



**New York State
Office of the Medicaid Inspector General**

**Work Plan
State Fiscal Year 2012-2013**

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REVISION HISTORY

5/30/12: Activity relating to Home and Community-based Waiver Services is transferred from the Home and Community Care Services Business Line Team (Page 7, Paragraph 6) to the Mental Health, Chemical Dependency and Developmental Disability Services Business Line Team (Page 12, Paragraph 2).

7/17/12: Under Residential Health Care Facilities, two new items were added: Capital and Medicaid Rate Part B Carve-Out. (Page 16)

11/28/12: Under Rate Conformance with Generally Accepted Accounting Principles, “bases” was changed to “basis”. (Page 5)

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EXECUTIVE SUMMARY

The mission of the Office of the Medicaid Inspector General (OMIG) is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high-quality patient care. This work plan provides a roadmap for taxpayers, policymakers, providers, and managed care organizations to follow as a guide to OMIG's review activities planned for State Fiscal Year 2012-13 on fighting fraud, improving integrity and quality, and saving taxpayer dollars.

OMIG is an independent program integrity entity within the Department of Health (DOH). While review work is coordinated on a business line (BL) basis, OMIG consists of seven core components:

- Division of Medicaid Audit
- Division of Medicaid Investigations
- Division of Technology and Business Automation
- Division of Administration
- Office of Counsel
- Bureau of Compliance
- Office of Central and External Relations

Each of these core components help to staff multidisciplinary teams known as business line teams (BLTs). These teams look at specific categories of services that are listed below:

- Managed Care
- Medical Services in an Educational Setting
- Home and Community Care Services
- Hospital and Outpatient Clinic Services
- Mental Health, Chemical Dependence, and Developmental Disabilities Services
- Pharmacy and Durable Medical Equipment
- Physicians, Dentists and Laboratories
- Residential Health Care Facilities
- Transportation

Additionally, OMIG maintains a close working relationship with federal law enforcement agencies such as the Federal Bureau of Investigation, the Department of Health and Human Services' Office of the Inspector General, as well as state and local law enforcement and program integrity entities.

INTRODUCTION

The New York State Office of the Medicaid Inspector General carries out a program integrity mission focused on fighting fraud and improving integrity and quality through a cooperative approach, while also saving taxpayer dollars. This focus requires specialized, multidisciplinary teams that strongly coordinate with other federal, state and local partners.

In the last six months, OMIG implemented the first of nine business line teams (BLTs) that will focus on specific areas of Medicaid health care service delivery. These BLTs consist of personnel with experience within the various parts of OMIG—audit, investigations, legal, clinical, and technical—and bring together expertise at the beginning of a project rather than at the conclusion. By using this approach, OMIG is able to operate with improved efficiency, conduct more thorough reviews and investigations, and reduce time to completion.

In 2012-13, OMIG will use the BLTs to focus on finding those providers who commit fraud and abuse—and ensure that these people will no longer be able to participate in the state's Medicaid program. Recent BLT efforts have identified dozens of fraudulent providers who will face exclusion because of inappropriate and fraudulent acts. This information may also serve as the basis for referrals to law enforcement and potential prosecution.

Fighting fraud is only one part of OMIG's mission. OMIG will continue to stress compliance within the health care provider community and will encourage providers to use the self-disclosure process. OMIG will work with providers to improve their knowledge of the Medicaid program. OMIG will also continue to work to improve integrity and quality alongside its partners at the regulating agencies – the Department of Health, the Office for Alcoholism and Substance Abuse Services, the Office of Mental Health, the Office for People with Developmental Disabilities, the State Education Department, the Office of Temporary and Disability Assistance, the Office of Children and Family Services, and the Commission on Quality of Care and Advocacy for Persons with Disabilities. Understanding a category of service before completing a review is important. OMIG's work with these agencies has helped to leverage decades of Medicaid regulation and guidance experience and develop review instruments used by field staff while also building internal expertise.

Additionally, OMIG will focus on partnership, education, and outreach as the vehicles to identify, prevent, and detect fraud and abuse in the Medicaid program. Legislators, policymakers, providers, enrollees, and taxpayers can all be part of the work to fight fraud, improve integrity in the Medicaid program, and, ultimately, save New York State taxpayer dollars. OMIG's role puts it at the center of these efforts.

With managed care taking on an increasing role within the Medicaid program, OMIG expects to see major changes in a number of services that have traditionally been provided in the fee-for-service realm. OMIG is working with regulating agencies, managed care organizations, and enrollee representatives so the transition can yield better results and stronger program integrity.

BUSINESS LINES

MANAGED CARE

The Managed Care business line includes all services provided by managed care organizations (MCOs). MCOs coordinate the provision, quality, and cost of care for their enrolled members. In New York State, several different types of managed care plans participate in Medicaid managed care, including health maintenance organizations, prepaid health service plans, managed long-term care plans, primary care partial capitation providers, and HIV special needs plans. Historically, OMIG has performed various match-based targeted reviews and audits of managed care organizations, leading to the recovery of overpayments and implementation of corrective action plans that address system and programmatic concerns. In the new Medicaid managed care environment, a series of robust initiatives have been identified which will significantly augment OMIG activity in detecting fraud and abuse in a managed care context.

Multiple Client Identification Numbers

OMIG will review Medicaid payments made for the same enrollee with multiple client identification numbers. As part of this effort, OMIG will work in conjunction with the Department of Health (DOH), local social service districts, and other regulating agencies.

Retroactive Disenrollment

In concert with local social service districts and DOH, OMIG will determine whether MCOs are returning monthly capitation payments based on local districts' retroactive disenrollment of enrollees.

Utilization Reviews

In concert with DOH, OMIG will review MCOs to determine whether MCOs have conducted adequate outreach and education so that enrollees know how to utilize their services. OMIG will also conduct utilization reviews to better analyze the overall availability of required services. OMIG will monitor MCO data to detect patterns of inappropriate utilization and will review internal coverage policies, such as prior approval practices and standards for referral to specialists, to assess whether underutilization is caused by overly restrictive policies. OMIG will also verify that those participating via auto-enrollment are able to access services.

County of Residence

OMIG will review and determine if payments are made appropriately for each enrollee based on their county of fiscal responsibility and other factors.

Recruitment and Retention – Managed Long-Term Care

OMIG will review payments made to managed long-term care plans for the purpose of recruitment, training, and retention of non-supervisory home health aides or other personnel with direct patient care responsibility.

Chargeback for Family Planning Services

OMIG will identify duplicate claims comprised of out-of-network claims made to Medicaid for family planning and reproductive health services that were included in the capitated payment. Enrollees have the option to secure family planning and reproductive health services from out-of-network providers.

Oversight of Managed Care Organizations’ Restricted Recipient Program

In concert with the DOH, OMIG will provide contractual, administrative, and medical utilization review oversight to MCOs’ restricted recipient program. This oversight will enhance adherence to federal and state regulations and also monitor program outcomes.

Third-Party Liability Utilization Review

Since the Medicaid program is the payer of last resort, providers of services to enrollees with private insurance are required to first bill the third-party insurer before billing the Medicaid program. OMIG will review MCO encounter data to determine if claims paid by the MCO should have been billed first to third-party insurers.

Duplicate Billing

OMIG will review fee-for-service billing to determine whether the Medicaid program was separately paying for services that should have been included in the rate.

Quality of Care

The Medicaid program requires that enrollees receive quality medical care from network providers. Working collaboratively with DOH, OMIG will investigate quality of care issues in cases where it is alleged that services were not provided or were not provided in accordance with the applicable standards of care.

Oversight of Managed Care Organizations’ Claims Processing System

OMIG will review the claims processing systems used by MCOs and their network providers to assess program integrity and determine whether claims were submitted in accordance with established policies and procedures.

Central Clearinghouse for Special Investigation Unit Information

OMIG will coordinate with MCOs' special investigative units (SIU) and serve as a central clearinghouse for SIU information. This will enable MCOs to learn of cross-plan issues and take appropriate action.

Managed Care Cost Report and Service Reviews

Because New York will be paying MCOs capitation rates that include enrollee services that have not traditionally been included in managed care, new issues will arise regarding capitation rate calculations. OMIG will review MCO cost reports by examining the underlying data, including, but not limited to encounter data and claim reports, to identify whether disallowed cost data is included in the MCO cost reports. Reviews will include, but will not be limited to:

- **Identifying questionable encounter data** – OMIG will analyze encounter data to identify patterns and trends that may reflect fraudulent claiming. OMIG will work with and assist SIUs to self-identify and report false billings within the MCO networks.
- **Rate conformance with Generally Accepted Accounting Principles** – OMIG will review the appropriateness of the costs underlying the rates approved by DOH to determine whether the underlying basis of the approved rates, as provided by the MCOs, were adequately supported by MCO data.
- **Costs associated with providing care to dual eligibles** – New York is participating in a demonstration project to improve coordination of care for enrollees who are dually eligible for Medicaid and Medicare. OMIG will review MCOs' cost reports, encounter data and rates to determine whether Medicaid and Medicare were appropriately billed.
- **Delivery methods that serve special needs populations** – OMIG will work closely with regulating agencies to determine whether special services are being provided in accordance with Medicaid requirements.
- **Efficiency factors** – OMIG will augment DOH's review of MCO management practices to assess whether MCOs are taking steps to manage their business operations such that efficiencies are identified and implemented.
- **Preventable health care acquired illnesses and injuries** – OMIG will review MCO clinical data to determine whether the cost of preventable health care acquired conditions are included in MCOs' justification for rates.
- **Provision of medically unnecessary care, services, and supplies** – Working in concert with DOH, OMIG will review utilization data to determine whether payments included unnecessary costs incurred by MCOs. OMIG will also work with MCOs to assess the fraud containment procedures in place to prevent MCOs from incurring unnecessary expenses.
- **Supplemental Maternity and Newborn Capitation Payments** – OMIG will review supplemental maternity/newborn capitation payments and associated inpatient delivery costs for duplicative payments.

MEDICAL SERVICES IN AN EDUCATIONAL SETTING

This business line focuses on school supportive health services provided to special education students between the ages of 3 and 21, and early intervention services for at-risk children up to three years of age.

School Supportive Health Services

Preschool programs, school districts, and many schools receive Medicaid reimbursement for services provided to special education students between the ages of 3 and 21. These services must be provided in accordance with the child's individualized education program in order to achieve desired outcomes. OMIG will audit school districts and county preschool providers that received reimbursement in calendar year 2011.

Early Intervention

Counties support at-risk children up to three years of age by contracting with practitioners and therapists in the community to provide needed services. Working in collaboration with DOH, OMIG will determine whether the services have been provided in accordance with Medicaid requirements. OMIG will also review the rejection or non-payment of early intervention claims by third-party payers for enrollees who have third-party coverage.

HOME AND COMMUNITY CARE SERVICES

The Home and Community Care Services business line includes home health care and personal care attendants as well as adult day health care. Traumatic brain injury (TBI) programs serve enrollees who have sustained such a disability, which warrant them eligibility for such services.

Spend Down Reviews

In certain situations, enrollees are required to expend their own funds to meet a predetermined threshold before the Medicaid program will pay for personal care and other services. OMIG will determine whether spend down requirements were processed correctly by the personal care provider.

Long Term Home Health Care Program – Home and Community-Based Waiver Services

Long term home health care program (LTHHCP) providers deliver a coordinated plan of services to eligible enrollees in their homes, the home of a responsible adult, or an adult care facility (other than a shelter for adults). Prior audits of LTHHCP providers found that the required waiver documents demonstrating eligibility for services billed under this program were not completed prior to the time the services were rendered. OMIG will expand its review of LTHHCP providers focusing on timely completion of these key documents.

Long -Term Home Health Care Program – Rates

OMIG will conduct audits of LTHHCP cost reports to verify per-visit and hourly rates calculated for the various ancillary services provided with an emphasis on both high Medicaid utilization and rate capitations. OMIG will also audit rate add-ons, including funds dedicated to worker recruitment, training, and retention.

Home and Community-Based Services – Medicaid Waiver for Individuals with Traumatic Brain Injury

The Home and Community-Based Services waiver program allows for the provision of alternative services for individuals who would otherwise require care in nursing homes. OMIG will continue to examine traumatic brain injury claims to determine compliance with program requirements. Reviews will primarily focus on verification that services were provided, that services billed were included in the service plan, that service plans were updated in a timely manner, and that services were provided by qualified staff.

Consistency with Patient Care Plans

Patient care plans must be created and approved by designated professional staff for home care programs; plans of care form the basis of authorized services. OMIG will analyze claims to determine whether an approved patient care plan exists, plan services were deemed necessary, services were rendered consistent with the patient care plan, and hours billed were authorized by the care plan.

Provision of Services

OMIG will analyze personal care attendant (PCA) claims to determine whether the provision of services was adequately documented, that required supervision of aides was conducted, that PCA staff rendering services were properly licensed, and that other personnel requirements were met.

Pre-Claim Verification

OMIG will work with DOH to complete implementation of controls that will determine whether service providers were present during the time a service was provided. Home health providers who claim more than \$15 million per year must participate in this program. These providers will be able to select a verification vendor from a list created jointly by OMIG and DOH. After implementation, OMIG will monitor provider behavior and compliance, will review claims and supporting documentation, and will provide compliance guidance and training.

Home Health and Personal Care for Inpatients and Nursing Facility Residents

OMIG will identify home health and personal care providers who bill while the enrollee is not at home, but instead, is in a hospital or resides in an institutional setting where the billed services are covered by the facility rate.

Home Health Aide Overlapping Payment Review

OMIG will examine overlapping payments for enrollees receiving home health services who are dually eligible for Medicare and Medicaid. OMIG will determine whether Medicaid, as the payer of last resort, paid an excessive amount for home health aide services.

Private Duty Nursing

OMIG will examine claims for private duty nursing services to determine whether billed services were provided in accordance with Medicaid requirements.

HOSPITAL AND OUTPATIENT SERVICES

The Hospital and Outpatient Services business line includes services provided by hospitals, clinics, and diagnostic and treatment centers (D&TC).

Outpatient Department Services

OMIG will review Medicaid payments for selected hospital outpatient services and review emergency room, clinic, and ordered ambulatory services (other than laboratories) and review the underlying documentation, such as physician orders and test results. A limited number of these reviews will involve time periods preceding the implementation of ambulatory patient groups (APGs).

Inpatient Crossover to Emergency Room/Clinic Visits

Emergency visits and clinic visits should not be billed during a hospital inpatient stay. Clinics and emergency department services are included in the hospital rate from the day of admission and throughout the hospital stay. OMIG will review claims to determine whether ineligible costs were being claimed.

Hospital Compliance Guidance

Guidance will be issued identifying best practices for hospital compliance programs. OMIG is working with DOH to develop guidance about hospital charity care, which will be included in the compliance guidance.

Diagnostic and Treatment Centers Coding and Medical Necessity

OMIG will review payments for services provided by diagnostic and treatment centers (D&TCs) to determine whether services were provided, that appropriate coding was used, and that services were deemed medically necessary. A key component of the review will be to determine the appropriateness of payments for physical, speech, and occupational therapy services as well as HIV primary care services.

Diagnostic and Treatment Centers - Products of Ambulatory Care

OMIG will review D&TCs participating in products of ambulatory care (PAC) reimbursement to determine whether reimbursed PAC services were provided in accordance with Medicaid requirements. In addition, OMIG will expand its review to encompass new rate codes for federally qualified health centers.

Diagnostic and Treatment Centers Capital Add-Ons to Ambulatory Patient Group Rates

OMIG will review D&TCs for the periods prior to APG implementation and will audit capital add-ons to clinics' APG rates. OMIG will review rate sheets and cost reports to determine if the capital add-ons were calculated correctly.

MENTAL HEALTH, CHEMICAL DEPENDENCE, AND DEVELOPMENTAL DISABILITIES SERVICES

This business line works in close collaboration with the Office for People with Developmental Disabilities (OPWDD), the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH), and the Commission on Quality of Care and Advocacy for Persons with Disabilities to promote program integrity among the service providers under their regulatory purview. OPWDD has developed a quality improvement work plan which will serve as an important guide in conducting reviews and other activities with that agency.

Ambulatory Patient Groups Compliance Assistance and Review

As part of the overall effort to reform Medicaid reimbursement and reconsider service delivery, the outpatient Medicaid payment system now uses an ambulatory patient group (APG) methodology. OMIG will work in concert with the regulating agencies to provide guidance and education to providers in the application of APGs. OMIG will then review providers' use of APGs to determine the appropriateness and accuracy of their application.

Chemical Dependence Inpatient Rehabilitation Services – Clinical

OMIG will review payments for inpatient chemical dependence rehabilitation services to determine whether services were provided in accordance with Medicaid requirements.

Chemical Dependence Inpatient Rehabilitation Services – Rates

OASAS inpatient rehabilitation providers offer services through a prospective per diem payment rate system. OMIG will assess the accuracy of providers' rates in free-standing inpatient chemical dependence rehabilitation programs.

Outpatient Chemical Dependence Services

OMIG will review Medicaid payments for outpatient chemical dependence services to determine whether services were provided in accordance with Medicaid requirements.

Community Residence Rehabilitation Services

OMIG will review payments made for rehabilitative services provided to enrollees living in community-based residential programs to determine whether Medicaid services were provided in accordance with Medicaid requirements.

Case Management Services

Case management is a process designed to assist individuals in gaining access to necessary services in accordance with goals contained in a written case management plan. OMIG will review case management services to determine whether these services were provided and

billed correctly. OMIG will also review case management plans to determine whether they were deemed medically necessary.

Comprehensive Outpatient Program Supplemental Reimbursement

The amount of comprehensive outpatient program supplemental (COPS) reimbursement that a provider can receive is limited to a yearly threshold amount. OMH will identify COPS reimbursements that exceeded the threshold amounts and OMIG will continue to issue COPS reports and facilitate the collection of overpayments.

Outpatient Mental Health Services

OMIG will review payments for outpatient mental health services to determine whether services were provided in accordance with Medicaid requirements. These reviews will include clinic, continuing day treatment, children's day treatment, partial hospitalization, and intensive psychiatric rehabilitation program.

Partial Hospitalization

Partial hospitalization (PH) is an intensive outpatient treatment program designed to provide patients with profound or disabling mental health conditions with comprehensive treatment in outpatient settings. OMIG will review services to determine whether services were provided in accordance with Medicaid requirements.

Medicaid Service Coordination

Medicaid service coordination (MSC) assists persons with developmental disabilities and their families in gaining access to services and support appropriate to their needs. MSC is provided by qualified service coordinators, who develop and implement individualized service plans. OMIG will review MSC services to determine whether services were provided in accordance with Medicaid requirements.

Residential Habilitation

Residential habilitation services provide individually tailored supports that assist with skills related to living in the community. OMIG will review individual residential alternative services to determine whether services were provided in accordance with Medicaid requirements.

Day Treatment

An OPWDD day treatment facility is a certified free-standing or satellite site that provides a planned combination of diagnostic, treatment, and habilitative services for persons with developmental disabilities. Persons attending day treatment receive a broad range of services but do not need intensive 24-hour care and medical supervision. OMIG will review day treatment providers to determine whether services were provided in accordance with Medicaid requirements.

Day Habilitation

Day habilitation services provide various supports and services that assist people to work at their jobs and participate in the community and are delivered primarily outside of the person's residence. These supports include assistance with acquisition, retention and improvement of self-help and socialization, and adaptive and motor skills development. OMIG will review day habilitation providers to determine whether services were provided in accordance with Medicaid requirements.

Home and Community – Based Services Waiver

This waiver allows OPWDD to offer support and services to people with developmental disabilities so they can live richer lives in a community setting rather than in an institutional setting. OMIG will review payments to providers to determine whether these waiver services were provided in accordance with Medicaid requirements.

PHARMACY AND DURABLE MEDICAL EQUIPMENT

The Pharmacy and Durable Medical Equipment (DME) business line includes prescription drugs, durable medical equipment, and fiscal orders (a written request by a qualified provider for non-prescription drugs or medical/surgical supplies).

Claiming Accuracy

Claims will be reviewed to identify pharmacies' billing for prescriptions, fiscal orders, or DME items that were not furnished, contain inaccurate data in claim submissions, were claimed more than once, or were a consequence of inappropriate drug therapy, missing information about medical necessity, early refills, black box medications, and off-label use.

Prescription and Durable Medical Equipment

OMIG will identify prescription and/or DME utilization patterns that are inconsistent with medical necessity. OMIG will help MCOs create edits to self-identify enrollees who abuse prescriptions. OMIG will restrict in cases where fee for service payments are involved and work cooperatively to assist MCOs in placing managed care enrollees who abuse prescriptions and/or DME into the MCO restricted recipient program.

Inventory Reviews

Payments made for prescriptions or DME items claimed will be compared with pharmacy inventory purchases to determine whether the pharmacy had ordered at least the volume of drugs or DMEs necessary to fill the prescriptions that were claimed.

Drug Diversion

Drug diversion can take many forms, such as a prescriber who is over-prescribing, an act which allows an enrollee to sell excessive medication, or the forging of prescriptions by an enrollee with the intent to sell. OMIG will identify high users of potentially diverted medications as well as pharmacists, orderers, and other providers/enrollees who participate in drug diversion.

Improper Use of Atypical Antipsychotics

Atypical antipsychotics are a class of prescription medications used for the treatment of schizophrenia and bipolar disorder. These drugs may be used at times in residential facilities for unapproved purposes ("off-label"), as well as in situations where enrollees are not receiving behavioral interventions as prescribed. Further, the Food and Drug Administration (FDA) has issued a long-standing and strong warning (referred to as a "black box" warning) of a high risk of death for individuals with dementia who are given atypical antipsychotics. OMIG will review residential facilities' use of atypical antipsychotics to determine whether nursing facility residents were being chemically restrained and whether these drugs are being used consistent with federal law and FDA direction.

PHYSICIANS, DENTISTS, AND LABORATORIES

The Physician, Dentist, and Laboratory business line includes health practitioners such as physicians and dentists, as well as laboratories. Physicians must be licensed and currently registered by the New York State Education Department or meet the certification requirements of the appropriate state in which they practice. Dental care in the Medicaid program includes only essential care rendered by dentists, oral surgeons, and orthodontists. Laboratory services may only be provided to enrollees by clinical laboratories, physicians, or podiatrists within their scope of practice.

Obstetrics/Gynecological Physicians

OMIG will review billings of obstetrical/gynecological physicians for duplicate delivery billings or billing for global delivery fees when delivery-only codes were appropriate for the services rendered.

Physician Place of Service

OMIG will identify inappropriate physician billings for office visits when the services were instead delivered in another setting, such as a clinic or outpatient hospital setting.

Ordered Services

OMIG will determine whether ordered services were medically necessary. The project will begin with a review of enteral feeding claims and providers who ordered a high volume of home health services.

Dental Consultations

Dental consultations must arise from referrals from other providers followed by written reports to the referring providers. OMIG will determine whether a consultation was authorized, was deemed medically necessary, and whether appropriate follow-up occurred.

Dental Procedure Combinations

OMIG will review inappropriate combinations of procedure codes billed by private dentists. Examples include claims for a pulled or crowned tooth for an enrollee who has full dentures or dental services included in a residential capitated rate.

RESIDENTIAL HEALTH CARE FACILITIES

The Residential Health Care Facilities (RHCF) business line includes skilled nursing facilities and assisted living programs. Residential health care facilities are reimbursed for covered services to eligible recipients based on prospectively determined rates. An assisted living program provides long-term residential care, room, board, housekeeping, personal care, supervision, and provides or arranges for home health services to five or more eligible residents unrelated to the operator.

Base Year Audits

RHCFs use the same reported costs, with appropriate trend factors, for multiple years of reimbursement until a new base year is set. OMIG will review new base year rates approved by DOH. OMIG reviews will focus on inappropriate and unallowable costs included in the new RHCF rates. OMIG will also review add-ons to determine whether they were appropriately calculated.

Dropped Ancillary Services

Medicaid rates for RHCFs include various ancillary services. OMIG will review whether RHCFs are providing ancillary services that were included in their Medicaid per diem rate, and whether any changes in billing have occurred.

Notice of Rate Changes (Rollovers)

Reported base year operating costs are increased by an inflation factor (also known as a trend factor) and used as a basis for RHCF rates for subsequent years. OMIG will carry forward base year operating cost audit findings through March 2009 and adjust rates accordingly.

Rate Appeals

RHCFs may file rate appeals to contest their Medicaid rates. OMIG will review rate appeals that have been approved by DOH and, where appropriate, audit underlying costs associated with those appeals to determine the appropriateness of each appeal issue.

Bed Reservations

When qualifying criteria are met, the Medicaid program reimburses nursing homes on a per diem basis to hold a resident's bed while that resident is temporarily absent from the home. OMIG will review nursing home reserved bed payments to determine whether facilities are qualified to receive these payments.

Patient Review Instrument – Clinical Audits

The number of nursing facility residents classified in the various resource utilization group (RUG-II) categories determines the facility's overall case mix index and affects its per diem reimbursement rate. Each resident's condition and functional ability is assessed by means of

the patient review instrument (PRI). OMIG will examine the accuracy of the preparation of PRIs and perform clinical reviews of PRI calculations. OMIG will transition from PRI audits to Minimum Data Set audits during 2012, in line with the new screening tool currently used by RCHFs in New York State.

Inappropriate Fee-for-Service Billings for Assisted Living Program Residents

Medicaid will not pay for any items furnished to an assisted living program (ALP) when the cost of these items is included in the facility's rate. OMIG will identify goods and services delivered to ALP residents by other providers and billed to the Medicaid program but which were also included in the ALP payment rate, resulting in the Medicaid program having paid twice for these services.

Quality of Care of Assisted Living Program Residents

OMIG will review the documentation of care given to ALP residents, focusing on timely medical evaluations, interim assessments, plans of care, functional assessments, and the presence of relevant evidence of service provision. The results of such reviews will be shared with the DOH.

Capital

Reported RHCF capital costs are used as a basis for the capital/property component of the RHCF Medicaid rate. OMIG will review each RHCF capital cost component of their promulgated rate and, where appropriate, audit the underlying costs that determined the capital component and make appropriate adjustments to the rates.

Medicaid Rate Part B Carve-Out

Medicaid rates for nursing facilities include billable rates for Medicaid patients who are not eligible for Medicare Part B service reimbursement, as well as rates for those who are eligible. The difference between the non-eligible and eligible rates is called the "Part B carve-out." The OMIG has developed an approach to systematically capture the Part B reimbursement information associated with Medicaid enrollees through data gathering and computer matches with the Centers for Medicare and Medicaid Services, the federal department responsible for oversight of the Medicare and Medicaid programs.

OMIG will conduct risk assessments and perform reviews of the Part B carve-out for facilities that are rated as high risk for any years within the statute of limitations, and any appeals processed by DOH's Bureau of Long Term Care Reimbursement.

TRANSPORTATION

The Transportation business line includes all medical transportation services, including public transportation, ambulances, ambulettes, taxis, and liveries. Transportation services are offered to enrollees when medically necessary.

Unqualified Drivers or Vehicles

Ambulette drivers are required to have certification authorizing them to operate such vehicles by the New York State Department of Motor Vehicles (DMV). OMIG will work with DMV and other regulating entities to identify transportation providers submitting claims when unqualified drivers were used. In addition, OMIG will review transportation providers to determine whether qualified vehicles were used when transporting Medicaid patients.

Transportation Services during a Hospital Stay

OMIG will evaluate billed transportation services during a period when the enrollee was a hospital inpatient. OMIG will determine whether services were provided in accordance with Medicaid requirements.

Claim Review and Investigation

OMIG will review claims for transportation services to identify whether they were provided or if they were provided at a threshold of service beyond that which was deemed medically necessary.

ACTIVITIES RELATING TO ALL BUSINESS LINES

The following activities help assess program integrity as it relates to any line of business within the Medicaid program. Each business line team will incorporate these activities into its overall strategy for holistically addressing fraud and abuse within the specific line of business.

Kickbacks and Inducements

Providers are prohibited from offering, soliciting, giving, or receiving any referral fee, rebate, discount, bribe, or kickback, whether in-kind or financial, in return for referring, accepting a referral from, or providing services to an enrollee. Providers doing so will be identified and appropriate actions taken to recoup overpayments, to refer them for prosecution, and/or to exclude them from the Medicaid program.

Effective Compliance Program General Guidance and Assistance

OMIG's compliance efforts educate and assist providers in meeting requirements to have effective compliance programs. OMIG will issue compliance publications, including *Compliance Alerts*, articles in *Medicaid Updates*, other guidance that can be found on OMIG's Web site, compliance-focused Webinars, as well as presentations and meetings with provider associations. OMIG will update and publish the procedure used in conducting effectiveness reviews of providers' compliance programs, including protocols for effectiveness reviews and suggestions for providers to successfully complete a self-assessment of their compliance program. In addition, guidance will be issued identifying best practices about provider interactions and responsibilities with service bureaus.

Compliance Program Effectiveness Reviews

OMIG will access in-house expertise in conducting compliance program effectiveness reviews of provider compliance programs. Effectiveness reviews will primarily focus on providers who fail to certify that they are meeting the obligation to implement an effective compliance program.

Corporate Integrity Agreement Enforcement

Corporate integrity agreements (CIAs) are established when a provider would otherwise be excluded from continued participation as a result of provider noncompliance with program obligations. Prior to the decision to create a CIA, OMIG will review the compliance program of a provider to determine if the provider has sufficient resources and established its compliance program to meet the program integrity obligations that would be required by a CIA. A CIA enables a provider to continue as a participating provider despite identified deficiencies. OMIG will monitor provider compliance with the terms of CIAs and will impose consequences identified in CIAs when providers fail to comply with their CIAs.

Self-Disclosure Efforts

Providers are required to promptly self-identify and disclose to OMIG any overpayments and repay them. The federal Affordable Care Act also requires providers to identify, self-disclose, explain, and repay overpayments within 60 calendar days of identification of the overpayment regardless of the financial threshold of participation in the Medicaid program. OMIG has a self-disclosure protocol that enables providers to make disclosures directly to OMIG. Through this process, providers who identify that they received reimbursement to which they were not entitled, whether caused by mistake, fraud, or accident, must disclose the parameters of the problem and its potential Medicaid financial impact. OMIG will also issue additional compliance guidance, Webinars, and offer additional educational opportunities to providers explaining how compliance programs should address identification of overpayments and the methods available for self-disclosure.

Medicare Coordination of Benefits with Provider-Submitted Claims

OMIG will monitor the implementation of the Medicare/Medicaid claim crossover process and identify inaccuracies in payment information. OMIG will:

- Coordinate with DOH to identify and correct linked providers with different entity identification numbers.
- Monitor, track, and recover overpayments due to other weaknesses in the claiming process via provider mail-out.
- Request additional enhancements to payment system edits as additional system weaknesses are identified.
- Monitor and report cost avoidance resulting from Evolution Project Request (EPR) 1625 and refine edit logic for Medicare crossover claims.

Patient Protection from Disqualified Providers

OMIG will identify individuals and entities disqualified from providing services and compare them to enrolled and non-enrolled entities that have provided service to enrollees in fee-for-service and managed care organizations. OMIG will also work with the Office for People with Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services, the Office of Mental Health, and the Commission on Quality of Care and Advocacy for Persons with Disabilities to develop controls to prevent excluded or terminated staff and contractors from participating in the Medicaid program.

Enrollee Eligibility Status Reviews

OMIG will examine claims for enrollees who had a date of service after their date of death, prior to their date of birth, or during a period of incarceration or institutionalization.

Service Bureaus Run by Disqualified Providers

Service bureaus provide enrolled Medicaid providers with billing and other assistance. Disqualified providers are not allowed to participate in the Medicaid program. OMIG will identify disqualified providers who have an ownership interest in service bureaus.

Location of Services Unknown to New York State Department of Health

Medicaid providers are required to inform DOH of any new service location. OMIG will identify providers with service locations that have not been disclosed to DOH.

Pre-Payment Insurance Verification and Fee-for-Service and Rate-Based Third-Party Recovery Projects

Some enrollees have other health insurance in addition to Medicaid. Medicaid is always the payer of last resort. OMIG will determine whether enrollees have other health insurance and will then require providers to adjust their Medicaid claims to reflect the other insurance coverage. OMIG will identify third party insurers of enrollees and provide this information as an edit to the state's payment system. This added information will require providers to bill third party insurers before billing Medicaid.

Estate and Casualty Recovery

OMIG has statewide responsibility for Medicaid recoveries from the estates of deceased enrollees and for personal injury awards and settlements for all enrollees. OMIG will identify situations in which these recoveries are appropriate.

County Demonstration Program

OMIG works in partnership with counties to identify cost-effective ways to deliver services. Participating counties audit activities of local providers with oversight from OMIG. OMIG expects joint activities to expand and anticipates additional counties will join the county demonstration program in the coming year.

Medicaid Recovery Audit Contractor

Payment integrity reviews play a crucial role in the ability to effectively leverage data mining capabilities as well as improve the enforcement of billing and reimbursement policies. OMIG will work with commercial carriers and pharmaceutical benefit managers on suspected mis-reported or duplicate payment reviews using the carrier claim information as our source data.

Payment Controls and Monitoring

OMIG will conduct pre-payment review activities and review claims for providers of interest. This capability allows for the monitoring and reviewing of claiming practices of providers who demonstrate aberrant, unacceptable, or inappropriate billing practices.

Recipient Investigations

OMIG will investigate allegations related to recipient eligibility issues, issues involving misuse of benefits cards, and cases where enrollees lend or rent their benefits cards to others to obtain medical benefits for which they are not entitled. OMIG will coordinate with local, state, and federal law enforcement to investigate recipients defrauding Medicaid and referring those recipients for prosecution as well as to the Recipient Restriction Program.

Enrollment and Reinstatement

OMIG will review new provider enrollment applications to determine if applicants should be enrolled into the Medicaid program. OMIG will review reinstatement applications to determine whether the circumstances that led to the exclusion or termination will be repeated if the provider were allowed to reenroll in the Medicaid program. OMIG will review ownership changes to identify whether previously excluded individuals are purchasing businesses or if excluded providers or providers undergoing an audit or investigation are selling their businesses to affiliated individuals.

Medicaid Electronic Health Records Incentive Payment Program

Through the Medicaid Electronic Health Record (EHR) Incentive Payment program, eligible hospitals and health care practitioners in New York State who adopt, implement, or upgrade certified EHR technology, and subsequently become meaningful users of the EHR technology, can qualify for financial incentives. OMIG will provide oversight of the EHR program and conduct reviews.