. A "Controlled Substance Accumulation" notice will be sent to alert providers of the potential overutilization and abuse.

Similarly, OMIG developed Medication Therapy Review Form to alert prescribers to instances of apparent therapeutic duplication. This will allow the prescriber to reconcile the recipient's medication list and identify potential forgeries or overutilization.

Recipient and Provider Investigations

OMIG will review recipient data to identify and investigate physicians prescribing excessive amounts of controlled substances or providing unnecessary services, and refer them to MFCU, if appropriate, for prosecution.

Recipient Restriction Program

OMIG will use the Recipient Restriction Program (RRP) to limit a recipient's access to Medicaid care and services if it is found that they have received duplicative, excessive, contraindicated or conflicting health care services, drugs, or supplies. This addresses a Medicaid recipient's ability to obtain duplicate prescription fills through doctor or pharmacy shopping. It

also may be utilized where recipients have engaged in fraudulent or abusive practices such as forgery, selling drugs obtained through Medicaid, or providing their Medicaid card to another person.

OMIG will monitor MCO compliance in: administering their RRP programs, providing monthly data on current restriction information; sharing new OMIG-initiated restrictions on enrollees; monitoring enrollees who change plans and sending the appropriate restriction information to the new plan; and coordinating provider changes with the MCO by acting as a conduit of the plan to the local district or the Health Benefit Exchange (HBE), as appropriate, to make changes in eMedNY.

Collaborative Partnerships

OMIG will continue to work closely with the Centers for Medicare and Medicaid Services (CMS), the Department of Justice, the FBI, and national health insurance companies, as well as state and local law enforcement agencies, and continue to participate on the Governor's Task Force to Combat Heroin and Opioid Addiction.

Home Health and Community-Based Care Services

Home and community-based care services continue to grow as the population ages and the Medicaid program moves away from hospitalization and long-term care placements under the value-based payment system. The need for oversight of the home care services workers providing services to vulnerable home-bound recipients is critical.

Long-Term Home Health Care Program (LTHHCP)

OMIG will continue to audit LTHHCP fee-for-service (FFS) Medicaid claims to verify per-visit and hourly rates calculated for the various ancillary services provided, with a focus on LTHHCPs with both high Medicaid utilization and rate capitations. OMIG will also review rate add-ons, including funds dedicated to worker recruitment, training, and retention.

Certified Home Health Agencies (CHHA)

OMIG will continue to conduct both CHHA FFS audits and CHHA Episodic Payment System (EPS) audits.

Personal Care Services (PCS)

OMIG will continue to audit and investigate PCS FFS Medicaid claims, as well as PCS services provided through MCOs. MCOs are responsible for assessing Medicaid recipients and making service determinations. OMIG convenes a monthly meeting with a cross section of team representatives to discuss initiatives relating to personal care services. When auditing or investigating matters related to personal care assistants, OMIG also assesses the responsibilities of any entity associated with the personal caregiver and takes appropriate actions when those responsibilities are not being met.

The Consumer Directed Personal Assistance Program (CDPAP) continues to expand. OMIG will audit and investigate CDPAP providers to ensure compliance with rules and regulations. Audit activities will include services reimbursed through fee-for-service and MCOs.

Traumatic Brain Injury (TBI) Waiver Services

OMIG will continue to examine TBI FFS claims to determine compliance with program requirements.

Nursing Home Transition and Diversion Waiver

OMIG will continue to examine NHTD FFS claims to determine compliance with program requirements.

Wage Parity

OMIG will continue to conduct reviews and work collaboratively with DOH and the Department of Labor to ensure that home care providers are providing wage and fringe benefit compensation to employees in compliance with wage parity laws.

Minimum Wage/Fair Labor Standards Act

OMIG will continue to conduct reviews and work collaboratively with DOH to ensure that MCOs are appropriately passing on supplemental Medicaid payments to home care providers, in compliance with DOH directives.

Long-Term Care Services

Assisted Living Program (ALP)

Resident Care Audits

OMIG will conduct field audits to validate payments for services and ensure the documented needs of patients are being met. OMIG will also provide oversight of ALP resident care audits that are conducted as part of the County Demonstration program.

OMIG and DOH Division of Adult Care Facilities and Assisted Living Surveillance will continue to coordinate efforts to monitor ALP provider's compliance with Medicaid regulations. In the event OMIG identifies a potential quality of care or patient endangerment issue, DOH will be contacted immediately and remedial activities will be coordinated. Quality of service and fiscal issues of entities will be addressed to ensure that the population serviced by the program is safe and adequately served while maintaining claiming accuracy.

Nursing Home Audits

Rate Audits

OMIG will continue to work with DOH's Bureau of Long-Term Care Reimbursement (BLTCR) to ensure facilities conform to BLTCR's policy and reimbursement regulations and will audit submitted pertinent costs and data related to the capital calculations.

Minimum Data Set

OMIG will continue to coordinate with BLTCR to review the accuracy of nursing home Minimum Data Set (MDS) submissions.

Managed Long-Term Care

Social Adult Day Care (SADC) Centers

OMIG will continue to independently investigate SADCs, and work jointly with MFCU, DOH, the New York City Buildings Department, the New York City Department for the Aging (DFTA) and the State Office for the Aging (SOFA). OMIG will also continue to have bimonthly discussions regarding complaints and new initiatives with MLTC plans, DOH, DFTA, and SOFA to review complaints, and discuss investigations and new initiatives.

Partial Capitation

OMIG will audit MLTCs to ensure enrollees are eligible to qualify for the program and that appropriate care management is being provided by the MLTC plans.

Enrollment and Eligibility Reviews

OMIG will review the enrollment records, recipient Plans of Care and claims data to determine if the MLTC plans are providing the specific services deemed medically necessary by those MLTC plans for their recipients. Additionally, OMIG will examine Case/Care Management system notations to confirm that appropriate care management is also being rendered to its members. OMIG will continue to assess MLTC plans to ensure that their contractual obligations in serving their recipient population are being met.

Medicaid Managed Care

OMIG's ongoing efforts include performance of various match-based targeted reviews and other audits identified through data mining, analysis, and other sources. These audits lead to the recovery of overpayments and implementation of corrective actions that address system and programmatic concerns. As more service areas are transitioned into managed care, OMIG will continue to pursue initiatives that significantly enhance the detection of fraud, waste, and abuse in the MMC environment.

Managed Care Contract and Policy Relationship Management Project Team

OMIG's Managed Care Contract and Policy Relationship Management Project Team will work to develop and advance new MCO contract amendments to address current and future Medicaid program integrity challenges and support the work of the other project teams, as well as work with DOH to continue implementation of provisions included in prior contract amendments.

Managed Care Plan Review Project Team

OMIG's Managed Care Plan Review Project Team will conduct audits of Medicaid managed care operating reports (MMCOR). Audits will focus on the review of reported pertinent medical and administrative costs for accuracy and allowability to ensure only proper costs were utilized in the development of respective rate components.

Network Provider Review Project Team

OMIG's Network Provider Review Project Team will perform audits of providers within MCOs' networks to ensure the accuracy of encounter claim submissions and confirm that provider records are in regulatory and contractual compliance. OMIG will identify improper encounter claims that contribute to inflated capitation payments. OMIG will coordinate with MCOs and their Special Investigation Units (SIU) in its audit efforts.

Pharmacy Review Project Team

OMIG's Pharmacy Review Project Team will conduct managed care network pharmacy audits to ensure pharmacy compliance with federal and state regulations, contract requirements, and the pharmacy benefit component of MMC.

The team will also audit pharmacy encounter data to verify accuracy in billing and payment of encounter claims.

Value-Based Payments Project Team

OMIG's Value-Based Payments (VBP) Project Team will continue to work with DOH to: gain an understanding of how value-based payments will be reflected in the Medicaid data; to discuss ways of ensuring integrity within the data; and to ensure access to information is readily available to OMIG to be able to audit and investigate in a VBP environment.

Managed Care/Family Planning Chargeback

OMIG will audit claims for family planning and health reproductive services paid by MCOs for enrollees who go to non-network providers when family planning services are included in the managed care organization's benefit package.

MC Capitation Payment Audits

OMIG will audit instances where MC plans receive a capitation payment from Medicaid subsequent to an enrollee's month of death.

OMIG will audit instances where MC plans receive a capitation payment from Medicaid when the enrollee was incarcerated for the entire payment month.

MC Investigations

OMIG will continue to strengthen the MCO referral process and work with MCO SIUs to coordinate activities related to fraud investigations. Each MCO has been assigned a designated OMIG liaison to work with their SIU representative. OMIG liaisons meet regularly with the MCOs' SIU representative to discuss fraud, waste, and abuse-related referrals and general fraud trends. The liaison process was implemented to improve communications and increase referrals so that appropriate action can be taken to address overall program integrity.

Retroactive Disenrollment Monitoring/Recovery

OMIG will continue to maintain and update the database file used to monitor the retroactive disenrollment of enrollees by MCOs and to perform a secondary review of retroactive disenrollment activities by other agencies.

Transportation

OMIG will continue to work with the New York State Department of Motor Vehicles, MFCU, DOH, and New York State Department of Transportation, as well as individual counties, to conduct reviews of Medicaid ambulette and taxi services providers. Reviews will determine if services were properly ordered, if paid services were provided, if Medicaid claims were accurately submitted to eMedNY, and if drivers were qualified to drive the vehicles used to provide the service.

Transportation Review

OMIG is conducting Credential Verification Reviews (CVR) throughout New York State to ensure Medicaid transportation providers are adhering to all of the requirements outlined within the Department of Health Transportation Manual policy guidelines.

Ongoing Program Integrity Activities

County Demonstration Program

OMIG will continue to work with LDSSs and the New York City Human Resources Administration (NYC-HRA) to conduct reviews of pharmacy, durable medical equipment, transportation (ambulette, taxi and livery), long-term home healthcare and ALPs.

Enrollment, Reinstatement, and Removal from the Excluded Provider List

OMIG will continue to provide a secondary review of provider enrollment applications in certain high-risk categories such as pharmacies, durable medical equipment suppliers, physicial therapists, and transportation providers to determine if applicants should be enrolled in the Medicaid program. OMIG will also review all reinstatement applications and requests for removal from the OMIG Exclusion List.

External Audits

OMIG will respond to external audits from other government entities such as the Office of the New York State Comptroller, the federal Health and Human Services Office of Inspector General, and CMS. OMIG will analyze the external audit data, searching for and providing documentation not found during the course of the audit, researching applicable regulations, contract language and policy, and working with OMIG staff to recover inappropriately paid claims.

Fee-for-Service Audits

OMIG will conduct audits of various FFS providers in areas of concern or to meet federal waiver requirements. Programs that will be audited include, but will not be limited to:

- Diagnostic and Treatment Centers
- Durable Medical Equipment
- Health Homes
- Office of Alcoholism and Substance Abuse Services
    - Outpatient Services
    - Inpatient Rehabilitation Services
    - Opioid Treatment Program

- Office of Mental Health
    - Clinic Treatment
    - Continuing Day Treatment
    - Children's Day Treatment
    - Partial Hospitalization
    - Intensive Psychiatric Rehabilitation Program
    - Children with Serious Emotional Disturbances
- Office for Persons With Developmental Disabilities
    - Clinical and Medical Services
    - Day and Residential Habilitation
- Pre-School and School Supportive Health Services
- Private Duty Nursing Agencies

Investigations

OMIG will continue to investigate both providers and recipients to identify those who abuse the Medicaid program.

Medicaid Electronic Health Records (EHR) Incentive Payment Program

OMIG will continue to provide oversight and conduct reviews to ensure that the CMS eligibility requirements of the Medicaid EHR Incentive program are met. In addition, the post-payment audit team will continue to conduct knowledge-sharing and collaboration sessions with stakeholders throughout the state in an effort to keep providers informed of changes in audit requirements and provide updates to the post-payment audit section of the program website as necessary.

Self-Disclosure

OMIG staff will continue to work closely with providers through the self-disclosure process and will be available to address any questions or concerns that they may have.

Goal #3: Develop innovative analytic capabilities to detect fraudulent or wasteful activities

Data Review Project Team

The Data Review Project Team will continue to ensure OMIG has reliable and usable data from a wide variety of sources, including the Medicaid Data Warehouse (MDW), Salient Data Mining Solution, All Payer Database, Data Mart, and Encounter Intake System. The Team represents OMIG on the Encounters Steering Committee, a committee that is accountable for governance of Encounter Intake System changes with the goal of promoting transparency, stakeholder communication and shared decision-making.

Encounter Analysis

OMIG will continue to analyze and evaluate the integrity of encounter data, performing comparative analyses of encounters and other plan-submitted data to evaluate the consistency and completeness of MCO encounter reporting. OMIG will also

collaborate with DOH to improve data reporting by plans and facilitate data availability in the MDW.

Innovative Analytics

OMIG and DOH will be partnering with a data analytics firm to recover erroneous payments made on behalf of incarcerated and/or deceased recipients.

System Match Recovery

OMIG will continue to use analytical tools and techniques, as well as knowledge of Medicaid program rules, to data mine Medicaid claims and identify improper claim conditions for potential recoveries of inappropriate Medicaid expenditures.

Recovery Audit Contractor (RAC)

OMIG will continue to collaborate and coordinate recovery initiatives with its Recovery Audit Contractor (RAC), Health Management Systems Inc. (HMS). During FY19, HMS will focus reviews on the following:

- Credit Balance Audit FFS and Encounter
- Graduated Medical Education and Indirection Medical Education
- MCO/FFS/Same Plan Overlap
- Long-Term Care - Bed Hold Days/Net Available Monthly Income/Correct Co-insurance/Coordination of Benefit Errors/Rate Code Errors
- Duplicate Payment of Professional Services Included in Ambulatory Patient Group Rate Code
- Alternate Level of Care Days
- Medicare - Inpatient Part B/Crossover Overpayment/Incorrect Reimbursement for Medicare Part C Claims (NY RAC 033)
- Medicare Medicaid Duplicate Payment/Crossover Overpayments
- Medicaid Payment Exceeds Billed Charge
- Intensity Modulated Radiation Therapy Plan Unbundling
- Duplicate Comprehensive Psychiatric Emergency Program Case Rates/Inpatient Overlap/Brief vs. Full
- Intensive Rehab Add On
- Ordered Ambulatory Services
- JCode Incorrect Reimbursement
- Home Health

Unified Program Integrity Contract

OMIG will continue its collaboration with Safeguard Services (SGS) under CMS's Unified Program Integrity Contract (UPIC). OMIG and SGS have multiple projects in process involving data analysis, audits, investigations, and pre-payment reviews covering the following program areas: dental providers; home health; consumer-directed assistance program; and opioids. OMIG is looking to expand UPIC review areas to hospice and transportation providers.

Third Party Liability (TPL) Match and Recovery Services

OMIG's contractor, HMS, will continue to conduct pre-payment insurance verification to identify and utilize third-party coverage for Medicaid recipients, to conduct third-party retroactive recoveries, and engage in estate and casualty recoveries.

Medicare Home Health Maximization

OMIG will continue to work collaboratively with its contractor, the University of Massachusetts Medical School (UMass), to maximize Medicare coverage for dual-eligible Medicare/Medicaid recipients who have received home health care services paid by Medicaid. OMIG will continue to work with CMS and the Office of Medicare Hearings and Appeals to achieve favorable outcomes of hearings and appeals for Medicaid cases.

Medi-Medi Crossover

OMIG is collaborating with both UPIC and RAC contractors to identify duplicative payments occurring between Medicare and Medicaid. By utilizing Medicare data supplied by SGS and having our RAC contractor, HMS, match this data to the Medicaid paid claims, providers who are not properly using the Medicare crossover process and, therefore, obtaining duplicative payments will be identified and repayment of Medicaid claims will be sought.

Previous OMIG Work Plans

- 2017 - 2018 Work Plan
- 2016 - 2017 Work Plan
- 2015 - 2016 Work Plan
- 2014 - 2015 Work Plan
- 2013 - 2014 Work Plan
- 2012 - 2013 Work Plan
- 2011 - 2012 Work Plan
- 2009 - 2010 Work Plan

Work Plan Acronyms and Abbreviations

ALP	Assisted Living Program
BLTCR	Bureau of Long-Term Care Reimbursement
BNE	New York State Bureau of Narcotic Enforcement
CHHA	Certified Home Health Agency
CIA	Corporate Integrity Agreement
CMS	Centers for Medicare and Medicaid Services
DFTA	New York City Dept. for the Aging
DOH	New York State Department of Health
DOJ	U.S. Department of Justice
EHR	Electronic Health Record
eMedNY	Electronic Medicaid of New York
EPS	Episodic Payment System
FFS	Fee-For-Service
HBE	Health Benefit Exchange
HMS	Health Management Systems, Inc.
LDSS	Local Department of Social Services
LTHHCP	Long-Term Home Health Care Program
MCO	Managed Care Organization
MDS	Minimum Data Set
MDW	Medicaid Data Warehouse
MFCU	New York State Attorney General Medicaid Fraud Control Unit

MLTC	Managed Long-Term Care
MMC	Medicaid Managed Care
MMCOR	Medicaid Managed Care Operating Report
MRT	Medicaid Redesign Team
NHTD	Nursing Home Transition and Diversion Waiver
NYC-HRA	New York City Human Resources Administration
NYCRR	New York Codes, Rules and Regulations
NYSoH	New York State of Health
OIG	Health and Human Services Office of the Inspector General
OMIG	New York State Office of the Medicaid Inspector General
PCS	Personal Care Services
RAC	Recovery Audit Contractor
RRP	Recipient Restriction Program
SADC	Social Adult Day Care
SGS	Safeguard Services
SIU	Special Investigation Unit
SOFA	New York State Office for the Aging
SSL	Social Services Law
TBI	Traumatic Brain Injury
TPL	Third-Party Liability
UMass	University of Massachusetts
UPIC	Unified Program Integrity Contact
VBP	Value-Based Payment

OMIG Strategic Plan

Mission

To enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high-quality patient care.

Vision

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

Goal 1

Collaborate with Providers to Enhance Compliance

Objectives

- Promote provider outreach and education through engagement and participation efforts
- Generate policy based on provider collaboration efforts

Goal 2

Coordinate with partners, including law enforcement and managed care SIUs, to identify and address fraud, waste, and abuse in the Medicaid program

Objectives

- Referring and supporting prosecution of cases related to suspected or confirmed allegations of fraud in program integrity partnership with the Attorney General's Medicaid Fraud Control Unit
- The Managed Care Plan Review, Network Provider Review and the Pharmacy Project Teams will focus on developing efficient and effective audit processes to enhance the integrity of the managed care environment.

Goal 3

Develop innovative analytic capabilities to extract high-level data on fraudulent or wasteful Medicaid activities

Objectives

- Enhance multidisciplinary activities, including improved data access, storage and mining capabilities
- Utilize multidisciplinary activities to improve upon audit and investigation efforts to recover and save Medicaid funds