2015 ANNUAL REPORT

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GOVERNOR

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Message from the Inspector General

The New York State Office of the Medicaid Inspector General (OMIG) is nationally recognized for its commitment to protecting the integrity of the state's Medicaid program. OMIG accomplishes its mission through investigative work and partnerships with law enforcement agencies, innovative auditing techniques, proactive outreach, and compliance initiatives – all of which have resulted in billions of dollars in cash recoveries and cost savings for 2015.

Results for 2015 demonstrate that OMIG's comprehensive program integrity efforts resulted in over $339 million in recoveries.

Cost savings initiatives are a key component of OMIG's work. These proactive initiatives are utilized by OMIG to save taxpayer dollars and prevent inappropriate payments from being made. In 2015, OMIG's cost savings topped $1.8 billion.

As the health care delivery system shifts from a predominantly fee-for-service (FFS) model to a managed care approach, OMIG continues to strengthen its audit and investigative efforts in this area. In 2015, OMIG completed 301 managed care audits with more than $48 million in identified overpayments.

Additionally, OMIG's Managed Care Investigations Unit works closely with managed care organizations' (MCOs) special investigative units (SIUs) to identify suspicious trends across plans, coordinate responses to referrals, and provide SIUs with information to enhance program integrity.

To help address the opioid crisis, OMIG has been involved in investigating drug diversion cases, which include forged prescriptions, doctor shopping for narcotics, and selling drugs obtained through the Medicaid program. OMIG efforts include identifying subjects and assisting law enforcement agencies with surveillance, data mining, and reviewing documentation for prosecution. Additionally, in cases where Medicaid consumers engage in opioid abuse, OMIG's Recipient Restriction Program restricts their care to a single practitioner for various needed services. In 2015, more than 1,600 recipients were reviewed for potential restriction and 1,393 were recommended for restriction to the appropriate Medicaid managed care plan, county agency, or NY State of Health (NYSoH) for implementation. Statistics for 2015 demonstrate the strength of OMIG's investigation division. OMIG opened 2,976 investigations, completed 3,443 and referred 1,146 cases to law enforcement or other agencies for further action. In addition, OMIG took 1,020 administrative actions against enrolled and non-enrolled individuals excluding them from participating in the Medicaid program – surpassing 2014 exclusions by nearly 200.

In 2015, OMIG issued more than 30 compliance-related guidance materials and conducted over 20 educational presentations and webinars. The compliance section of OMIG's website had 36,000 visits to compliance webinars, 25,000 visits to compliance publications, and 40,000 visits to compliance resources and FAQs.

OMIG will remain focused on provider education and outreach programs, and improving provider compliance programs. By enhancing its program integrity efforts to adapt to the changing Medicaid environment, OMIG will continue to improve upon its demonstrated record of achieving cost savings, identifying and recovering inappropriate Medicaid payments, and protecting the Medicaid program from fraud and abuse.

Sincerely,

DENNIS ROSEN
MEDICAID INSPECTOR GENERAL

OMIG is headquartered in Albany. Certain headquarter responsibilities, as well as field office functions, are based in New York City (NYC). Regional offices are located in 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 New York State 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 work of fighting fraud and abuse in the Medicaid program. To fulfill its mission, OMIG performs its own reviews of the Medicaid program, while also working with other agencies which have either primary regulating authority or law enforcement powers. This means OMIG needs to understand Medicaid program regulations and guidance. OMIG uses this knowledge to fight fraud and abuse, and to recommend improvements to the program.

Mission Statement

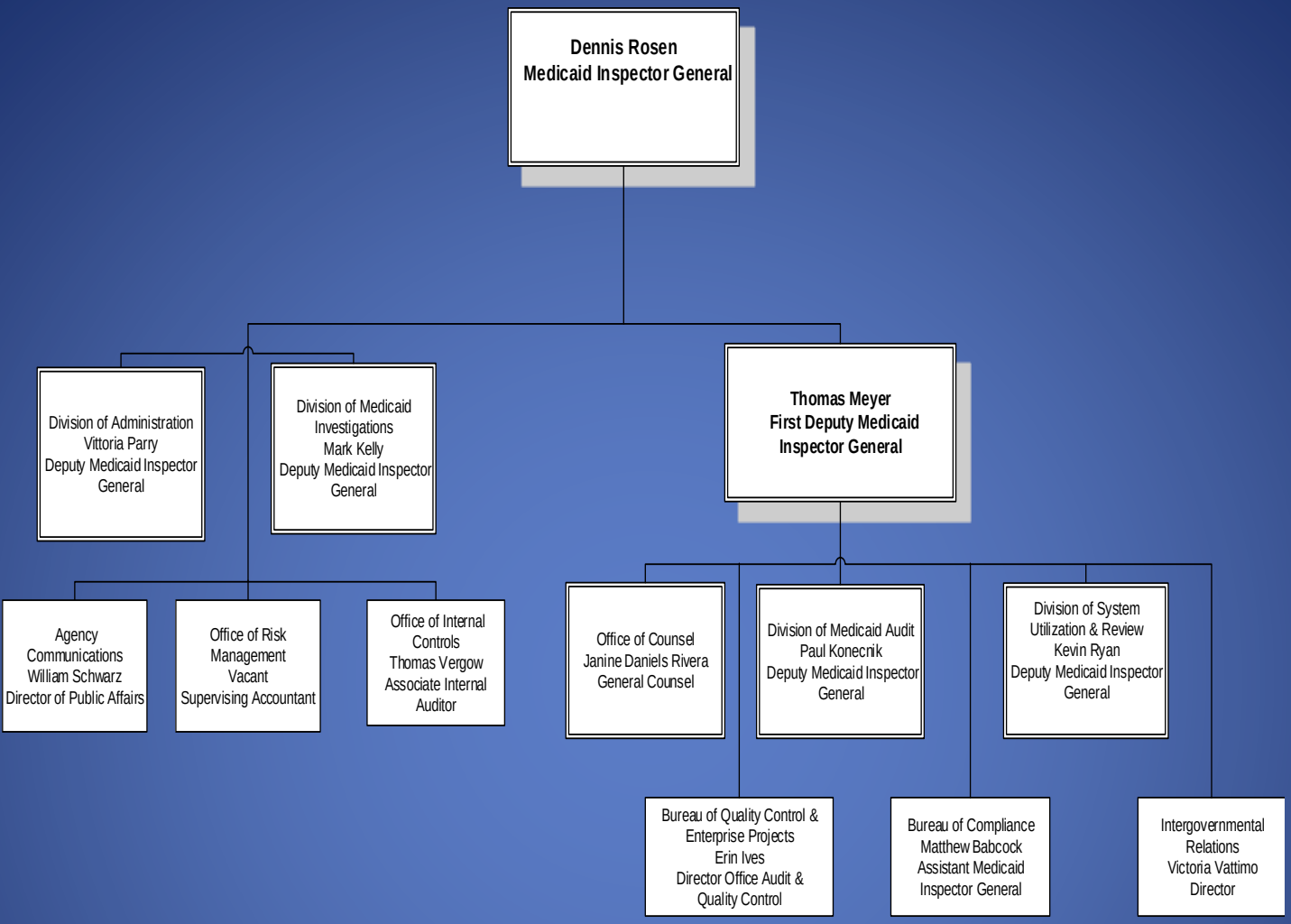
The mission of OMIG is to enhance the integrity of the New York State (NYS) Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds, while promoting high-quality patient care.

Annual Reporting

As required by NYS Public Health Law §35(1), OMIG must annually submit a report that summarizes the activities of the agency for the prior calendar year. This Annual Report includes information about the 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, stipulations, and settlements.

OMIG Organizational Chart



2015 Program Integrity Activities

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

OMIG receives and processes complaints of alleged fraud and abuse against the Medicaid program. These allegations are reviewed and investigated, and if it is suspected that fraud has occurred, OMIG is required, in compliance with applicable regulations and laws, to refer cases to the NYS Attorney General's Medicaid Fraud Control Unit (MFCU) and/or other appropriate law enforcement entities.

Managed Care

In NYS, several different types of managed care plans participate in Medicaid managed care, including mainstream managed care, 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, investigations of providers and enrollees, and collaborative meetings with the MCOs' SIUs to identify targets and discuss cases.

Managed Care Audit Activities

OMIG's ongoing audit efforts include performing various match-based targeted reviews and utilizing data mining and analysis to identity audit targets. These audits lead to the recovery of inappropriate premium payments and implementation of corrective actions that address system and programmatic concerns. During 2015, these efforts resulted in 301 finalized audits with over $48 million in identified overpayments. Highlights of managed care audit activities are described below.

Managed Care Retroactive Disenrollment Monitoring/Recovery

When a managed care monthly premium payment is inappropriately made to an MCO due to eligibility errors or untimely eligibility file updates (i.e., death, incarceration, institutionalization, enrollees assigned more than one client identification number, enrollees who have moved out-of-state, etc.), NYSoH, Local Districts (LDSS) or the New York City Human Resources Administration (NYC HRA) are instructed to retroactively adjust the enrollee eligibility file, notify OMIG of the retroactive disenrollment, and also notify the MCO to void the premium payments for any month where the MCO was not at risk to provide services. OMIG maintains and updates the retroactive disenrollment

database file which is used to monitor the retroactive disenrollment of enrollees.

In addition, OMIG performs a secondary review of the other agencies' activities and issues retroactive disenrollment audit reports to MCOs who fail to void the premium payments after having been requested to do so by the other agency (LDSS, NYC HRA, or NYSoH). During 2015, OMIG finalized 116 retroactive disenrollment audits and identified more than $9.5 million in overpayments. OMIG works with the MCOs, NYSoH, LDSS and NYC HRA on an ongoing basis to identify issues, provide educational materials, and modify retroactive disenrollment procedures to accommodate the dynamic managed care environment.

Incarceration Match

On an annual basis, OMIG conducts an incarceration match by comparing Medicaid Data Warehouse (MDW) Medicaid and/or Family Health Plus managed care enrollees to files provided by the NYS Department of Corrections and Community Supervision and the NYS Division of Criminal Justice Services. Incarceration data is matched to monthly premiums paid during the period of incarceration. Contract language allows recovery of monthly premium payments for enrollees listed on the monthly roster who are later determined to be incarcerated for an entire payment month.

In 2015, OMIG obtained the NYC Department of Corrections data files for NYS Medicaid enrollees incarcerated at the Riker's Island facility for the period 2010-2014. The data files for Riker's Island are now provided to OMIG on a monthly basis and will be included in the annual incarceration match going forward. OMIG issued 45 final audit reports for the 2015 incarceration match and identified more than $18 million in overpayments.

Death Match

OMIG receives files from both the NYS and NYC Bureaus of Vital Statistics and annually matches this data against premiums paid to MCOs. OMIG uses this information to identify payments made for individuals who were deceased for an entire payment month and were not identified during the LDSS, NYC HRA, and NYSoH retroactive disenrollment processes. In 2015, OMIG finalized 47 audits with identified overpayments of $8.8 million.

Managed Long-Term Care

Partial Capitation

The MLTC Partial Capitation program is designed to allow Medicaid enrollees who require high acuity attention to receive care in their homes and communities. OMIG audits MLTCs to ensure enrollees are eligible to qualify for the program and that appropriate care management is being provided by the MLTC Plans. To qualify for the MLTC program, enrollees are required to receive 120 days of community based long-term care services. The MLTC Plan is responsible for the care management of their enrollees, and to ensure the care is determined to be medically necessary and received

by their enrollees. Through OMIG's efforts and in collaboration with DOH, enrollees are now assessed by a third-party to determine if they are eligible to qualify for this program, which was originally a responsibility of the MLTC Plans. In 2015, four audits were finalized with over $3.2 million in identified overpayments.

Social Adult Day Care

As noted on the New York State Office for the Aging's (NYSOFA) website, social adult day care (SADC) services are provided as part of a structured, comprehensive program that provides functionally impaired individuals with socialization, supervision and monitoring, personal care, and nutrition in a protective setting. This is an important component of the community-based service-delivery system for older persons with cognitive and/or physical impairments. SADCs help to delay or prevent nursing home placement and the need for other costly services. SADCs do not receive funding directly from Medicaid. If the participant is eligible for enrollment in an MLTC plan, a center may collect indirect Medicaid revenue by contracting with an MLTC.

In 2015, DOH, in conjunction with NYSOFA and OMIG, established a new certification process for SADC providers. The SADC certification is now mandatory for all SADC entities that are currently contracting with an MLTC plan, or entities that wish to enter into a contract with an MLTC plan. Completion of the certification attests to an SADC's compliance with Title 9 of the New York Codes, Rules, and Regulations (NYCRR) §6654.20 as required under Article VII, Section C of the MLTC model contract. The SADC certification form is hosted on OMIG's website.

Managed Care Investigations Unit

In 2015, OMIG's Managed Care Investigations Unit established quarterly meetings with the MCOs' SIUs. These meetings include coordinating and disseminating pertinent investigative information relating to allegations of potentially fraudulent provider activity, and identifying investigative targets across the MCO provider universe. Prior to each meeting, an agenda is prepared and the minutes from the previous meeting are shared with the SIUs. As a result of these cooperative meetings and the sharing of information, a number of MCOs' SIUs have identified program integrity issues not previously-discovered, and have referred such matters to OMIG.

In addition to the quarterly meetings, OMIG held monthly calls with MCOs' SIUs to update the MCOs on recent referrals and to allow the MCOs to share information on pending provider investigations.

Recipient Restriction Program

OMIG continued its efforts to assist MCOs with Recipient Restriction Program (RRP) guidelines by providing specific training and program guidance. OMIG collaborates with MCOs to ensure they are meeting program responsibilities within their organizations in accordance with the Managed Care Model Contract.

RRP is a tool that OMIG and MCOs can utilize to control recipient misuse or abuse of Medicaid services when recipients are identified as abusing the Medicaid program. OMIG or the MCO can restrict a recipient's access to services to one doctor, one pharmacy, one hospital, etc. In 2015, 580 managed care enrollees were identified and recommended for restriction based on these reviews. OMIG's RRP in both FFS and managed care resulted in more than $86 million in cost savings to the Medicaid program.

New MCO Requirements under the Medicaid Managed Care Model Contract

During 2015, MCOs were required to begin submitting quarterly data reports (Comprehensive Provider Report) to OMIG that identified the value of payments made by MCOs to providers servicing MCO enrollees under the Medicaid program and the value of the services ordered and referred by MCOs' providers. Additionally, MCOs must identify a provider's network participation status, and the values of payments to providers that any subcontractor made on behalf of the MCO. Among other uses, this data is combined with other data sources to improve OMIG's ability to identify Medicaid providers who are subject to the mandatory compliance program obligation established in NYS Social Services Law §363-d and Title 18 NYCRR Part 521.

In August 2015, OMIG posted on its website the Data Dictionary for the Comprehensive Provider Report. This Data Dictionary is intended to serve as a resource to providers when submitting their reports. The Initial Comprehensive Provider Report submission for the data period of October 1, 2014 through June 30, 2015 was due from the MCOs by September 15, 2015. The first regular quarterly submission was due on October 31, 2015 for the data quarter that ended on September 30, 2015. All subsequent quarterly submissions are due by the last day of the month immediately following the end of the calendar quarter.

Generally, MCO submissions were timely and in the form and format requested by OMIG. A limited number of MCOs did not provide timely data for various reasons and OMIG took operative steps to work with MCO management to address issues hindering timely submissions.

Managed Care Transition

Technology and Encounter Data Issues

As NYS Medicaid has transitioned most of the enrollee population into managed care, the encounter data representing the services provided to enrollees has become vital to program integrity. OMIG has continued efforts to improve the completeness, accuracy, and timeliness of encounter data reporting by expanding the agency's understanding of systematic reporting changes and collaborating with DOH to identify and implement solutions for data insufficiencies. OMIG participated in weekly meetings with DOH and MCOs to discuss system and reporting issues related to the September 2015 implementation of the new encounter intake data system (EIS) and reporting format. In addition, OMIG is collaborating with DOH on correcting plan-specific encounter reporting issues identified through analysis of encounter data.

Executive Initiatives

OMIG's executive staff sponsored a new project team approach to guide the agency's program integrity efforts in Medicaid managed care. OMIG established a project management office (PMO) with a dedicated project manager. OMIG executive staff collectively comprise the PMO Steering Committee which provides guidance and direction to the PMO. OMIG created five project teams to oversee the following focus areas:

- Data
- Managed Care Contract and Policy/Relationship Management
- Managed Care Plan Review
- Managed Care Network Provider Review
- Pharmacy

Teams have established charters to outline their specific purpose and goals. Team leaders and members identify and assign tasks with target completion dates, regularly monitor their progress, and discuss upcoming deliverables. OMIG's project manager maintains an agency-wide portfolio of these efforts.

Data Project Team

The Data Project Team reviews, assesses, and improves the availability and quality of data used to support program integrity in managed care. The various Medicaid data repositories include the EIS, the MDW, and data mining solutions such as Salient. The team seeks to increase OMIG's access to new and emerging data sources such as the Data Mart and All Payer Database. The team will also evaluate the completeness and accuracy of encounter data reported by MCOs and increase OMIG's institutional knowledge of data systems.

Managed Care Contract and Policy/Relationship Management Project Team

The Contract and Policy/Relationship Management Team develops, tracks, and advocates for amendments to the managed care mainstream and the MLTC model contracts to enhance and support OMIG's authority to perform program integrity activities. The team also initiates outreach to and collaborates with various stakeholders in the managed care environment.

The above-mentioned teams provide assistance to the remaining three project teams.

Managed Care Plan Review Project Team

The Plan Review Project Team performs audits of mainstream and MLTC MCOs' Medicaid Managed Care Operating Reports (MMCOR) to verify that MCOs are reporting complete and accurate information to the State. Additionally, the team develops detailed audit plans to guide the reviews of the various aspects of MMCORs.

Managed Care Network Provider Review Project Team

The Network Provider Review Project Team is tasked with creating an effective and efficient process to conduct audits of network providers in managed care. The team will adapt OMIG's FFS audit processes to include methodologies for auditing network providers in managed care, perform field audits, identify overpayments, and recoup inappropriate Medicaid funds received by network providers.

Pharmacy Review Project Team

The Pharmacy Review Project Team reviews and analyzes the pharmacy benefit component within Medicaid managed care. For managed care enrollees, pharmacy benefits are included in the services provided by MCOs, and subcontracted to pharmacy benefit managers (PBMs) and network pharmacies. PBMs develop and maintain drug formularies, negotiate discounts and rebates with drug manufacturers, and process and pay prescription drug claims. PBMs contract with participating network pharmacies who perform the dispensing of drugs and supplies. The team will develop an effective and efficient process for OMIG to perform audits and reviews of network pharmacies and PBMs. OMIG will review for accurate formulary and benefit administration, as well as financial and pricing arrangements.

Accomplishments

In 2015, OMIG worked with MFCU and DOH to develop proposed amendments to the mainstream model contract to strengthen program integrity requirements under the contract and expand OMIG's ability to perform program integrity activities in managed care.

Beginning in September 2015, MCOs started using DOH's new EIS to submit encounter data. It is vital for OMIG to monitor this data transition and ensure that the agency continues to receive access to useable encounter data. OMIG staff mapped the flow of FFS and managed care claim data from the MCO to the EIS to the MDW. OMIG staff continue to monitor the encounter data submitted by mainstream and MLTC MCOs as well as the resolution of known encounter issues.

OMIG staff attended training on DOH's actuarial rate setting process and the Clinical Risk Groups (CRG) model. The CRG model describes the health status and burden of illness in an identified population; DOH's contractor, 3M, is responsible for calculating CRG weights. The training included an overview of how CRGs are used to administer care to a population and determine premium rates for managed care populations.

OMIG mapped out the flow of data and claim payments in managed care pharmacy transactions and identified the related parties and intermediaries that are involved in pharmacy transactions (such as PBMs, electronic prescribing vendors, electronic data intermediaries or clearinghouses, drug manufacturers, wholesalers, and the enforcement agencies). Further, staff identified the transaction standards that are to be utilized for pharmacy transactions. Staff are also analyzing MCO, PBM, and network pharmacy contracts to identify pricing variances and outliers.

OMIG engaged 19 mainstream MCOs in a survey to obtain an overview of the MCOs' post-payment activities to reduce fraud and abuse. The survey answers provided valuable insight into the methods used by the MCOs to identify and recover overpayments from network providers.

OMIG staff performed a comparative analysis of encounter data submitted by an MCO and other MCO-submitted data sources such as the MCO's paid claim files, Comprehensive Provider Reports, and PBM data to evaluate the consistency and completeness of reporting by the MCO. OMIG will continue to perform such analyses to validate the encounter data being reported by MCOs. In addition, OMIG is working to develop a collaborative relationship with PBMs contracted by the MCOs, similar to the cooperative relationship OMIG has developed with SIUs.

Audits

OMIG conducts audits of Medicaid services provided to beneficiaries. The objectives of the audits are to assess the provider's 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 contained the documentation required by regulations; and,
- claims for payment were submitted in accordance with DOH regulations and the appropriate provider manuals.

In 2015, OMIG finalized 234 FFS audits which resulted in identified overpayments of over $51 million. The most common audit finding identified by OMIG's FFS auditors is missing, late, or not properly authorized plan of care documentation. These care plans may have different titles across all audit types, but nevertheless form the basis for authorized Medicaid services. Errors of this nature resulted in identified overpayments and reinforced to the affected providers the importance of maintaining this documentation.

OMIG uses analytical tools and techniques, as well as knowledge of Medicaid program rules, to data mine Medicaid claims and identify improper claim conditions. The System Match and Recovery unit finalized 293 reviews with identified overpayments of $3.9 million. The following reviews contributed to these findings:

- FFS Deceased Beneficiary Review - OMIG identified claims for beneficiaries who had a purported date of service past the date of death, as reported by NYS Vital Statistics. There were 203 Final Audit Reports issued identifying $657,000 in overpayments.

- Dental Matching Project – OMIG reviewed combinations of procedures codes billed by dentists for adherence to Medicaid regulations. Billed consultation documentation was reviewed to ensure that there was a referral from and follow up reports to the referring provider. OMIG issued 38 Final Audit Reports with identified overpayments of $1.6 million.

- Inpatient Crossover with Clinic/Emergency Room – OMIG identified clinic and emergency room services that were billed for patients where an inpatient stay was also billed for the same time period. OMIG issued 47 Final Audit Reports with identified overpayments of $729,000.

2015 Initiated Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	13	0	11	0	24
Managed Care	291	80	76	9	456
Medicaid in Education	1	0	8	0	9
Provider	372	185	203	19	779
Rate	374	112	165	3	654
Self Disclosure	73	59	70	4	206
System Match Recovery	281	36	40	30	387
Total	1,405	472	573	65	2,515

2015 Finalized Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	18	6	3	0	27
Managed Care	208	53	39	1	301
Medicaid in Education	0	1	0	0	1
Provider	132	57	44	1	234
Rate	27	5	7	0	39
Self Disclosure	33	44	42	2	121
System Match Recovery	185	28	50	30	293
Total	603	194	185	34	1,016

2015 Overpayments Identified for Recovery by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	$ 4,220,864	$2,227,151	$ (130,447)	$ 0	$ 6,317,568
Managed Care	36,740,798	8,392,620	3,316,914	110	48,450,442
Medicaid in Education	0	7,764	0	0	7,764
Provider	47,818,361	1,650,876	1,872,936	14,007	51,356,180
Rate	7,206,820	708,639	2,943,791	0	10,859,250
Self Disclosure	1,771,127	1,828,511	1,587,289	1,840	5,188,767
System Match Recovery	2,468,298	169,971	844,469	470,049	3,952,787
Total	$ 100,226,268	$14,985,532	$10,434,952	$ 486,006	$126,132,758

2015 Overpayments Recovered by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	$ 2,163,172	$ (119,604)	$ 90,480	$ 0	$ 2,134,048
Managed Care	33,546,879	7,557,875	2,492,669	110	43,597,533
Medicaid in Education	0	2,309	14,373	0	16,682
Provider	28,992,993	6,602,440	2,174,067	2,263,293	40,032,793
Rate	25,342,580	1,135,858	6,225,746	0	32,704,184
Self Disclosure	2,660,156	1,142,934	757,108	(1,354)	4,558,844
System Match Recovery	2,906,397	213,027	724,783	504,367	4,348,574
Total	$95,612,177	$16,534,839	$12,479,226	$2,766,416	$127,392,658

Data Mining and Technological Support

OMIG's Bureau of Business Intelligence (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 the 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 organizations within the federal, state, and county government.

In 2015, BBI processed the following requests:

- 2,385 data requests which consisted of Medicaid FFS and managed care data extraction and analysis in support of:
  - Division of Medicaid Audit (DMA) and Division of Medicaid Investigations (DMI);
  - statewide System Match Audits;
  - Centers for Medicare and Medicaid Services (CMS) Payment Error Rate Measurement (PERM) 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) investigations;
  - Island Peer Review Organization (IPRO) Audits; and
  - self-disclosure unit.

- 213 statistical samples created for DMA audits and DMI investigations, including:
  - County Demonstration Audits;
  - IPRO Audits;
  - Self-Disclosure Reviews;
  - Medicaid Electronic Health Record (EHR) Incentive Program Audits; and
  - Dental Reviews

Protocols

For the past few years OMIG has published protocols on its website. Audit protocols are developed for FFS categories of service or programs audited by OMIG. The protocols assist the provider community in evaluating compliance with Medicaid requirements . Audit protocols are intended solely as guidance in this effort.

In 2015, the Traumatic Brain Injury (TBI) protocols were added to the list of OMIG's posted protocols. OMIG finalized four TBI audit projects resulting in identified overpayments of more than $730,000. Additionally, five OMIG protocols for OMH outpatient mental health services were finalized and posted to the OMIG website. This will facilitate the completion of open billing and documentation audits of mental health services and provide guidance for future audits of clinic based mental health services that are paid under the Ambulatory Payment Group (APG) methodology. OMIG and OMH staff worked extensively in finalizing the protocols and OMH provided technical assistance for services paid under the APG process.

Positive Provider Reports

In the process of an audit there are times when OMIG finds that, for the audit period and objective reviewed, the provider has generally adhered to applicable Medicaid billing rules and regulations. In these instances, 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 Department	Audit Summations
Fee-for-Service Audit	547
Rate Audit	138
Medicaid in Education	11
County Demonstration Program	8
Total	704

Third-Party Liability

Medicaid is the payer of last resort; however, providers often do not bill the responsible third-party insurer before billing Medicaid. A significant amount of the State's Medicaid recoveries are the result of OMIG's efforts to obtain payments from private insurers responsible for services inappropriately reimbursed by Medicaid funds. Other insurance coverage, including Medicare and/or commercial insurance, should be identified during the beneficiary intake process.

Third-Party Liability Recoveries and Medicaid Recovery Audit Contractor

In 2015, OMIG recovered over $180 million in Medicaid payments through its third-party liability recovery efforts. These recoveries were made from providers, commercial insurance carriers, casualty settlements, and the estates of deceased Medicaid beneficiaries.

Additionally in 2015, as part of the Recovery Audit Contractor (RAC) program, more than $26 million in Medicaid overpayments were recovered by HMS – the NYS RAC. .

HMS continued its reviews of long-term care facilities, assuring that appropriate patient liability amounts were used in Medicaid payment calculations, other payer responsibilities were exhausted, and that service days reimbursed were appropriate.

The HMS Credit Balance Review project had a strong performance recovering over $10 million in Medicaid overpayments. HMS reviews the financial records and reports of a facility to determine if a credit balance exists on a Medicaid account. HMS informs OMIG of payments made to the hospital that were not credited to Medicaid. These identified overpayments are then recovered.

In addition to the standard credit balance reviews, HMS piloted the review of the providers' debit balance reports. Providers "debit off" accounts that are in a credit balance status if they believe that the payments and charges are accurate. By doing this, the account is no longer considered to be in a credit balance status and therefore no longer appears on the credit balance report. HMS reviews the debit balance report to find these "accurate" payments and charges that were "debited off" in order to determine the overpayments and make appropriate recoveries.

Another milestone for this year was the development of Medi-Medi scenarios, where HMS uses Medicare adjudicated data – Part A and B paid claim data - to confirm that Medicaid payments were appropriate for the dually eligible population. HMS presented four new scenarios under this project and released five pilot mailings. HMS recovered approximately $250,000 related to these projects.

2015 Third Party Liability and RAC Recoveries		
Activity Area	**Amount**	
Third Party Liability	**$**	**99,296,734**
Casualty & Estate		**81,327,962**
Recovery Audit Contractor		**26,781,974**
Home Health Care Demonstration Project		**3,148,752**
Self-Disclosed TP Health Insurance		**1,343,094**
Total	**$**	**211,898,516**

Investigations

OMIG actively investigates allegations of fraud and abuse within the Medicaid program. OMIG also conducts investigations of enrolled and non-enrolled providers, entities, and recipients. Allegations are analyzed utilizing a variety of methods, including but not limited to data mining, undercover operations, analyses of returned Explanation of Medicaid Benefits, and interviews of complainants and subjects. Investigations can lead to administrative actions and sanctions, where appropriate. 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	295	414	181	192	1	3	477	609
Fiscal Agent Fraud Unit	0	7	0	0	0	0	0	7
District Attorney	22	2	1	0	0	0	23	2
Enrolled Recipient	67	147	46	56	0	0	113	203
Federal Agencies	169	84	21	9	6	0	196	93
General Public (Non-enrolled)	161	265	127	148	1	5	289	418
Law Enforcement	0	21	0	8	0	0	0	29
Local District Social Services	7	19	142	137	0	1	149	157
Managed Care Plans	237	223	81	91	3	3	321	317
Non-Enrolled Provider	6	7	2	4	0	0	8	11
Non-Enrolled Recipient	1	9	4	4	0	5	13	
Provider	56	55	36	43	1	5	93	103
Qui Tam	0	26	0	2	0	24	0	52
State Agencies (including OMIG)	948	1,081	294	307	60	41	1,302	1,429
Total	1,969	2,360	935	1,001	72	82	2,976	3,443

Health Care Fraud Prevention and Enforcement Action Team

A Health Care Fraud Prevention and Enforcement Action Team Strike Force initiative led to nine individuals associated with a medical center in Brooklyn being charged by the United States Department of Justice (U.S. DOJ) and the U.S. Attorney's Office, Eastern District of New York for engaging in a scheme to defraud the Medicare and Medicaid programs of over $13 million. OMIG participated in the investigation by providing investigators and Russian speaking staff, as well as furnishing Medicaid data, conducting surveillances, and assisting in other investigative activities.

Patients at the medical center received medically unnecessary physical therapy, diagnostic testing and other services, which were provided by a physician assistant who was acting without supervision. These medical services were then fraudulently billed to Medicare and Medicaid by the medical center under the medical director's provider identification number. For several

* Investigations completed may represent cases opened in prior periods.

years, the medical center billed Medicare and Medicaid seeking reimbursement for a wide variety of fraudulent medical services and procedures that were not medically necessary and often did not even occur.

One individual in this case, an ambulette driver, pleaded guilty for his role as a patient recruiter for the medical center. The driver paid employees of the medical center a cash kickback for each recipient referred to them for which his ambulette company could then bill Medicaid for associated transportation costs. He also paid the recipients a cash kickback to continue to attend the medical center for unnecessary physical therapy and diagnostic tests, all ultimately billed to Medicare and Medicaid. He was sentenced to 21 months in prison, three years of supervised release, and forfeiture of $10,000.

Additionally, on August 14, 2015, the medical director was sentenced to 24 months of incarceration as a result of being a "no show" doctor at the medical center. The physician was also ordered to pay $6,429,330 in restitution to CMS and forfeit $6,550,036 to the U.S. Government.

Twenty-three Defendants Charged with Enterprise Corruption

On March 31, 2015 OMIG, along with the Brooklyn District Attorney (DA), HHS OIG, and NYC HRA, announced that charges were being brought against nine physicians and 14 other individuals pursuant to a 199-count indictment. These individuals allegedly participated in a massive scheme in which they lured people from low-income neighborhoods, homeless shelters and welfare offices to corrupt medical clinics for unnecessary tests with the promise of free footwear, such as sneakers, shoes, and boots.

According to the indictment, the defendants, including 23 men and women and eight companies, engaged in a criminal enterprise by intentionally participating in a pattern of criminal activity through the fraudulent operation of medical clinics and the submission of fraudulent claims to Medicaid, Medicaid MCOs, and Medicare. In addition to doctors, the defendants included nurses, nurse practitioners, physician's assistants, technicians, office staff, recruiters, managers, and billers.

OMIG provided Russian-speaking staff as well as Medicaid data and intelligence in the course of this investigation. During a press conference, then-acting Medicaid Inspector General, Dennis Rosen stated,

> *"Health care fraud compromises the integrity of the Medicaid program as well as the health care delivery system, and it wastes tax payer dollars. Today's indictment, which is the result of the collaborative efforts of the Brooklyn District Attorney, Health and Human Services, New York City Human Resources Administration and OMIG, sends a clear, unmistakable message that those who commit health care fraud will be identified and held accountable for their actions."*

OMIG excluded all of the defendants on May 7, 2015. These exclusions accounted for over $1.6 million in cost savings for the NYS Medicaid program.

Prescription Forgery Investigations

The Recipient Fraud Unit uses data mining as a way to identify possible fraud. To uncover opioid prescription abuse in the NYS Medicaid recipient population, OMIG utilized data mining to detect suspected forgeries. Through forged prescription investigations, OMIG is able to track trends and develop target methodology to identify suspected forgeries. Some of these trends and schemes repeat themselves every few years. Using these techniques, OMIG identified 272 recipients who forged 861 prescriptions in 2015.

On-Site Investigations

In 2015, OMIG conducted training in its NYC office for CMS staff regarding pharmacy investigations and reviews. The training was based on recent case findings and fraud trends. After completing this training, CMS approached OMIG to conduct joint on-site investigations at specific locations where both Medicaid and Medicare recipients were served.

Several joint on-site investigations were conducted in Nassau, Suffolk, and Kings Counties, where OMIG investigators conducted credential verification reviews (CVRs) while CMS staff, including a CMS pharmacist, shadowed and observed. Based on the conditions found during these joint on-site investigations, OMIG issued referrals to NYSED's Office of Professions, NYS Department of Environmental Conservation, MFCU, NYS Board of Pharmacy, and local village and town building departments.

Additionally, several Notices of Immediate Agency Action (NOIAAs) were issued based on health and public safety issues observed during these on-sites. Thirteen NOIAAs in total were issued in 2015 due to the imminent danger posed by the continued participation of the provider in the Medicaid program. The NOIAAs resulted in providers being excluded from participating in the Medicaid program, including physicians, dentists and a pharmacy. Issues in the medical offices included; improperly stored used hypodermic needles; regulated medical waste in the regular garbage; unused disposable impression trays mixed in with used trays; no documentation of spore testing; open containers containing bio-hazardous materials; rusty instruments; and unsecured patient files. Issues in the pharmacy included: questionable medication sources; medication vials without lot numbers; outdated medication used to fill prescriptions; questionable hygiene procedures; and unknown medications in plastic vials. These NOIAAs protect the safety and welfare of Medicaid recipients until such time as the problems are rectified by the providers.

CMS plans to incorporate lessons learned from these joint investigations while creating its own CVR/Investigative process that will be implemented nationwide in its agency.

Joint Investigation with IRS, FBI and U.S. Attorney's Office

OMIG provided assistance in a joint investigation with the IRS, FBI, and the U.S. Attorney's Office in an investigation of a pharmacy owner who was allegedly behind a multimillion-dollar Medicaid and Medicare fraud scheme. The pharmacy owner bought pharmaceuticals, including expensive medications used to treat HIV, from patients who sold them to the pharmacy rather than use them to treat their own illness. The pharmacy owner then repackaged and resold the drugs, and requested and received reimbursements from Medicaid and Medicare. In some instances, Medicaid and Medicare had already paid for the drugs when they were originally dispensed. The pharmacy owner also billed and received reimbursements for medications that he did not actually fill, exchanging scripts for cash with recipients.

OMIG provided medical and technical assistance and expertise, OMIG nurses examined recipients' medical records and provided leads regarding suspicious Medicaid transactions. OMIG pharmacists reviewed drugs that were dispensed at the pharmacy and provided technical assistance at the search warrant site. OMIG auditors examined financial records for irregularities and for possible leads for witnesses. In December 2013, the collaborative efforts led to the pharmacy owner's arrest. On March 26, 2015, the owner of the pharmacies, located in Queens and the Bronx, was sentenced in a Manhattan federal court to 36 months in prison and ordered to pay more than $7 million in restitution for conducting a scheme to defraud Medicaid, Medicare and the NYS funded AIDS Drugs Assistance Program. The pharmacy owner was also sentenced for tax evasion. OMIG has filed a Petition for Remission with the FBI to recover some of the money that was seized at the time of the owner's arrest.

Licensed Practical Nurse Investigation Leads to Conviction

A Licensed Practical Nurse (LPN), was convicted of Grand Larceny in the 3rd Degree on September 22, 2015, in Rochester City Court. This case was predicated upon a hotline complaint received from the parent of a recipient, who advised that the LPN had provided private duty nursing services for his child before he fired her for being unreliable. The father had obtained the billings submitted by the LPN through his child's service coordinator, and after reviewing the records, found that the LPN had billed for 12 dates of service for which she did not work or claimed more hours than she actually worked.

Through its investigation, OMIG examined all claims submitted by the LPN, including those submitted for services rendered to other recipients. After conducting interviews and record reviews, OMIG found that the LPN had billed approximately $32,742 for services not rendered within a one year time period. OMIG referred this investigation to MFCU, and upon their request assisted in the interview. OMIG excluded the LPN from the NYS Medicaid program as a result of the felony charges brought by MFCU. She was also ordered to pay restitution of $27,978.

Wrong Formula Leads to the Conviction of Medical Suppliers

OMIG's use of proactive data analysis for enteral formulas led to an on-site investigation of a medical supply provider. OMIG investigative staff found that the pediatric formulas on-site were of the over-the-counter variety, despite the provider's extremely high billings for specialized formula. OMIG referred the findings to MFCU, and then worked the case jointly with them. In July 2013, the NYS Attorney General announced the indictment of the owner, her brother who acted as store manager, and two employees. The defendants faced up to 25 years in prison on charges that the company and its employees billed Medicaid approximately $3.2 million dollars for the specialized, expensive pediatric nutritional formula intended for children with rare illnesses when, in fact, it was dispensing over-the-counter formulas like Pediasure®. In July 2015, it was announced the provider was convicted, received a sentence of seven to 21 years in prison, and was ordered to pay a $1.7 million fine.

OMIG Referral to MFCU Leads to Large Settlement for NYS

The NYS Attorney General issued a press release announcing a $22.4 million settlement with a statewide pharmacy for improperly billing Medicaid for Synagis®, an injectable pediatric drug.

OMIG initiated this case and submitted comprehensive reports and analyses when referring the case to MFCU. Based on information referred by OMIG, MFCU extended the review period and continued to work closely with OMIG. The Synagis® investigation and settlement relates to a whistleblower lawsuit filed in U.S. District Court alleging violations of the federal and state False Claims Acts. OMIG had previously audited the provider's Medicaid claims for an earlier time period and was conducting a new audit of the provider's Synagis® claims when the whistleblower case was filed. The Attorney General's investigation and audit encompassed this new audit period and extended it.

Nurse Practitioner Sentenced for Operating a Multi-Million Dollar Pill Mill

On June 29, 2015, a nurse practitioner was convicted on five counts, including Criminal Sale of a Prescription/Controlled Substance for operating what authorities called a multi-million dollar pill mill from a pain management clinic. On August 25, 2015, she was sentenced to nine to 19 years in prison by the State Supreme Court.

The nurse practitioner, dubbed the "painkiller peddler" by prosecutors, illegally prescribed more than 400,000 Oxycodone pills with a street value of over $6 million between June 2011 and June 2012. The Suffolk County District Attorney stated "She used a pen and prescription pad to make enormous sums of cash over the span of a year, an estimated $1 million paid to her by addicts and dealers who resold the Oxycodone pills. She is a drug dealer who sold prescriptions for a powerful habit-forming narcotic for cash".

OMIG provided assistance to the federal Drug Enforcement Administration which included surveillance, data mining, and coordinating with NYSED's Office of Professional Discipline (OPD) and MCOs to procure documentation relative to the investigation. At sentencing, the nurse practitioner made an emotional plea with the judge for probation, however, the judge denied the request and scolded her for being in a state of denial.

Program Integrity Referrals to MFCU and Outside Agencies

OMIG is required by NYS law to refer suspected fraud and criminality to MFCU. OMIG also refers its findings to the agencies responsible for oversight of professional licensure, specifically, 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	**2015**
Clinical Psychologist	1
Clinical Social Worker	1
Dental Groups	4
Dentist	9
Diagnostic and Treatment Center	4
Home Health Agency	5
Laboratory	1
Long Term Care Facility	2
Medical Appliance Dealer	2
Multi-Type	2
Multi-Type Group	1
Nurse	9
No Provider Type	1
Non Enrolled Provider	52
Pharmacy	73
Physician	17
Physicians Group	4
Transportation	4
Total	**192**

Referrals to Outside Agencies	
Agency	**2015**
Law Enforcement Agency	84
Local District Attorney	41
Local District Social Services	134
Local Municipality	5
Managed Care Organizations	3
NYC Department of Buildings	1
NYC Department of Health	4
NYC Department of Sanitation	7
NYC HRA Bureau of Client Fraud Investigations	448
NYC Office of the Special Narcotics Prosecutor	1
NYC Taxi and Limousine Commission	2
NYS Bureau of Narcotic Enforcement	3
NYS Department of Environmental Conservation	13
NYS Department of Financial Services	1
NYS Department of Health	25
NYS Department of Motor Vehicles	3
NYS Department of Transportation	3
NYS Education Department – Not Prof. Discipline	25
NYS Insurance Frauds Bureau	3
Office for People with Developmental Disabilities	2
Office of Health Insurance Programs	56
Office of Mental Health	2
Office of Professional Discipline	49
Office of Professional Medical Conduct	10
Office of Welfare Inspector General	2
Other Federal Agency	9
Other State Agency	15
Out of State	1
US Health and Human Services	2
Total	**954**

2015 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 equal the actual dollars recouped by OMIG, and reflect cash deposits and voids resulting from OMIG and contractor audits, less any refunds paid to providers.

2015 Recoveries	
Activity Area	**Amount**
Third-Party Liability	$ 99,296,734
Casualty & Estate	81,327,962
Managed Care	43,597,533
Provider	40,032,793
Rate	32,704,184
Recovery Audit Contractor	26,781,974
Self Disclosure	4,558,844
System Match Recovery	4,348,574
Home Health Care Demonstration Project	3,148,752
County Demonstration Program	2,134,048
Self-Disclosed TP Health Insurance	1,343,094
Investigation Financial Activities	458,906
Medicaid in Education	16,682
Total	$ 339,750,080

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 cash recoveries. Cost savings initiatives are proactive actions to save taxpayer dollars up front 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 intervention with a provider, the agency will compare billing patterns prior to the intervention with those after to determine the cost savings attributable to the agency's actions.

OMIG puts great effort into developing, reviewing, and approving its cost savings methodologies including utilizing an internal workgroup consisting of cross functional staff. This team will review all cost savings initiatives on an ongoing basis to identify and assess fluctuations in the savings amounts reported. Fluctuations 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, if needed.

Throughout 2015, OMIG estimates it saved NYS taxpayers more than $1.8 billion as a result of these proactive efforts. Some examples of these activities are outlined below.

Third-Party Liability Pre-payment Insurance Verification – The NYS third-party liability vendor, HMS, obtains rosters of insured individuals from many insurance carriers across the country. HMS matches this identified coverage against Medicaid beneficiaries enrolled in NYS in an effort to identify those beneficiaries that have additional insurance coverage. Once identified, this information is added to eMedNY so that medical services are first billed to the other insurance leaving Medicaid as the payer of last resort. This Pre-payment Insurance Verification resulted in cost savings of over $1.5 billion in 2015.

Medical and Dental Pre-payment Review – The Bureau of Payment Controls and Monitoring has both a medical and a dental provider pre-payment review (PPR) process, otherwise known as Edit 1141. In 2015, PPR initiated 271 reviews. These reviews looked at private duty nursing, transportation, personal care aides, and individual and group dental providers. Capabilities within the Medicaid claims processing subsystem allow staff to review some or all of the claims for providers of interest. Staff use specific criteria to identify claims of interest, which are pended for further review. Staff will then work with the providers to obtain documentation to assist in determining the appropriateness of the claims. This documentation review provides a wealth of information and in many cases produces evidence which can be used as a basis for further action. PPRs can have manual resolutions, automatic resolutions, or a combination of each.

PPR activities differ from traditional auditing activities in that they take place on the front end before the money goes out the door. This process allows staff the flexibility to react to situations

on an ad hoc basis by building issue specific editing criteria into the claims processing subsystem. PPR staff perform comprehensive case reviews on each provider by reviewing patient histories, patient records, prior approval information, and related provider billings to obtain a complete picture of each claim and treatment plan, the appropriateness of claim submissions, and an understanding of a provider's billing patterns. The PPR process complements OMIG's audits and investigations, and reviews may very often run parallel tracks, simultaneously all working toward the same goal. Provider education is a big component of the PPR process. The PPR process has a cost savings associated with claim denials. In addition, because of the education offered to the provider during the review, there can be significant cost avoidance as a result of the corresponding change to providers' billing. That change in billing patterns and practices is monitored and tends to be a lasting change in behavior.

Collaboration is another key component to the PPR process. Staff often work joint cases with other divisions within OMIG as well as MFCU, OPD, the NYS Department of Transportation, and DOH's Office of Health Insurance Programs (OHIP). Pre-payment staff work closely with DOH policy staff on a regular basis, and statewide stakeholder associations as needed, resulting in valuable program oversight.

OMIG can also recognize cost savings by measuring the "sentinel" effect on the provider's Medicaid billings. The sentinel effect is achieved by measuring the change in a provider's Medicaid billing practices by determining the average Medicaid billings before placing the provider on PPR, and comparing it to the Medicaid billing after PPR has been completed.

OMIG's PPR initiatives resulted in cost savings of over $50 million to the Medicaid program.

Enrollment Screening Activities

In 2015, 152 applications for provider enrollment or reinstatement were denied by OMIG's Enrollment and Reinstatement Unit (EAR), resulting in a total cost savings of over $18 million. The categories of providers that were denied included pharmacies, durable medical equipment (DME) suppliers, physicians, nurses, laboratories, transportation providers, podiatrists, practitioner groups, dentists, psychologists, physical therapists, and home health agencies. The tools and methods used in reviewing these cases included pre-enrollment on-site inspections conducted by investigation staff, undercover operations on pharmacies, federal and state database checks, and coordination between EAR and OHIP policy staff.

Although some of the application reviews are required by the Affordable Care Act (ACA), OMIG's reviews exceed the requirements by conducting pre-enrollment on-site inspections of pharmacy and DME applicants. OMIG reviews categories where pre-enrollment reviews are not specifically required by ACA, in order to prevent potentially fraudulent, abusive, or fiscally irresponsible providers from being enrolled.

Dental Group Enrollment Denial – an on-site inspection conducted by OMIG in February 2015 found used and contaminated dental trays stored with new trays intended for patients, and locked hypodermic needle containers that were overfilled with used syringes found sitting on top of the containers. Based on the on-site inspection, the dental group's enrollment application was denied and the dentist that owned the group and practiced at that location was immediately excluded from Medicaid based on health and safety concerns.

2015 Cost Savings Activities	
Activity Area	**Amount**
Clinic License Verification	$ 8,177,312
Corporate Integrity Agreement Sentinel Effect	13,180,204
Dental Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	635,824
Duplicate Claim included in Inpatient Coverage – Edit 760	1,317,208
Enrollment and Reinstatement Denials	16,827,470
Exclusions/Terminations – Internal	7,608,400
Exclusions/Terminations – External	3,596,853
Managed Care Locator Code	28,511,845
Medical Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	249,286
Medicaid Claim Denials (Providers Removed from Active PPR <= 12 Months) – Edit 1141	151,767
Medicaid Claim Denials (Providers Removed from Active PPR 13-24 Months) – Edit 1141	347,329
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	17,665,751
Ordering Provider Excluded Prior to Order Date – Edit 939	2,495,494
Ordering/Referring Provider Number Missing – Edit 903	5,416,221
Order/Servicing/Referring Provider Number Verification – Edit 1236/1238	3,864,444
Pharmacies License Verification	6,303,569
Pre-Payment Insurance Verification Commercial	1,053,572,492
Pre-Payment Insurance Verification Medicare	474,254,367
Pre-Payment Review Sentinel Effect – Edit 1141	49,100,197
Prescription Serial Number Missing, Lost, Stolen, Altered	43,275,405
Provider ID/Service ID are the same – Edit 1357	886,078
Recipient Restriction	86,639,402
Service Date prior to Birth Date – Edit 102	637,238
Transportations Claims-Modifier Invalid for Submitted Procedure Code – Edit 927	2,201,086
Transportation Claims-Procedure Code Modifier Missing – Edit 1344	177,456
Transportation Service Performed During Inpatient Stay – Edit 02062	30,843
Total	**$ 1,827,123,541**

Compliance Initiatives

NYS Social Services Law §363-d and 18 NYCRR Part 521 outline the specific criteria for determining which providers are required to adopt and implement a compliance program. For these providers, an effective compliance program is required in order to be eligible to receive Medicaid payments or submit claims for Medicaid services.

Certification and Review

Annually in December, Medicaid providers subject to the mandatory compliance program obligation must submit a certification via OMIG's website, stating that their compliance programs meet statutory and regulatory requirements. In 2015, the total number of providers meeting the annual certification obligation increased by more than ten percent from 2014. The increase in certifications and in OMIG's universe are due in part to OMIG's expanded outreach efforts to providers and OMIG receiving information from MCOs on amounts paid to the MCOs' network providers, respectively.

OMIG conducts compliance program reviews of Medicaid providers subject to the mandatory compliance program obligation. As part of these reviews, all reasonable steps are taken to work with providers to assist them in meeting these compliance obligations. OMIG reserves the right to conduct unannounced follow-up reviews to confirm the provider has corrected any previously identified insufficiencies.

Corporate Integrity Agreements

OMIG imposes Corporate Integrity Agreements (CIA) on certain providers that OMIG determines have committed unacceptable practices, but whose removal from the Medicaid program would negatively impact beneficiary access to necessary services. The CIA allows for strict oversight of a provider. Providers under a CIA are subject to monitoring that includes, but is not limited to, annual claims reviews, cost reporting reviews, and compliance program reviews. OMIG's monitoring of Medicaid providers' performance under the terms of CIAs resulted in more than $13 million in cost savings to the Medicaid program in 2015. CIAs are imposed for a five year term.

Management of CIAs requires coordination and collaboration within OMIG divisions as well as with other state and federal agencies. During 2015, OMIG collaborated with DOH, OPWDD, MFCU, and HHS OIG on issues related to changes being made to providers' reimbursement rates, the CIA provider's performance in meeting Medicaid program requirements, unacceptable practices for Medicaid providers being considered for a CIA, and other enforcement matters.

Education and Outreach

In addition to presentations and webinars, OMIG's education and outreach to providers includes publication of a compliance self-assessment form and other compliance-related guidance. General compliance guidance was supplemented in 2015 with the publication of three Delivery System Reform Incentive Payment (DSRIP) Compliance Guidance documents. OMIG also participated with DOH on two DSRIP-related open conference calls with the public, and included DSRIP matters in presentations to trade and provider groups. Additionally, during National Compliance week, in November 2015, OMIG posted a nine-part webinar series addressing the general compliance obligation and the seven areas that apply to a compliance program. These webinars were approved by the Health Care Compliance Association for Compliance Continuing Education credits and by the NYS Continuing Legal Education Board for Continuing Legal Education credits (4.5 credits for the nine-part webinar series) to attendees at no cost. Along with the recorded webinars, OMIG provided 12 in-person program integrity compliance presentations to a number of audiences including the U.S. DOJ Medicaid Integrity Institute in South Carolina, Medicaid provider trade associations, and various compliance focused conferences across NYS.

In 2015, OMIG issued more than 30 compliance-related guidance materials, conducted over 20 educational presentations and webinars, and published articles in DOH's *Medicaid Update*. The compliance section of OMIG's website had 36,000 visits to compliance webinars, 25,000 visits to compliance publications and 40,000 visits to compliance resources and FAQs. OMIG also responded to 1,577 telephone calls and 766 emails on various compliance topics.

Collaborative Activities

Transfer of Recipient Eligibility Functions

With the inception of NYSoH, the State now determines eligibility for recipients to receive Medicaid, removing the responsibility from the LDSS and NYC HRA. LDSSs have begun referring all complaints regarding eligibility they receive through their own fraud hotlines to OMIG when the Medicaid case was opened by NYSoH.

In 2015, OMIG coordinated with DOH to obtain NYSoH data for Medicaid recipients who may have submitted false information to obtain benefits. OMIG continues to work closely with DOH to strengthen its awareness of possible fraudulent information provided during the NYSoH enrollment process, and receives referrals from DOH when fraud is suspected. If recipient fraud is identified, OMIG refers the case to the appropriate law enforcement agency for prosecution.

OMIG, MFCU and DOH Update Policy Manuals

Private Duty Nursing

OMIG and MFCU met in August 2015 to identify issues related to accurate and complete recordkeeping by private duty nurses. OMIG staff, in collaboration with MFCU, proposed updates to current policy guidelines to address the identified problems. These updates include significant changes to nursing recordkeeping requirements, additional clarification of unacceptable practices, and clearer definitions of the duties and responsibilities of private duty nurses providing services to Medicaid beneficiaries.

These changes will allow DOH and OMIG to better protect the Medicaid beneficiaries being served, while also improving the integrity of the program.

In September 2015, OMIG and MFCU met with DOH and presented the suggested changes. DOH issued the updated Private Duty Nursing Manual Policy Guidelines on June 1, 2016, which incorporated the OMIG/MFCU recommendations.

Transportation

On September 21, 2015, OMIG and MFCU staff met with DOH transportation policy staff to discuss incorporating additional program integrity requirements to existing policy. OMIG and MFCU gave a joint presentation, which was followed by discussions where DOH agreed with the proposals to improve program integrity within the Medicaid transportation program. The changes include requiring a driver signature and attestation on trip documentation, driver's license and vehicle plate information on taxi/livery claims, and ending the practice of subcontracting Medicaid transportation services. These additions are necessary to support that services were in fact provided and to document who provided the services. Ending subcontracting prevents the use of unauthorized or excluded providers from furnishing services. DOH issued a policy statement in the December 2015 edition of the *Medicaid Update*, detailing these requirements.

Medicaid Integrity Contract Audits

As part of a federally required Medicaid program integrity project, OMIG continued to collaborate with IPRO auditors contracted by CMS to conduct audits of paid Medicaid claims from various Medicaid providers. OMIG assisted in identifying audit areas and targets, evaluated the proposed audit targets, and assembled audit universes and samples.

IPRO Medicaid Integrity Contract audit areas included diabetic test strip supplies, OASAS inpatient chemical dependence rehabilitation treatment services, and physician services. Overpayments identified for the finalized 11 audits totaled more than $2 million.

Electronic Health Records Incentive Payment Program

Through the EHR Incentive Program, eligible hospitals and health care practitioners in NYS applied for financial incentives to move from a paper-based system of maintaining patient records to a certified EHR. As part of their Adoption, Implementation, and Upgrade (AIU) attestations in the first year of participation in the Medicaid EHR Incentive Program, providers were required to supply documentation that, at a minimum, demonstrated either a binding financial commitment (such as a contract) or actual expenditures for AIU activities to a certified EHR technology. Each system must be certified by the Office of National Coordinator for Health Information Technology as meeting required standards and specifications.

For a provider's subsequent years of participation, the phases of meaningful use (MU) are defined by the use of certified EHR technology in a meaningful manner (e.g., electronic prescribing), for exchanging patient clinical data between healthcare providers, healthcare providers and insurers, and healthcare providers and patients. Given this, it is not enough for providers to simply own a certified EHR; providers must also demonstrate that they are using their EHRs in ways that positively affect the care and outcomes of their patients. To do this, providers are required to meet all MU objectives and measures as defined by CMS, such as maintaining active medication and active medication allergy lists, for each phase of the program to be considered a meaningful user.

The majority of the audits conducted in 2015 were for MU. In 2015, OMIG finalized 74 audits with identified overpayments of more than $2 million.

In addition, OMIG collaborated with DOH on activities related to the design and development of the NYS MMIS, and the EHR Incentive Program Provider Attestation Portal as DOH transitions to a new fiscal agent. In this effort, OMIG participates in meetings and workgroups related to EHR post-payment audit requirements, processes, and activities on a regular basis.

OMIG and OMH Comprehensive Outpatient Program Supplemental Reconciliation Project

OMIG continued its joint project with OMH to identify and recover Medicaid payments from providers of mental health services who have exceeded their prior yearly thresholds for Level I and Level II Comprehensive Outpatient Program Supplemental (COPS) and Community Support Program (CSP) payments. These supplemental payments are paid in addition to a provider's base Medicaid rate, and serve as a deficit-funding mechanism. The amount of Level I and Level II COPS and CSP payments that a provider can retain in any fiscal year is limited to a specific OMH calculated COPS/CSP threshold. The threshold amounts are both provider and program specific. Level I and Level II COPS and CSP received by a provider in excess of a specific year's threshold amount are recouped by the State. In 2015, nine audits were finalized identifying $4.2 million in overpayments.

Collaboration between OMIG Bureau of Rate Audit and DOH

OMIG is working with DOH's Bureau of Long Term Care Reimbursement to develop a plan to streamline the appeal process for the capital component of nursing home Medicaid rates. Instead of filing appeals to correct inaccuracies on an issued rate, nursing homes will be issued a proposed capital rate prior to the beginning of each rate year. The nursing homes will have the opportunity to self-correct the proposed rate to eliminate any inaccuracies and submit back to DOH what they believe to be the correct rate. The revised rate submissions must be accompanied by an attestation completed by the facility confirming the accuracy of the rates. The attested to rates will be reviewed by DOH in a timely and be subject to immediate audit by OMIG. This process will efficiently resolve rate appeals, and serve as a tool for targeting new audits.

Licensed Practical Nurse Signoffs on Annual Health Assessments

OMIG auditors identified instances where LPNs were signing off on annual health assessments and making a final decision on the results of a Purified Protein Derivative (PPD) skin test. As part of the statewide TBI audits conducted by OMIG, the personnel file of the caregivers were examined. OMIG identified four providers where LPNs were assessing the results of a PPD test. According to the Nursing Guide to Practice published by NYSED, LPNs do not have assessment privileges in NYS. This determination was made in collaboration with staff in the Home and Community-Based Waiver program within OHIP. Regulations are already in place to prohibit this practice, and OMIG plans to further address this issue with providers through collaborative efforts with DOH.

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 2015, OMIG conducted investigations and imposed administrative actions based upon:

- investigations 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 Office of Professional Medical Conduct 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 1,020 exclusions and 222 censures in 2015. The NYS Medicaid Exclusion List contains 5,901 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.

Sanctions By Type

Administrative Actions	Number of Actions
Censures	222
Affiliations – 18 NYCRR 504.1(d)(1)	50
Unacceptable Practice – 18 NYCRR 515.2	19
Indictments – 18 NYCRR 515.7(b)	185
Convictions – 18 NYCRR 515.7(c)	249
Imminent Danger – 18 NYCRR 515.7(d)	13
Professional Misconduct – 18 NYCRR 515.7(e)	208
Mandatory Exclusion – 18 NYCRR 515.8	296
Grand Total	1,242

CONCLUSION

OMIG appreciates the opportunity to share the results of its Medicaid program integrity activities for 2015. 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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