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2016 ANNUAL REPORT

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Message from the Inspector General

I am pleased to share the New York State (NYS) Office of the Medicaid Inspector General's (OMIG) 2016 Annual Report. Nationally recognized for its efforts to protect the integrity of the state's Medicaid program, OMIG plays a vital role in saving taxpayer dollars, while promoting high quality patient care for Medicaid beneficiaries throughout the State.

In 2016, OMIG's comprehensive program integrity efforts resulted in more than $418 million in Medicaid recoveries. In addition, the Agency's proactive cost-avoidance initiatives, which prevent inappropriate payments from being made, delivered cost savings of over $1.9 billion in 2016, an increase of more than $80 million over 2015.

To root out Medicaid fraud, waste, and abuse, OMIG works both independently and in collaboration with partners at all levels, including law enforcement, provider organizations, and managed care organization special investigation units (SIU). Throughout 2016, OMIG investigators, data analysts, and other staff played a critical role in collaborative law enforcement actions that resulted in the takedown of major fraud schemes, arrests for enrollment fraud, and drug diversion cases.

Also in 2016, OMIG was active in the fight against the nationwide opioid abuse epidemic. Working closely with its law enforcement partners, OMIG's efforts helped secure the convictions of dozens of individuals for their actions related to illicit pill mills, fraudulent health clinics, and other drug-diversion schemes. These efforts helped our partner agencies secure hundreds of millions in restitution from those convicted.

A key tool in OMIG's arsenal to address the opioid epidemic is its Recipient Restriction Program (RRP). RRP addresses a Medicaid recipient's ability to obtain duplicate prescription fills through doctor or pharmacy shopping. Under the program, Medicaid recipients suspected of overuse or abuse are restricted to a single designated provider, pharmacy, or both. In 2016, more than 3,700 Medicaid recipients were recommended for restriction to the appropriate Medicaid managed care organization (MCO), county agency, or the New York State of Health (NYSoH) for implementation. These RRP efforts resulted in more than $78 million in cost savings to the Medicaid program.

As a member of the Federal Healthcare Fraud Prevention Partnership, OMIG worked closely with the Centers for Medicare and Medicaid Services (CMS), the United States Department of Justice (DOJ), the Federal Bureau of Investigations (FBI), and national health insurance companies to identify practices and strategies to address opioid prescription abuse. As a result of this collaboration, in January 2017, the Partnership released a white paper entitled *Healthcare Payer Strategies to Reduce the Harms of Opioids,* which describes best practices to address the dangers of opioids while ensuring access to necessary therapies and reducing fraud, waste, and abuse.

OMIG's statistics for its 2016 enforcement activities are robust, opening 3,493 investigations and completing 4,417 investigations. Cases referred to law enforcement and other agencies for further action totaled 1,078, including 155 to the NYS Attorney General's Medicaid Fraud Control Unit (MFCU), 352 to New York City Human Resources Administration (NYC HRA), and 571 to other federal, local and state entities. In addition, OMIG issued 936 Medicaid exclusion actions in 2016.

In the managed care arena, OMIG's Managed Care Investigation Unit investigates complaints received from MCOs relating to network provider fraud, and works with their SIUs to develop comprehensive investigative plans. For 2016, referrals from MCOs to OMIG totaled 518, up from 321 referrals in 2015.

Additionally, OMIG worked closely with the NYS Department of Health (DOH) in developing amendments to the NYS Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract (Model Contract) to enhance program integrity. These amendments include: the creation of a clearance process to ensure that OMIG and MCOs are not duplicating audit and investigative efforts; the submission by each MCO of a quarterly report showing all Medicaid overpayments it has identified or recovered; a provision enabling OMIG to obtain MCO assistance in recovering overpayments made to network providers identified by the State; and allowing an MCO to share in recoveries made as a result of a referral to OMIG.

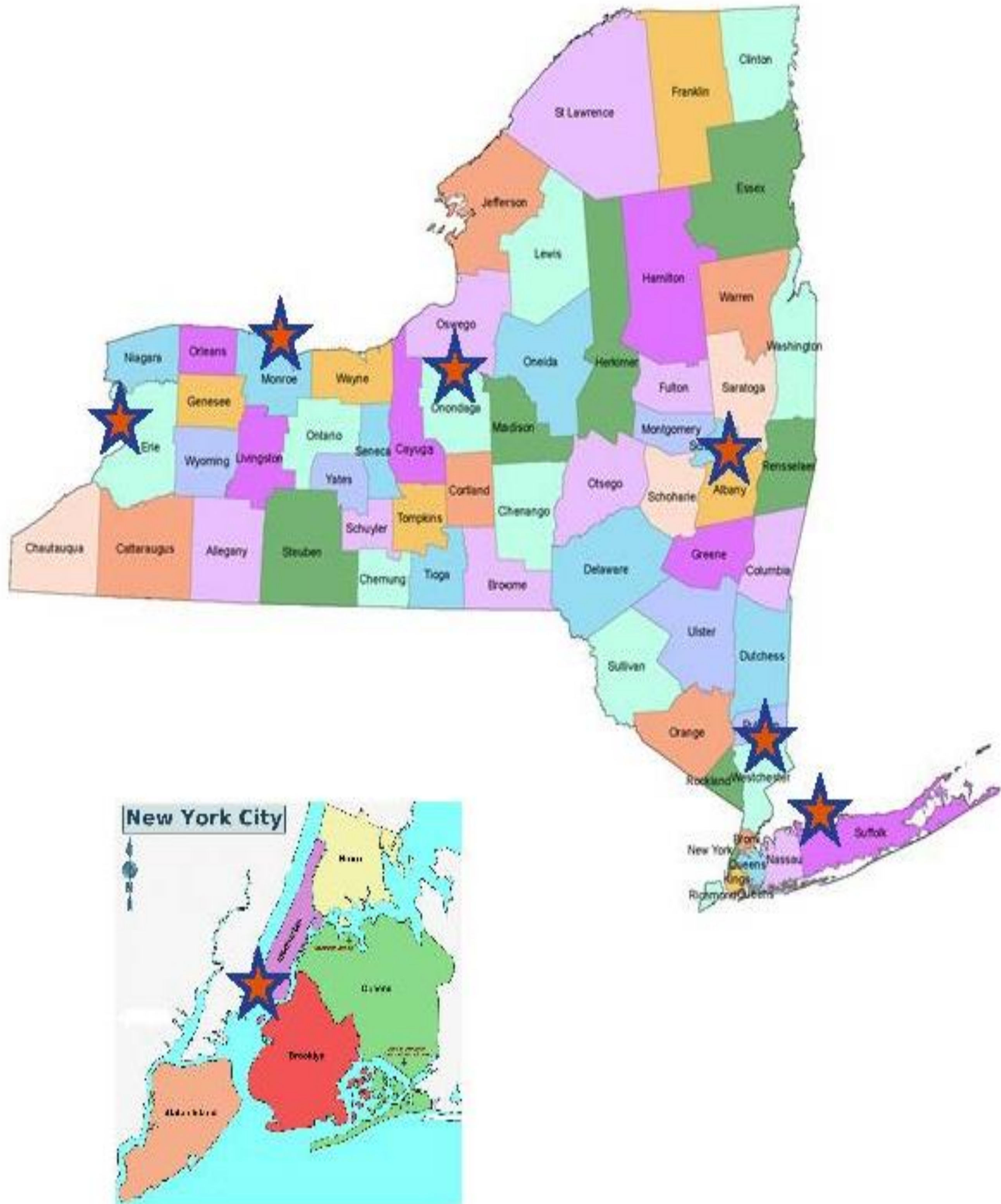
Throughout 2016, OMIG emphasized provider outreach and education, particularly in the area of compliance. Through a comprehensive array of webinars, guidance materials, self-assessment tools, protocols, and presentations, OMIG's oversight activities and educational efforts serve to increase provider accountability, contribute to improved quality of care, and save taxpayers' dollars. In 2016, OMIG issued 15 compliance-related guidance materials and conducted more than a dozen educational presentations and webinars. The compliance section of the OMIG website is among the site's most active areas, with close to 40,000 visits to compliance webinars, over 30,000 visits to compliance publications, and more than 40,000 visits to compliance resources and FAQs. In addition, many of OMIG's webinars are accredited for legal, accounting, or compliance continuing-education credits. In 2016, 439 participants received credits, up from 428 in 2015.

With the transformational changes occurring in the Medicaid program, OMIG's commitment to protecting the integrity of the program and ensuring a cost-effective sustainable healthcare delivery system remains unwavering.

Sincerely,

DENNIS ROSEN
MEDICAID INSPECTOR GENERAL

The Medicaid Inspector General 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 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

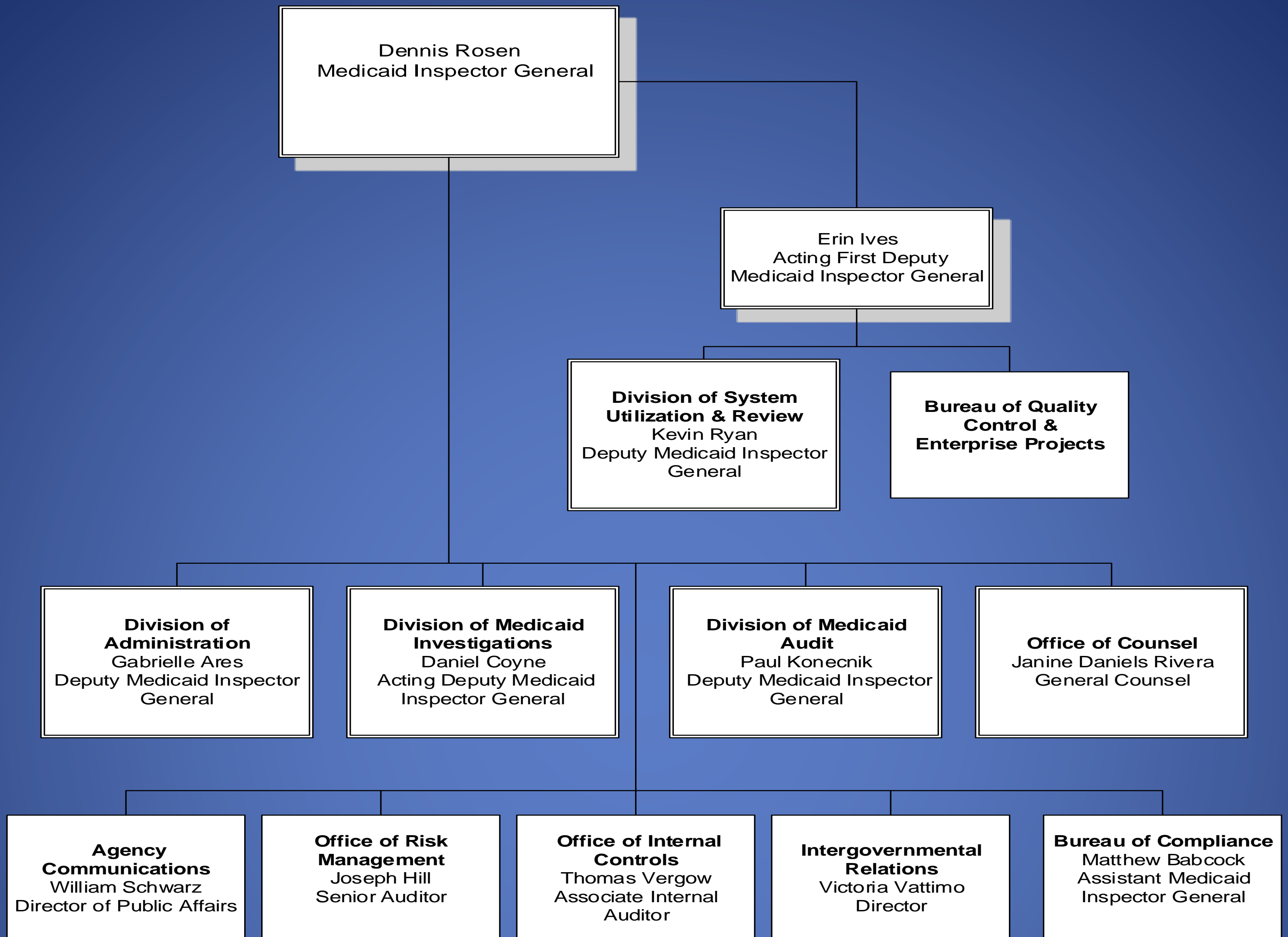
The mission of OMIG is to enhance the integrity of the NYS Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds, while promoting a high quality of patient care.

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 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, and stipulation of settlements.

OMIG Organizational Chart



2016 Program Integrity Activities

OMIG conducts and oversees program integrity activities that prevent, detect, and investigate Medicaid fraud and abuse. OMIG coordinates such activities with other NYS agencies such as DOH, the Office for People with Developmental Disabilities (OPWDD), 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 (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 by applicable regulations and laws, to refer cases to MFCU and/or other appropriate law enforcement entities.

Executive Initiatives

OMIG's Response to the Opioid Epidemic

Opioid addiction and its cost in lives and dollars has become a recognized national public health crisis. To combat opioid abuse in the NYS Medicaid program, in 2016 the OMIG RRP created specific data searches to detect alleged drug diversion. Collaboration across OMIG divisions and with other agencies has also been increased with the objective of coordinating efforts to combat opioid abuse. OMIG staff meets monthly to discuss ongoing drug diversion investigations, findings, and future program integrity projects related to opioid abuse. OMIG's Recipient Investigation Unit (RIU) has increased its presence with state and local law enforcement drug task forces, so as to share trends and information as it relates to drug diversion investigations.

Opioid Surveillance Task Force

OMIG staff participates on the Governor's Opioid Surveillance Workgroup/Task Force. Some of the objectives of the Task Force include:

- Coordinating surveillance efforts to support Center for Disease Control grants and state initiatives.
- Quickly responding to data needs by major stakeholders.
- Providing data presentations at state, regional, and county levels for better identification of high-burden areas and targeted interventions.
- Providing data technical support: identify and evaluate new data sources and measures.
- Facilitating data and information sharing and communication.
- Conducting evaluation/special analytic projects.
- Launching of "Opioid-related Data in NYS" website in 2016 https://www.health.ny.gov/statistics/opioid/

Project Teams

OMIG's executive staff sponsored a 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 providing guidance and direction to the PMO.

OMIG's five 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

Medicaid Systems Toolkit

As a training tool, the Data Project Team developed a Medicaid Systems Toolkit. OMIG staff were surveyed for their input regarding what types of information would be useful for training purposes. Each Medicaid data system consists of various formats, data elements, permissions, and access points. The Toolkit provides information about the Medicaid Data Warehouse (MDW), Encounter Intake System (EIS), eMedNY, the Provider Network Data System, and Salient.

The Toolkit provides an overview of each Medicaid data system, tool, and report to help both new and current OMIG employees become familiar with:

- What data systems, tools, and reports are available;
- Why they are used throughout the agency;
- How to gain access to a system, tool, or report;
- Where to go for more information; and
- How to troubleshoot concerns about each data system, tool, or report.

Managed Care Organization Summary Tool

The Data Project Team developed an MCO Summary Tool which makes managed care provider payment information available to all OMIG audit and investigative staff, in a timely and usable format. This excel-based interactive toolset enables OMIG staff to easily analyze data and information about the relationships between MCOs and both enrolled and non-enrolled network providers. This tool is refreshed monthly, allowing staff access to current summaries of managed care provider payments by MCO and by provider.

Contract Updates

MCCPRM proposed, negotiated, and finalized amendments to the October 1, 2015 Model Contract. These amendments include provisions addressing the recovery of overpayments, the referral of fraud and abuse by MCOs, and enhanced program integrity reporting. These provisions will strengthen OMIG's role as the NYS Medicaid program continues to transition to managed care, increase coordination and cooperation between OMIG and the MCOs, and protect the integrity of the Medicaid program. These amendments are currently under CMS review.

In the fall of 2016, MCCPRM began the process of proposing and negotiating amendments to the managed long-term care (MLTC) contracts. This began with the Medicaid Advantage Plus contract. In addition to the provisions added in the Model Contract, MCCPRM developed proposals specific to MLTC, working closely with MFCU, which will strengthen OMIG's audit and investigative activities in MLTC.

Pharmacy

In 2016, the Pharmacy Project Team developed a clearance process for pharmacy network provider reviews to prevent duplication of audit efforts between OMIG, MCOs, and the Pharmacy Benefit Managers (PBM). While the clearance process was being developed, a need for an audit notification process between OMIG and MCOs was identified. Subsequently, a workgroup was established to develop a process for notifying MCOs of OMIG's audit activities.

The team also reviewed and compared current MCO contracts with PBMs, and current contracts between the PBMs and the network providers, to gain a better understanding of the monies paid and received for pharmacy services. The contract reviews highlighted the differences in pharmacy management services paid for by MCOs, and the network pharmacy services paid for by PBMs.

Network Provider Reviews

The Network Provider Team opened audits of physicians which were contracted with MCOs. Initially facing obstacles with data and contractual arrangements, OMIG staff gained a better understanding of the complexities in reviewing network providers, allowing the team to improve the audit processes. While working on these reviews, staff worked directly with MCOs to verify contractual arrangements and data. Information gathered has shown the need for OMIG to increase its role in managed care oversight.

Plan Reviews

The Plan Review Project Team completed development of detailed audit plans and processes to review medical and administrative costs reported by MCOs. These audit plans and processes will assist staff in determining whether mainstream and MLTC MCOs provided NYS with complete and accurate information in the Medicaid Managed Care Operating Reports (MMCOR). In addition, the team received and conducted various capitation rate development training.

The Project Teams' efforts provide necessary cross-divisional education development and communication to ensure audits and investigations are conducted appropriately and efficiently.

Managed Care

In NYS, several different types of MCOs participate in Medicaid managed care, including mainstream managed care, health maintenance organizations, prepaid health service plans, 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 regular 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 reviews and 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 system and programmatic concerns. During 2016, these efforts resulted in 395 finalized audits with over $94 million in identified overpayments. Highlights of managed care audit activities are described below.

Managed Care Retroactive Disenrollment Monitoring/Recovery Efforts

When a managed care monthly premium payment is inappropriately made to an MCO due to eligibility errors or untimely eligibility file updates, NYSoH, Local Departments of Social Services (LDSS), and 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.

OMIG issues retroactive disenrollment audit reports to MCOs that fail to void the premium payments after having been requested to do so by the other agencies and/or have enrollees that have been reported to OMIG as being retroactively disenrolled. During 2016, more than $46 million was identified in overpayments through this retroactive disenrollment project. OMIG continues to collaborate with the MCOs, NYSoH, LDSS and NYC HRA to identify issues, provide educational materials, and modify retroactive disenrollment procedures to accommodate the dynamic managed care environment.

Family Planning Chargeback

Federal law states that access to family planning and reproductive services cannot be restricted for Medicaid recipients. As a result, Medicaid managed care enrollees may receive these services from any fee-for-service (FFS) Medicaid provider, without referral or prior approval from the MCO. If the enrollee's MCO includes family planning and reproductive services as part of its benefit package, the Model Contract includes a chargeback provision. Under this provision, if a managed care enrollee seeks treatment from a provider outside the

MCO network, the provider is compensated by Medicaid, and the MCO agrees to reimburse Medicaid for the payments made to the non-network provider. OMIG works with DOH to develop the criteria to identify these family planning services and reconcile the claims subject to the chargeback with the MCO. In 2016, OMIG finalized 20 audits and identified overpayments of $6.9 million.

Managed Long-Term Care

The MLTC Partial Capitation program allows for high acuity Medicaid enrollees to receive care in their home and community. OMIG's reviews ensure enrolled recipients are eligible for the program, and that appropriate care management is being provided by the MLTC plans. In order for an enrollee to qualify for the MLTC program, 120 days of community-based long-term care services (CBLTCS) must be received. The MLTC plan is responsible for the care management of their enrollees, to ensure the care has been determined to be medically necessary and it has been received by their enrollees. Through OMIG's efforts in collaboration with DOH, enrollees are now assessed by a third-party entity to determine if they are eligible to qualify for this program, which was originally a responsibility of the MLTC Plans. In 2016, seven audits were finalized, identifying over $11 million in overpayments.

Managed Care Recipient Restriction Program Reviews

OMIG's RIU conducted focused reviews of the RRPs with key personnel of three MCOs. The purpose of the managed care RRP reviews is to assess the effectiveness of the MCOs restriction programs and to ensure they were compliant with Appendix Q "*New York State Department of Health Recipient Restriction Program Requirements for MMC and FHPlus Programs*" of the Model Contract. These reviews revealed best practices, which included how MCOs structure their RRPs and followed up after a restriction has been implemented on a recipient. Other discussions included strengthening communications between OMIG and MCOs, and how MCOs can improve their identification of recipients for restriction.

Audits

OMIG conducts audits of Medicaid services provided to beneficiaries. The objectives of the audits are to assess the 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 2016, OMIG finalized 335 FFS audits which resulted in identified overpayments of more than $51 million. The most common audit findings identified by OMIG's FFS auditors were missing, late, or not properly authorized plan of care documentation. These care plans may have different titles across all audit types, but they form the fundamental 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 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.

Long-Term Home Health Care Program Audits

Long-term home health care programs (LTHHCP) must be a certified home health agency (CHHA), however, they have specific regulatory and documentation requirements in addition to what is required of the CHHAs. LTHHCPs provide comprehensive services in the home for individuals who might otherwise be in a nursing home. These services are intended to promote, maintain and/or restore health, or lessen the effects of illness or disability. LTHHCP services are enhanced under the Home and Community-Based Services (HCBS) federal waiver.

Six audits of LTHHCPs were completed in 2016. Two key findings were that the NYS Long Term Placement Medical Assessment Abstract (DMS-1) and the Home Assessment Abstract were not documented, incomplete, or completed late. These documents are required to determine the patient's current medical condition and if the patient's total health, social, and environmental care can be met in the home environment. Additional findings involved caregivers who failed to complete required in-service training, and instances where the minimum training standards were not met for home health aides. OMIG auditors also found hours/visits billed that lacked documentation, services billed in excess of ordered hours, and signatures of the authorizing practitioner that were not obtained within the required time frame.

OASAS, OMH, and OPWDD Audits

In 2016, OMIG continued its audits of Medicaid-funded services for mental hygiene programs. OMIG finalized 17 audits identifying $8.1 million in overpayments for substance abuse disorder services. The audit findings included missing treatment plans, discharge plans, discharge summaries, and lack of physician oversight of the treatment planning process. In 2016, OMIG finalized nine audits for more than $1.8 million in identified overpayments for mental health services. Identified errors involved use of incorrect rate codes, missing treatment plans, failure to ensure proper duration of service delivery, and lack of oversight of service plans by qualified mental health service providers.

OMIG continued to audit HCBS waiver billings for developmental disability services finalizing nine audits identifying $3.5 million in overpayments. Identified errors included failure to forward revised habilitation plans to the service coordinator within 30 days, missing required elements of habilitation plans, staff members identified as delivering service who were absent on the date of service, and missing habilitation plan reviews.

Minimum Data Set Reviews

Minimum Data Set (MDS) is an important tool that nursing homes use to evaluate each resident and develop a plan to provide the services that best meet the resident's needs. MDS data submissions to DOH's Bureau of Long Term Care Reimbursement (BLTCR) are used 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, initiated reviews of the accuracy of the semi-annual nursing home MDS submissions. The objective of these reviews is to verify that the MDS information submitted by the nursing home was an accurate representation of each resident's medical condition, functional abilities, and care needs. OMIG finalized 353 reviews resulting in identified overpayments of more than $13.9 million.

System Match and Recovery Projects

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 374 reviews with identified overpayments of over $5 million. The following reviews contributed to these findings:

- FFS claims submitted which duplicate services that are reimbursed as part of rate-based payments to facilities.
- Duplicate payments that occur when one claim crosses over from Medicare, and a second claim is billed directly by the provider to Medicaid for the same service.

Duplicate Pharmacy Project

Under this project, providers who received duplicate pharmacy payments were reviewed. An example of these payments would be, the provider receives payment as a result of a Medicare crossover claim and also receives a second payment by directly billing Medicaid for the same specifications (i.e., same drug, on the same date of service, for the same recipient, with a pharmacy claim containing the specific drug's National Drug Code number). For this project, OMIG finalized 193 audits with identified overpayments of more than $3.1 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 (ACA) and New York's Compliance Program obligations under Title 18 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 2016, OMIG's self-disclosure unit finalized 217 audits with identified overpayments of more than $11.6 million.

2016 Initiated Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	16	8	12	0	36
Managed Care	253	69	57	0	379
Medicaid in Education	3	5	5	0	13
Fee-For-Service	478	128	146	5	757
Rate	17	7	18	0	42
Self Disclosure	102	86	62	3	253
System Match Recovery	177	19	26	18	240
Total	1,046	322	326	26	1,720

2016 Finalized Audits by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	8	2	4	0	14
Managed Care	258	65	68	4	395
Medicaid in Education	0	0	4	0	4
Fee-For-Service	203	52	65	15	335
Rate	99	112	156	0	367
Self Disclosure	89	66	61	4	220
System Match Recovery	276	28	43	27	374
Total	933	325	401	50	1,709

2016 Overpayments Identified for Recovery by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	$ 3,558,882	$ 139,417	$ 284,507	$ 0	$ 3,982,806
Managed Care	66,734,462	14,386,291	13,015,662	81,192	94,217,606
Medicaid in Education	0	0	120,710	0	120,710
Fee-For-Service	38,064,288	3,492,156	5,708,734	4,279,429	51,544,607
Rate *	(278,898)	3,591,648	5,853,524	0	9,166,274
Self Disclosure	7,883,495	2,444,943	1,671,178	41,744	12,041,361
System Match Recovery	4,214,690	272,786	347,871	238,597	5,073,944
Total	$120,176,919	$24,327,241	$27,002,186	$ 4,640,962	$176,147,308

2016 Overpayments Recovered by Region					
Audit Department	Downstate	Upstate	Upstate Western	Out of State	Total
County Demonstration Program	$ 1,342,542	$ 366,062	$ 110,413	$ 0	$ 1,819,018
Managed Care	71,744,775	15,253,444	14,265,686	81,192	101,345,097
Medicaid in Education	0	7,978	74,403	0	82,381
Fee-For-Service	36,594,781	3,676,836	4,221,028	2,598,928	47,091,573
Rate	2,861,272	4,607,093	8,048,577	0	15,516,942
Self Disclosure	4,897,419	2,620,233	1,341,379	1,888	8,860,919
System Match Recovery	4,606,573	262,055	450,823	494,558	5,814,009
Total	$122,047,362	$26,793,701	$ 28,512,309	$ 3,176,566	$ 180,529,939

*Audit Overpayments identified for recovery were lowered due to stipulations issued in 2016 related to final audit reports issued in prior reporting periods.

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 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 2016, BBI processed the following requests:

➢ 1,617 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) activities;
  ❖ System Match audits;
  ❖ CMS Payment Error Rate Measurement audit;
  ❖ Office of the State Comptroller audits;
  ❖ U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) audits;
  ❖ Island Peer Review Organization (IPRO) audits;
  ❖ Self-disclosure reviews.

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

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

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 Summations	
Audit Department	2016
County Demonstration Program	11
Managed Care	1
Medicaid in Education	11
Fee-For-Service	284
Rate	453
Total	760

Third-Party Liability

Medicaid is the payor of last resort; however, there are times when Medicaid payments are made on claims for which third-party liability was not known or available 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. OMIG initiated several projects with the RAC to perform reviews of services rendered to beneficiaries that are dually eligible for Medicare and Medicaid. OMIG facilitated the exchange of Medicare data with the CMS Medi-Medi contractor to enhance the RAC's ability to identify potential overpayments that would likely not be identified by reviewing Medicaid claims data alone. RAC projects that utilized the combined Medicare/Medicaid data include, but are not limited to, incorrect Medicare coinsurance, inpatient duplicate claims, no Medicare deductible remaining, incorrect Medicare patient liability, and incorrect reporting for individuals with Medicare Part C eligibility. In 2016, the RAC recovered more than $18 million in Medicaid overpayments.

Medicaid Maximization Project

OMIG contracts with the University of Massachusetts Medical School (UMass) to maximize Medicare reimbursement for dual eligible Medicare/Medicaid recipients who have received home health care services paid by Medicaid. Since Medicaid is always the payor of last resort, when a beneficiary is eligible for both Medicare and Medicaid, or has other third-party insurance benefits, the provider must bill Medicare or the other third-party insurance first for covered services prior to submitting a claim to Medicaid. UMass identifies home health providers who have not billed Medicare for home health services paid by Medicaid and directs the provider to bill Medicare for those services. Through an appeals process, UMass also pursues Medicare coverage for claims that were denied payment by Medicare at initial determination and paid by Medicaid. In 2016, over $10 million was recovered as a result of this project.

2016 Third-Party Liability and RAC Recoveries		
Activity Area	Amount	
Third-Party Liability	$	108,196,165
Casualty & Estate		98,256,636
Recovery Audit Contractor		18,629,294
Home Health Care Demonstration Project		10,140,109
Self-Disclosed TP Health Insurance		1,270,657
Total	$	236,492,861

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 (EOMB) letters, and interviews of complainants and subjects. Investigations can lead to administrative actions and sanctions. 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	334	454	227	230	1	3	562	687
District Attorney	13	3	0	0	0	0	13	3
Enrolled Recipient	83	131	54	55	4	5	141	191
Federal Agencies	96	174	14	26	6	5	116	205
Fiscal Agent Fraud Unit	13	2	1	0	0	0	14	2
General Public (Non-enrolled)	185	278	154	160	3	5	342	443
Law Enforcement	0	9	0	1	0	2	0	12
Local Departments of Social Services	12	19	100	94	0	0	112	113
Managed Care Plans	304	308	197	193	17	14	518	515
Non-Enrolled Provider	3	5	9	1	0	0	12	6
Non-Enrolled Recipient	1	0	1	3	0	0	2	3
Provider	58	116	82	70	1	1	141	187
Qui Tam	0	0	0	1	0	4	0	5
State Agencies (including OMIG)	1,146	1,555	289	356	85	134	1,520	2,045
Total	**2,248**	**3,054**	**1,128**	**1,190**	**117**	**173**	**3,493**	**4,417**

Anesthesiologist Sentenced for Unlawfully Dispensing Oxycodone Pills

OMIG, HHS OIG, the NYC Police Department, and the Drug Enforcement Administration (DEA) commenced a joint investigation in 2014 of a licensed anesthesiologist who was allegedly involved in a drug trafficking ring.

OMIG provided the DEA and HHS OIG with computer background checks, including NY physician profile, NYS Office of Professional Medical Conduct hearing report, National Insurance Crime Bureau, eJustice NY, criminal history, Healthgrade inquiry, Department of Motor Vehicles (DMV) check, Accurint, Salient, and MDW reports. OMIG also provided other evidence obtained from pharmacy enrollment inspections.

The anesthesiologist allegedly wrote more than 10,000 medically unnecessary oxycodone prescriptions in a two-year period, resulting in the unlawful distribution of nearly 1.2 million oxycodone tablets with a street value of at least $36 million. The provider also allegedly collected more than $2 million in fees for "doctor visits" during this time. The provider was arrested on federal charges including conspiracy to distribute, and possession with intent to distribute oxycodone.

* Investigations completed may represent cases opened in prior periods.

The provider was found guilty on all counts March 17, 2016 and on September 28, 2016, the United States Attorney for the Southern District of New York, announced that this provider received a sentence of 160 months in prison, forfeiture of $2,046,600 to the Federal government, and three years of supervised release. Ten other individuals have pled guilty in connection with this investigation.

Explanation of Medicaid Benefits Leads to Investigation

OMIG received multiple responses from Medicaid recipients stating they had not received the durable medical equipment (DME) billed for by a DME provider, as indicated on the EOMBs. OMIG's subsequent investigation incorporated EOMBs, interviews with the recipient complainants, surveillance, and DMV and various database searches. As a result of the investigation, OMIG referred the DME provider to MFCU.

The owner pled guilty to Grand Larceny in the 2nd Degree on September 30, 2016. On December 7, 2016, the owner received a sentence of two to six years incarceration and was ordered to pay restitution to the Medicaid program in the amount of $2,002,253, jointly and severally with the DME provider for submitting false claims defrauding the Medicaid program.

OMIG Referral to MFCU Leads to Arrest of Not-for-Profit Organization Owner

On June 20, 2016, the NYS Attorney General announced the arrest of the owner of a not-for-profit provider, for allegedly defrauding Medicaid of over $5 million. This organization helped developmentally disabled New Yorkers find affordable housing.

It was alleged that potential clients were lured into providing personal medical information, subjected to medically unnecessary exams and procedures, and had their Medicaid identification numbers used by the owner and his employees to file false Medicaid claims.

OMIG staff worked extensively on the investigation leading to the owner's arrest, including providing data and analysis, reviewing financial information, gathering and reviewing background information, coordinating with multiple agencies, and assisting MFCU in the execution of search warrant activities. In late 2016, the owner was hospitalized with a serious illness, and passed away before being tried on these charges.

Program Integrity Referrals to MFCU and Other Agencies

OMIG is required by NYS 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	2016
Clinical Psychologist	4
Clinical Social Worker	1
Consumer Directed Aide	1
Diagnostic and Treatment Center	1
Enrolled Recipient	5
Home Health Agency	9
Hospital	1
Managed Long Term Care	1
Medical Appliance Dealer	1
Multi-Type Group	1
Non-Enrolled Provider	40
Nurse	4
Optician	1
Optometrist	1
Personal Care Aide	12
Pharmacy	19
Physician	34
Physicians Group	2
Service Bureau	1
Social Adult Day Care	1
Therapist	3
Transportation	12
Total	155

Referrals to Other Agencies	
Agency	2016
AG - Not MFCU	2
Law Enforcement Agency	120
Local Departments of Social Services	140
Local District Attorney	10
Local Municipality	2
Managed Care Organizations	1
NYC Department of Buildings	1
NYC Department of Health	4
NYC Department of Sanitation	10
NYC HRA Bureau of Client Fraud Investigations	352
NYC Office of the Special Narcotics Prosecutor	8
NYS Bureau of Narcotic Enforcement	12
NYS Department of Environmental Conservation	14
NYS Department of Financial Services	1
NYS Department of Health	66
NYS Department of Justice	6
NYS DOH- Child Health Plus	1
NYS DOH Office of Professional Medical Conduct	29
NYSED – Not Prof. Discipline	23
NYSED Office of Professional Discipline	79
Office for People with Developmental Disabilities	5
Office of Health Insurance Programs	19
US Attorney	13
US Health and Human Services (HHS-OIG)	5
Total	923

2016 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 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.

2016 Recoveries	
Activity Area	**Amount**
Third-Party Liability	$ 108,196,165
Managed Care	101,345,097
Casualty & Estate	98,256,636
Fee-For-Service	47,091,573
Recovery Audit Contractor	18,629,294
Rate	15,516,942
Home Health Care Demonstration Project	10,140,109
Self Disclosure	8,860,919
System Match Recovery	5,814,009
Investigation Financial Activities	1,845,717
County Demonstration Program	1,819,018
Self-Disclosed TP Health Insurance	1,270,657
Medicaid in Education	82,381
Total	**$ 418,868,517**

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 actions 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 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 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 as needed.

Throughout 2016, OMIG saved NYS taxpayers more than $1.9 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 $1.6 billion in 2016.

Medical and Dental Pre-Payment Review

OMIG utilizes the eMedNY system Edit 1141 to monitor and, when appropriate, deny claims, preventing inappropriate payments from being issued. This system edit is currently being utilized by both the dental and medical pre-payment claims review (PPR) units in OMIG. PPR staff monitor and review the claim submissions of providers who demonstrate aberrant or inappropriate billing practices. Edit 1141 allows the flexibility to tailor the PPRs to each unique case situation. As claims are reviewed, staff work with providers to obtain documentation to determine the appropriateness of the claim. 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 be manual or automatic resolutions, or a combination of both.

Staff often work joint cases with other divisions within OMIG, as well as MFCU, OPD, Department of Transportation (DOT), CMS, Office of Health Insurance Programs (OHIP), and contractors. PPR staff work closely with DOH policy staff and statewide stakeholder associations as needed. The benefit of collaboration is effective program oversight with a corresponding increase in more compliant billing by providers. Provider education is also a key component of the PPR process.

In 2016, the Medical Pended Claims Unit processed 251 claim review cases for transportation, private duty nursing, and medical treatment records. In addition, the Dental Pre-Payment Review Unit manually reviewed 7,713 dental treatment records. These reviews resulted in seven private duty nurses, four dental providers, and ten transportation providers being referred to DMI for additional action.

For 2016, the total cost savings associated with Edit 1141 activities was more than $24 million.

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 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 December 2015, due to a Medicaid policy change, transportation providers can no longer subcontract services provided to Medicaid recipients. In early 2016, discussions between OMIG and DOH policy staff resulted in the decision that new applications for taxi or livery enrollment would no longer be approved if there were providers already enrolled at the same service location for the same category of service. In 2016, EAR added taxi and livery enrollment applications to the list of categories reviewed.

In 2016, EAR reviewed 1,424 new enrollment and reinstatement applications. These reviews resulted in 229 applications being denied, the cost savings associated with these denials was more than $22 million.

Pharmacy Enrollment Denials

While conducting on-site inspections as part of the process to enroll pharmacies, issues related to public health are sometimes uncovered. In one on-site inspection of a pharmacy seeking to enroll in the NYS Medicaid program, OMIG investigators found 20 expired medications on the pharmacy's shelves, along with missing equipment necessary for measuring medication. While reviewing the application, EAR found that the pharmacy has a history of enrollment denials from 1995-2012, based on repeated violations of NYS Education Law, Board of Pharmacy regulations, federal regulations, and Medicaid requirements. This pharmacy's application for enrollment into the NYS Medicaid program was denied.

During a different on-site inspection of a pharmacy seeking to enroll in the NYS Medicaid program, OMIG investigators found numerous deficiencies. The pharmacy reported inflated numbers on its daily logs; a non-pharmacist was found to be signing off on daily logs; the pharmacy was employing sales representatives to recruit specialty physicians who could prescribe high-priced drugs for the pharmacy to fill; the pharmacy's shelves contained expired medications; the pharmacy was filling an average of less than two prescriptions daily; and the pharmacy was not clean or organized. This pharmacy was denied enrollment into the NYS Medicaid program.

Dental Group Enrollment Denial

On-site inspections can also be conducted on dental groups seeking to enroll. During one on-site dental group inspection, OMIG investigators found 113 vials of expired Lidocaine. When investigators requested the required spore test results for the autoclave, which is used to sterilize equipment, the provider indicated that the documentation would be provided when available, since the dentist was unsure of the location of the test results. After the on-site visit, investigators received the documents and determined that the serial number of the machine reported on the test results was found to belong to an unused autoclave machine at a different service address. Licenses and registrations were also not displayed as required. This dental group was denied enrollment in the NYS Medicaid program.

New Managed Care Cost Savings Initiative

Previously, when an OMIG investigation found that a Medicaid recipient was ineligible for benefits due to false information submitted on an application, the recipient's case would stay open due to the Continuous Care Rule in the ACA. In 2016, RIU developed an initiative with DOH to close these cases, thereby preventing them from staying open for an additional 12 months, allowing individuals to fraudulently receive Medicaid benefits. This initiative does not include criminal action cases where a recovery has been made. In 2016, cost savings totaled $109,001.

2016 Cost Savings Activities

Activity Area	Amount
Clinic License Verification	$ 8,453,898
Corporate Integrity Agreement Sentinel Effect	2,211,623
Dental Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	1,108,271
Duplicate Claim Included in Inpatient Coverage – Edit 760	1,061,053
Enrollment and Reinstatement Denials	22,379,494
Exclusions/Terminations – Internal	4,365,178
Exclusions/Terminations – External	4,178,333
Managed Care Locator Code	29,787,756
Medical Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	420,478
Medicaid Claim Denials (Providers Removed from Active PPR <= 12 Months) – Edit 1141	107,324
Medicaid Claim Denials (Providers Removed from Active PPR 13-24 Months) – Edit 1141	232,498
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	21,264,907
Ordering Provider Excluded Prior to Order Date – Edit 939	3,910,493
Ordering/Referring Provider Number Missing – Edit 903	4,156,788
Order/Servicing/Referring Provider Number Verification – Edit 1236/1238	3,700,855
Pharmacies License Verification	7,563,164
Pre-Payment Insurance Verification Commercial	1,247,072,950
Pre-Payment Insurance Verification Medicare	391,792,146
Pre-Payment Review Sentinel Effect – Edit 1141	23,088,430
Prescription Serial Number Missing, Lost, Stolen, Altered	45,919,848
Provider ID/Service ID are the same – Edit 1357	1,682,215
Recipient Medicaid MC Benefits – Case Closures for False Information	109,001
Recipient Restriction	78,824,001
Service Date prior to Birth Date – Edit 102	1,813,754
Transportations Claims-Modifier Invalid for Submitted Procedure Code – Edit 927	3,011,238
Transportation Claims-Procedure Code Modifier Missing – Edit 1344	251,365
Transportation Service Performed During Inpatient Stay – Edit 02062	37,087
Total	**$1,908,504,148**

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 to be eligible to receive Medicaid payments or submit claims for Medicaid services. 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. In determining what constitutes a substantial portion of business operations, 18 NYCRR Part 521 establishes a $500,000 threshold, during a consecutive 12-month period, for claiming, ordering, receiving payment, or submitting bills for others for Medicaid care, services, or supplies.

Certification and Review

Each 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. OMIG develops a list of Medicaid providers who must have compliance programs and compares that list with the list of providers who met the certification obligation. Medicaid providers who fail to conform to the certification requirement are more likely to become the subject of a compliance program review or compliance contact initiative.

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. During 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 enters into Corporate Integrity Agreements (CIA) with 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, which is for a five-year term, allows for strict oversight of a provider through 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 $2.2 million in cost savings to the Medicaid program in 2016. If a provider under a CIA violates a requirement of the CIA, they are considered to be in breach of the CIA and subject to the payment of stipulated penalties to NYS. If OMIG determines that a material breach of the CIA has occurred, OMIG can terminate the CIA and the provider will be excluded from participation in the Medicaid program.

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. In October 2016, OMIG posted a *Compliance Program Review Guidance* (CPRG) on its website outlining the points that OMIG uses when it conducts compliance program reviews. This CPRG, coupled with the *Compliance Program Self-Assessment* form (also on OMIG's website), provides the most complete direction on what is expected of Medicaid providers' compliance programs.

OMIG issued letters to providers who failed to meet the compliance program certification requirement referred to above. The goal of that mailing was to remind providers of the compliance program and certification requirements so that more providers will conform to those obligations.

During 2016, OMIG provided 13 compliance-related presentations and webinars and issued 15 compliance-related publications on OMIG's website and through DOH's *Medicaid Updates*. The compliance section of the OMIG website is among the site's most active areas, with close to 40,000 visits to compliance webinars, over 30,000 visits to compliance publications, and more than 40,000 visits to compliance resources and FAQs. In addition, many of OMIG's webinars are accredited for legal, accounting, or compliance continuing-education credits. In 2016, 439 participants received credits, up from 428 in 2015.

Collaborative Activities

Comprehensive Outpatient Program Supplemental Reconciliation Project

OMIG continued its joint project with OMH to identify and recover Medicaid payments from providers of outpatient 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. Any Level I and Level II COPS and CSP payments received by a provider that exceeded a specific year's threshold amount are recouped by the State. In 2016, 22 audits were finalized identifying $6.5 million in overpayments.

OMIG and External Entities Identify and Address Multiple Client Identification Numbers

Each Medicaid recipient is assigned a client identification number (CIN) for enrollment in the Medicaid program. Duplicate CINs can result in overpayments if the individual has overlapping enrollment in a MCO or in multiple MCOs. LDSS, NYC HRA, and NYSoH work to identify Medicaid enrollees with more than one currently active CIN. OMIG staff use data queries and analyses to identify individuals who may be inappropriately assigned more than one CIN. OMIG conducts a second-level review using this data to capture duplicate CINs that may not have been identified by LDSS, NYC HRA, and NYSoH. In 2016, OMIG conducted an extensive review of potential matches and coordinated efforts with LDSS, NYC HRA, and NYSoH to resolve instances where an individual had more than one currently active CIN.

Medicaid in Education

OMIG works closely with both OHIP and the NYSED Medicaid Unit regarding the Preschool and School Supportive Health Services Programs (P/SSHSP), also known as the Medicaid in Education Project. OHIP is continuously updating the guidance for P/SSHSP to address the changes in the program requirements mandated by CMS. NYSED provides training sessions to the school districts and county preschool programs. OHIP provides policy and program guidance and interprets documentation regarding certain Medicaid therapy service claims so that OMIG auditors can determine which P/SSHSP rate codes should apply for the claims.
OMIG informs NYSED's Medicaid Unit of the audit findings so that they can address the findings in their training sessions. NYSED's Medicaid Unit provides information for the changes to the Individualized Education Program (IEP), which is the treatment plan for the services provided to beneficiaries. NYSED acts as the point of contact for questions concerning the license and certification qualifications of the service providers.
Quarterly meetings are held between OMIG, OHIP, and NYSED's Medicaid Unit, where information is shared to assist with policy and training issues.

OMIG Collaboration with Multiple Agencies Regarding Transportation Oversight

OMIG established working relationships with both the Nassau and Suffolk County Taxi and Limousine Commission (TLC), as well as the local towns and villages within these counties. OMIG conducted joint operations involving Medicaid transportation providers in both of these counties. These operations resulted in summonses being issued by TLCs and/or the counties to providers operating illegally or without authority. OMIG issued administrative actions, including an immediate agency action for imminent danger, against providers operating in violation of regulations. Referrals were made to the Nassau County District Attorney's office, local building departments, the NYS Department of Environmental Conservation, MFCU, and the Town of Babylon Fire Marshal/Public Safety Office.
OMIG continues to build on the relationships made with the NYC TLC, DMV, DOH, and DOT, leading to the formation of a transportation task force in October 2016. The collective goal of the taskforce is to identify potential issues and public safety concerns and mitigate them through preemptive measures.

Participation in Program Integrity Conferences

In May 2016, OMIG staff participated in a Medicaid Patient Review and Restriction Program Expert Panel Virtual Meeting facilitated by The Pew Charitable Trusts. Representatives from several states discussed how recipients are reviewed for restriction as part of their respective RRPs. The purpose of the meeting was to present information to CMS for standardizing restriction programs, and share best practices, i.e., using specific data sets to target doctor/pharmacy shoppers, using the restriction programs as a means toward better coordination of care, etc., with other program integrity agencies across the country who have limited or no restriction programs.

In August 2016, staff from both OMIG and the Wisconsin Office of the Inspector General attended and co-presented at the National Association of Medicaid Program Integrity (NAMPI) Conference regarding their states' efforts to combat recipient fraud. Topics presented included recipient investigations, RRP, drug diversion, and best practices. The conference consisted of 550 attendees representing both policy and investigations personnel from 43 states, CMS staff, and private contract personnel who audit and investigate Medicare and Medicaid.

In October 2016, OMIG staff attended a Special Session of the Healthcare Fraud Prevention Partnership on Marketplace Fraud and Opioids at CMS headquarters in Baltimore, Maryland. The purpose of the Special Session was to assist in authoring a white paper indicating strategies and best practices for preventing and investigating fraud across the healthcare industry, and identifying and curbing opioid abuse. The session was an in-person meeting to follow-up on the three webinars that were used to compile information for the white paper. The session consisted of small breakout groups and large group discussions to determine the best way to share information through the white paper. OMIG shared its efforts to investigate Medicaid providers, cooperation with federal and state partners, and efforts to control opioid abuse by recipients through restriction programs. OMIG explained its cooperative efforts with Medicaid MCOs, through sharing information and coordinating Medicaid restrictions to control abusive behaviors. In attendance were federal representatives from CMS, DOJ, FBI, and HHS OIG, as well as representatives from health insurance companies.

In 2016, OMIG also attended working group meetings in New Jersey, to increase awareness of Medicaid providers defrauding Medicaid in both New York and New Jersey. Provider types discussed included physicians, registered nurses, DME providers, and pharmacies.

OMIG Collaboration with Centers for Medicare and Medicaid Services

The Dental Pre-Payment Claim Unit identified several NYS-enrolled dental providers billing medical codes as crossover claims inappropriately and placed them on a pre-payment review. OMIG staff identified weaknesses in the Medicare editing and oversight function and reached out to meet and collaborate with SafeGuard Services, the CMS contractor for Medicare data, to review the inappropriate claim activity. Some of the involved dental providers were the highest billers in the country for those identified medical codes that were being billed inappropriately as crossovers. CMS went on to identify over $1 million in inappropriate payments as a result of OMIG's referral and based on this information, CMS decided to modify and update their system controls and put the providers identified on the federal pre-payment review process.

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 2016, 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 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 936 exclusions and 230 censures in 2016. The NYS Medicaid Exclusion List contains 6,254 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.

Sanctions by Type	
Administrative Actions	Number of Actions
Censures	230
Affiliations – 18 NYCRR 504.1(d)(1)	57
Unacceptable Practice – 18 NYCRR 515.2	25
Indictments – 18 NYCRR 515.7(b)	150
Convictions – 18 NYCRR 515.7(c)	257
Imminent Danger – 18 NYCRR 515.7(d)	2
Professional Misconduct – 18 NYCRR 515.7(e)	188
Mandatory Exclusion – 18 NYCRR 515.8	257
Grand Total	1,166

CONCLUSION

OMIG appreciates the opportunity to share the results of its Medicaid program integrity activities for 2016. 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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