New York State
Office of the Medicaid Inspector General

Work Plan
State Fiscal Year 2013-14

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REVISION HISTORY

EXECUTIVE SUMMARY

New York's Medicaid program provides vital health care services to people across New York State. The New York State Office of the Medicaid Inspector General's (OMIG) role in the program is fighting fraud and abuse by ensuring that payments and services rendered correspond with appropriate billing measures. This work plan will structure the seventh year of agency operations, and recognizes both the federal and State changes in the Medicaid program.

At the national level, fraud, waste and abuse efforts have moved away from a traditional "pay and chase" model toward cost avoidance and improving program integrity. Today's models emphasize prevention – avoiding costs that should not occur. OMIG's work over the last four years has likewise changed to further align with this national emphasis and its achievements lead the nation in this regard. In its last reporting year, OMIG cost avoidance techniques saved taxpayers over $2.5 Billion. While the greater emphasis on avoidance structures the Office's work, OMIG also achieved strong recoveries – more than $410 million. This work plan commits OMIG to surpassing both those achievements.

Here in New York, a number of changes in the Medicaid program have also impacted the work of the OMIG. New and expanding systems of managed care and episodic payments have dramatically reorganized how health care providers are paid for services rendered to Medicaid patients. Under managed care system, Medicaid makes a single, flat monthly payment to a managed care company regardless of many services a Medicaid patient may receive. The managed care company manages costs and care and then pays health care providers who provided services. Under episodic payments, health care providers are reimbursed for each episode of care, not individual services. In light of these payment changes, methods of examining the relationship between claims, payment, and care delivery have to be redefined as well. As a result of these changes OMIG will refocus on how we audit payments and expand the review of reported costs and encounter data used to establish these new payment rates.

Over the last two years, OMIG has premiered new review types and processes which are adapted to focus on the Medicaid program as it stands today. New review types like inventory reviews look at pharmacy billings and compare them to drug inventories. This work squarely confronts aberrant pharmacies that are engaged in overbilling and potential drug diversion. Other OMIG efforts, like the establishment of pre-claim visit verification help to reduce fraudulent and wasteful home health billing.

The Medicaid global spending cap puts a hard cap on program expenditures. OMIG's audit target is subsumed within that cap and, therefore, if OMIG does not achieve its goals, providers will, as a group, be subject to rate adjustments or other cost containment measures. This fosters the common goal of ensuring program integrity and safeguarding program expenditures from fraud, waste and abuse.

OMIG's audit approach and protocols have also been re-examined as a result of actions by the State legislature. In 2011, both the Assembly and Senate unanimously passed a bill (S3184-A) that would have greatly constrained OMIG activities amidst complaints of unfair audit practices and excessive recoveries. Although the bill's proposed remedies were deemed unworkable and necessitated disapproval by the Governor, OMIG at the direction of the Governor, undertook a comprehensive reexamination of and restructuring of its own processes. This included revising its audit protocols and processes so that they were based upon guidance issued by the regulating agencies. OMIG also took the step of sharing audit protocols with provider associations to improve transparency and minimize disputes over audit methodology. In 2013-14 OMIG will implement the final actions resulting from this overall review.

OMIG's approach to program integrity recognizes the value added by helping providers improve their own practices New York is a nationwide leader in compliance efforts and the first state in the nation to require compliance programs. Providers who are the subject of a compliance review are given guidance on how to improve their own practices. This may result in corrective actions or corporate integrity agreements – structured improvement plans which condition a provider's continued participation in the Medicaid program. In 2013-14, OMIG will expand its compliance activities to further improve upon New York's nation-leading model.

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 federal, state, and local law enforcement and program integrity entities such as the Centers for Medicare and Medicaid Services, the Attorney General's Medicaid Fraud Control Unit, and local district attorneys. This effort will continue into 2013-14.

Finally, OMIG's efforts with social service districts will be an area of focus over the next year. While in past years, OMIG's County Demonstration Program has achieved some success, OMIG will work with local governments to dramatically improve recoveries over the next year. Pursuant to a recently enacted statute, OMIG will be meeting quarterly with representatives from social service districts to improve upon past efforts. OMIG will also seek local budgets and work plans to integrate into the OMIG work plan as an addendum. OMIG will also provide expanded guidance to this program and bring in additional county-level partners.

The reorganization of OMIG's work with social service districts will help to produce a more efficient, collaborative, and coordinated approach to fighting fraud and abuse in the Medicaid program. Specialized, multi-disciplinary teams within OMIG coordinate review activities and criteria with other federal, state, and local partners. These business line teams have actively focused agency resources on areas where more scrutiny is needed. Their efforts support the overall goal and focus of OMIG; fighting fraud and saving taxpayer dollars. As a result, in 2013-14, OMIG plans to conduct more audits, more investigations, and data matches than ever before.

The 2013-14 Work Plan is a roadmap to the review activities OMIG plans to carry out during this fiscal year. While the Work Plan is a collection of all the review categories that OMIG intends to

work on, particular focus will be placed on the areas of drug diversion of painkillers and narcotics, use of atypical antipsychotics, misuse of transportation services, and benefit card sharing.

The Work Plan is generally organized along Business Line Teams (BLTs). BLTs represent the recent organization of OMIG's work into specialized, multi-disciplinary teams. These BLTs actively focus agency resources on areas where more scrutiny is needed. They also focus on fighting fraud and saving taxpayer dollars. OMIG is strongly focused on identifying and fighting fraud and abuse.

OMIG will continue to strive for maximum transparency and accountability in the work that it does. The New York State Office of the Medicaid Inspector General Work Plan State Fiscal Year 2013-14 fulfills part of that commitment.

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Arranged by Business Line

INTRODUCTION

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 2013-14 on fighting fraud, improving integrity and quality, and saving taxpayer dollars.

While review work is coordinated on a business line basis, OMIG consists of nine 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
- Bureau of Risk Management
- Bureau of Quality Assurance
- Agency Coordination and Communications

Each of these core components helps 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 Services
- Mental Health, Chemical Dependence, and Developmental Disabilities Services
- Pharmacy and Durable Medical Equipment
- Physicians, Dentists, and Laboratories
- Residential Health Care Facilities
- Transportation

BUSINESS LINE TEAMS

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, and HIV special needs plans. Historically, OMIG has performed various match-based targeted reviews and audits of MCOs, leading to the recovery of overpayments and implementation of corrective actions 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 consumer 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 consumers.

Chargeback for Family Planning Services

OMIG will identify duplicate payments comprised of out-of-network claims made to Medicaid for family planning and reproductive health services that were included in the capitated payment. While consumers have the option of securing family planning and reproductive health services from out-of-network providers these services cannot be billed separately to Medicaid.

Supplemental Newborn/Maternity Capitation Payments

Supplemental capitation payments made in relation to the delivery of a newborn will be reviewed through the use of encounter data to determine appropriateness of the payment.

Utilization Reviews

In conjunction with DOH, OMIG will review MCOs to determine whether MCOs have conducted adequate outreach and education to new consumers about how to utilize their services. OMIG will verify that those participating via auto-enrollment are able to access services.

Duplicate Billing

OMIG will review fee-for-service (FFS) payments made for managed care consumers to determine if the services were for benefits that are included in the managed care benefit package.

Oversight of Managed Care Organizations' Recipient Restriction Program

In concert with DOH, OMIG will provide contractual, administrative, and medical utilization review oversight to MCOs' recipient restriction program (RRP). This oversight will enhance adherence to federal and state regulations and also monitor program outcomes. Additionally, it will include the ongoing provision of technical and program assistance to identify managed care consumer fraud/abuse by OMIG's RRP staff specifically assigned to each managed care plan, as well as attending managed care meetings statewide. OMIG's RRP staff will also continue to identify and support consumer fraud/abuse medical and non-medical FFS restrictions in partnership with local districts.

Enrollee Eligibility Status

OMIG will examine claims for managed care consumers who had a date of service after their date of death, or during a period of incarceration or institutionalization. OMIG will also examine retroactive disenrollment issues related to SNPs, specifically with the HIV population, since this involves determination of an HIV-positive diagnosis for an adult.

Special Investigation Information

OMIG will coordinate with special investigative units (SIU) of MCOs. This will enable MCOs to learn of cross-plan issues and take appropriate action.

Managed Care Cost Reporting

Because New York is now paying MCOs a capitation rate that includes consumer services that have not traditionally been included in managed care, new issues will arise regarding capitation rate calculations. OMIG plans to review various aspects of the cost reports by examining the underlying data to identify whether disallowed cost data is included in the report.

Managed Care Coding

OMIG will work with representatives from DOH to examine the appropriateness of ways in which managed care plans conduct coding on patient encounter forms. This coding is used for determining clinical risk groups and ultimately risk scores for managed care.

Managed Long-Term Care

As New York State moves toward implementing mandatory enrollment into managed long-term care (MLTC), and eligibility for enrollment into MLTC has been revised to allow non-nursing home-certifiable individuals to enroll, DOH has created separate rate cells to capture both categories of individuals. This distinction is made based on the semi-annual assessment of members (SAAM) score. The eMedNY computer processing system does not capture SAAM scores and does not have a programmed edit within the system. OMIG will review MLTC plans in 2013-14 to ensure that the appropriate rate cell is being billed on the basis of the SAAM scores.

MEDICAL SERVICES IN AN EDUCATIONAL SETTING

This business line focuses on school supportive health services provided to special education students between the ages of three and 21. OMIG plays a critical auditing role under the three-year School Supportive Health Services program agreement, signed in July 2009, and extended one year through July 2013. OMIG will continue to complete audits of upstate school districts, and will work with New York City on submitting their claims to OMIG for auditing, as required under the agreement's implementation plan.

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 three and 21. These services must be provided in accordance with the child's individualized education plan in order to achieve desired outcomes. OMIG will continue to audit school districts and county preschool providers that received reimbursement in calendar years 2009, 2010, and 2011.

Intermediate Care Facility School Supportive Health Services Program

OMIG will review School Supportive Health Services program claims billed by school districts for possible duplicate payments with claims also billed by the Office for People with Developmental Disabilities intermediate care facilities.

HOME AND COMMUNITY CARE SERVICES

The Home and Community Care Services Business Line Team is currently comprised of five program areas: certified home health agencies (CHHA), long-term home health care program (LTHHCP), personal care aides (PCA), traumatic brain injury (TBI), and private duty nursing (PDN) services.

For each of the following programs—CHHA, LTHHCP, PCA, TBI, PDN—OMIG will conduct audits that include the following components:

- Provision of Services: OMIG will analyze claims to determine if services were provided, that required supervision occurred, that staff rendering services were properly qualified, licensed and trained, and that other personnel requirements were met.

- Consistency with Patient Care Plans/Service Plans: Since plans of care form the basis of authorized services, such plans must be created and approved by designated professional staff for home care programs. OMIG will analyze claims to determine if 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.

- Spend Down Reviews: In certain situations, consumers 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 if spend down requirements were processed correctly by the home care provider. This would only be applicable in cases in which the respective county assigns responsibility for monitoring the spend down to the provider.

- Home Health and Personal Care for Inpatients and Nursing Facility Residents: OMIG will identify home health and personal care providers who bill while the consumer 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 consumers who are dually eligible for Medicare and Medicaid and are receiving home health services. OMIG will determine if Medicaid, as the payer of last resort, paid an excessive amount for home health aide services.

Long-Term Home Health Care Program and Certified Home Health Agency – Rates

OMIG will conduct audits of LTHHCP and CHHA 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 Health Verification Project/Certified Home Health Agency Conflict and Exception Reporting

OMIG, in consultation with DOH, is completing implementation of controls to determine if 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 are selecting a verification organization (VO) vendor from a list created jointly by OMIG and DOH. Using the VO repositories of providers' data, OMIG will monitor provider behavior and compliance, review claims and supporting documentation prior to payment, and provide compliance guidance and training.

Episodic Payment System for Certified Home Health Agencies

Effective May 1, 2012, DOH implemented an episodic payment system (EPS) reimbursement methodology to reimburse CHHA providers for services provided to Medicaid patients receiving home care. The EPS is based on a price for 60-day episodes of care which will be adjusted by patient acuity and regional wage differences. In September 2012, edits were placed on the number of service units per revenue codes. OMIG will review the Medicaid claims before the edit was put in place to identify overpayments to home health providers.

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.

Non-Emergency Services to Non-Residents

OMIG will review hospital emergency services provided to non-U.S. residents that lead to inpatient temporary and long-term care stays that do not comply with state and federal regulations. OMIG will examine both the initial emergency room service payment documentation, as well as any resulting paid claims for hospital or long-term care costs.

Diagnostic and Treatment Centers

OMIG will review payments for services provided by 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. These reviews will involve time periods preceding the implementation of APGs.

Diagnostic and Treatment Centers – Payments to Federally Qualified Healthcare Centers

OMIG will identify whether Federally Qualified Healthcare Centers (FQHCs) received the enhanced rate for services provided at an approved FQHC location when the services were provided at a non-FQHC-approved location. Additionally, OMIG will identify whether the FQHC received an inappropriate payment when the FQHC provided service to a Medicaid managed care consumer.

MENTAL HEALTH, CHEMICAL DEPENDENCE, AND DEVELOPMENTAL DISABILITIES SERVICES

This business line works in close collaboration with the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH), the Office for People with Developmental Disabilities (OPWDD), and the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) to promote program integrity among the service providers under their regulatory purview.

Chemical Dependence Inpatient Rehabilitation Services

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

Outpatient Chemical Dependence Services

OMIG continues to 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 continue to review payments made for rehabilitative services provided to consumers 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 has identified COPS reimbursements that exceeded the threshold amounts for prior years, and OMIG will continue to issue COPS reports and facilitate the collection of overpayments for remaining open COPS audits.

Outpatient Mental Health Services

OMIG continues to review payments for outpatient mental health services to determine whether services were provided in accordance with Medicaid requirements. These reviews 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 continue to review services to determine whether PH 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 continue to review MSC services to determine whether services were provided in accordance with Medicaid requirements.

Consolidated Support Services

OPWDD has applied for a 1915 waiver to develop new programs and products to examine the performance of managed care organizations in caring for the developmentally disabled population. OPWDD and OMIG are coordinating audit efforts and ensuring compliance with applicable government audit standards to address and avoid duplication of effort on the part of both agencies.

Residential Habilitation

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

Prevocational Services

Prevocational services provide the opportunity for individuals to participate in general training activities to build their strengths to overcome barriers to employment. These services assist individuals who want to work, but who need extra help to develop the skills needed to be successful in the workplace. OMIG will review prevocational service providers to determine whether services were provided in accordance with Medicaid requirements.

Supported Employment

Supported employment offers supports for individuals who have less intensive labor needs. Generally, individuals will transition to supported employment after they have been trained on the job and only require limited job coaching. OMIG will review supported employment providers to determine whether services were provided in accordance with Medicaid requirements.

Comprehensive Psychiatric Emergency Program

A Comprehensive Psychiatric Emergency program (CPEP) is designed to provide or ensure the provision of a full range of psychiatric emergency services in a general hospital, seven days a week, in a defined geographic area. OMIG will review CPEP providers to determine whether 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 and durable medical equipment services.

Inventory Reviews

Payments made for prescriptions and/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. OMIG will collaborate with law enforcement agencies and MCOs on inventory reviews to develop a comprehensive billing picture for pharmacies and DMEs servicing Medicaid consumers.

Drug Diversion

Drug diversion can take many forms, such as a prescriber who is over-prescribing, an act which allows a consumer to sell excessive medication, or the forging of prescriptions by a consumer with the intent to sell. OMIG will identify high users of potentially diverted medications as well as pharmacists, prescribers and other providers/consumers who participate in drug diversion. OMIG will collaborate with law enforcement agencies and MCOs to combat drug diversion in the Medicaid program.

Pharmacy Audits

OMIG conducts pharmacy audits to ensure provider adherence with applicable federal and state laws, regulations, rules, and policies governing the New York State Medicaid program. OMIG will verify that prescriptions were properly ordered by a qualified practitioner, the pharmacy has sufficient documentation to substantiate billed services, appropriate formulary codes were billed, patient-related records contain the documentation required by the regulations, and claims for payment were submitted in accordance with department regulations and appropriate provider manuals. OMIG audits various types of pharmacies, including retail chain pharmacies, long-term care pharmacies, and infusion/specialty pharmacies. OMIG continues to partner with counties in New York State through the County Demonstration program. OMIG provides oversight of retail independent pharmacy audits that are conducted by the County Demonstration program.

Customary Pricing

OMIG will examine pharmacy claim reimbursements to ensure that prices charged to the general public reflect the charges billed to the Medicaid program. OMIG collaborates with DOH on policy issues, such as actual acquisition cost, as they relate to pharmacy.

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 consumers are not receiving behavioral interventions as prescribed. Further, the Food and Drug Administration 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 continue to work with our partners, including DOH and the Centers for Medicare and Medicaid Services (CMS), to reduce the amount of antipsychotics being utilized in residential facilities. OMIG will also review the appropriate utilization of antipsychotic agents in children and will partner with other state agencies to determine if the use of these medications results in negative outcomes.

Atypical Antipsychotics Ordered for Children Three and Under

OMIG will conduct a thorough analysis of Medicaid claims for atypical antipsychotic drugs ordered for children three years old or under. There are no Food and Drug Administration-approved uses for this therapeutic class of drugs for children three and younger. OMIG will review all recipients, prescribing providers, and other Medicaid claim information on the recipients for use in future OMIG actions.

Pre-Enrollment Review

OMIG will continue to conduct provider pre-enrollment reviews on all applications for enrollment from pharmacies and DME providers. These reviews include the use of on-site visits, as well as collateral contacts with businesses and individuals associated with the business.

Durable Medical Equipment

OMIG will continue to review claims paid on behalf of DME providers. OMIG will verify that claims were submitted in accordance with Medicaid rules and regulations, DME equipment and supplies were authorized by a licensed practitioner, DME items were rendered for the dates billed, and that appropriate procedure codes were used in the billing process.

Medicare Part D Duplication

OMIG will collaborate with HHS to identify pharmacy services billed to both Medicare Part D and New York State Medicaid. OMIG will provide HHS with a pharmacy claim database to be matched with Medicare Part D data.

PHYSICIANS, DENTISTS, AND LABORATORIES

The Physician, Dentist, and Laboratory business line encompasses those health practitioners. 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 consumers by clinical laboratories, physicians, or podiatrists within their scope of practice.

OB-GYN Physicians and Nurse Midwives

OMIG will review Medicaid claims from physicians and nurse midwives for duplicate delivery billing and billing for services included in the global delivery rate. The global delivery rate includes antepartum care and inpatient/outpatient postpartum care. Separate billing for these services should not be done for providers billing the global rates.

Primary Care Services under the Affordable Care Act

The federal Affordable Care Act requires state Medicaid programs to reimburse qualified physicians for designated primary care services up to the Medicare fee schedule price in 2013-14. The Centers for Medicare and Medicaid Services (CMS) will require that OMIG complete an audit of a random sample of physician attestations from fee-for-service and managed care to ensure that requirements for payment enhancements were met.

Dental Review

OMIG will review providers of dental services to verify that services billed were performed, documentation supports the services billed, and that the claims are submitted in accordance with Medicaid program rules, regulations, and policy.

Orthodontic dental services will be reviewed for exceeding age limits and maximum number of treatment quarters outlined in Medicaid regulation. Excessive preventive services provided by private dentists that exceed the frequency limits to the same consumer within a certain time period will also be reviewed for possible recovery of overpayments.

Evaluation and Management Codes Review

Evaluation and management codes are a range of standardized codes used by physicians for reimbursement. These may vary by new and established patients, complexity of both patient condition and physician judgment, and place of service. Each code has its own requirement in Medicaid regulation and will be reviewed for adherence to Medicaid policy.

Clinical Psychologists and Social Workers Medicare Crossover Analysis

OMIG will identify and review situations where clinical psychologists and social workers billed both Medicare and Medicaid for similar services for the same consumer on the same date of service.

Excluded Providers as Servicing, Attending, Referring, and Ordering Providers

Excluded provider lists received from CMS will be matched with claims and encounters on the Medicaid Data Warehouse to identify services ordered or referred by an excluded provider. Also, clinic claims and encounters will be reviewed for clinic services rendered by an excluded provider.

Providers with Excessive Ordering of Controlled Substances

OMIG has produced a list of providers whose controlled substance ordering habits are exceptional when compared with their peers. OMIG will review the ordering for these providers to determine if the ordering was medically necessary.

RESIDENTIAL HEALTH CARE FACILITIES

The Residential Health Care Facilities (RHCF) business line includes skilled nursing facilities and assisted living programs (ALPs). RHCFs are reimbursed for covered services to eligible consumers based on prospectively determined rates. An ALP provides long-term residential care, room, board, housekeeping, personal care, and 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 the Department of Health (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 indicated, 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 facility. 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 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.

Minimum Data Set

OMIG will continue to review Minimum Data Set (MDS) submissions from nursing facilities. OMIG has collaborated with DOH and nursing home trade associations and has initiated reviews of the January 2012 MDS data submissions. OMIG will continue to initiate reviews of subsequent MDS submission periods.

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

Medicaid will not pay for any items furnished to an 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 had also been included in the ALP payment rate, resulting in the Medicaid program having paid twice for these services.

Fee for Service Reviews of Assisted Living Program Resident Care

OMIG may conduct the above-mentioned reviews which are concerned with the documentation of care given to ALP residents. These reviews would focus on timely medical evaluations, interim assessments, plans of care, functional assessments, and the presence of relevant evidence of service provision.

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 Offset

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 Offset.” 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.

OMIG will conduct risk assessments and perform reviews of the Part B Offset 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 BLT will work with the New York State Department of Motor Vehicles (DMV), the New York State Attorney General's Medicaid Fraud Control Unit (MFCU), Department of Health (DOH), and individual counties to determine whether services were provided in accordance with Medicaid requirements. OMIG will be looking to identify transportation providers who employ drivers or contractors who appear on the OMIG's List of Disqualified Individuals or Entities, who fail to maintain appropriate records, or who fail to comply with the New York State rules regarding 19-A certification for drivers, and rules and regulations regarding Medicaid claim submission.

Transportation System Match

OMIG will continue the system match initiative, which began in 2012, to look at transportation providers using disqualified drivers. DMV maintains a database of 19-A qualified drivers. The DMV data is matched with Medicaid transportation claims to identify drivers who are not 19-A-qualified on the date of service. In addition, this project will also examine transportation claims billed while the consumer was a hospital inpatient.

Transportation to Therapy Services

OMIG will be evaluating any Medicaid fraud referrals received from DOH and their transportation broker, LogistiCare. The area of concentration will include data analysis and investigation of transportation providers and their connection with occupational therapy, physical therapy, and speech therapy services.

Transportation Provider Pre-Payment Review

OMIG will examine transportation claims on a pre-payment review basis. As claims are submitted, selected transportation provider claims will pend (prior to payment) for review. Areas to be reviewed include providers using an inactive National Provider Identification (NPI) number as the prescribing provider, or failing to document the driver's license and/or the license plate number of the vehicle. In addition, OMIG will continue to collaborate with DMV to identify DMV data that will assist OMIG in evaluating Medicaid claims.

19-A Stop Project

This project is a cooperative effort between OMIG and various law enforcement agencies, including the New York City Taxi and Limousine Commission. The entities will work together to identify high-ordering Medicaid transportation providers for potential administrative and/or civil and/or criminal actions.

Claim Review and Investigation

Using information from a variety of sources to select transportation targets, OMIG will review and investigate 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. In addition, OMIG will continue to conduct audits of transportation services through its County Demonstration program. These reviews will focus on the adequacy of the documentation for the services provided, licensing of the driver, as well as vehicle registration and inspections.

ACTIVITIES RELATING TO MULTIPLE 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.

COST RECOVERY ACTIVITIES

Cost recovery activities relate to OMIG actions that result in actual cash deposits and voids from OMIG and contractor audit activities.

Self-Disclosure Efforts

OMIG developed a unique self-disclosure process in March 2009, in consultation with health care providers and industry professionals, to give providers an easy-to-use method for disclosing overpayments. OMIG designed this approach to encourage providers to investigate and report matters that involve possible fraud, waste, abuse, or inappropriate payment of funds that they identify through self-review, compliance programs, or internal controls that affect the state's Medicaid program.

The self- disclosure function is now supplemented by utilizing the OMIG/Health Management Systems, Inc. (HMS) PORTal, a web-based site maintained by our contracted agent - HMS, Inc. The PORTal is an online mechanism used by OMIG/HMS to issue various projects and process recoveries in a simple, effective and user- friendly electronic medium. This process has been revised to reflect the consolidation of the self- disclosure function within OMIG to better serve the providers and the New York State Medicaid program. Manual submissions may still be submitted directly to OMIG.

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 insurance carrier claim information as our source data.

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 consumers 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 consumers 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.

Medicaid Electronic Health Records Incentive Payment Program

Through the Medicaid Electronic Health Record (EHR) Incentive Payment program, hospitals and eligible providers 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 and conduct reviews to ensure that the eligibility requirements of the New York State Medicaid EHR Incentive program were met according to CMS guidelines.

Payment Error Rate Measurement Project – FFS Medical Reviews

New York State will participate in its third Payment Error Rate Measurement (PERM) review in Federal Fiscal Year 2014 (October 1, 2013 through September 30, 2014). Each state and the District of Columbia participate in a PERM review every third year, with one-third of the states in each federal cycle. New York State last participated in the PERM review during Federal Fiscal Year 2011.

OMIG will be responsible for the Medicaid fee-for-service and Medicaid managed care universe submission, as well as mirroring the medical review portion of the Medicaid fee-for-service sample that will be completed by the federal contractor for CMS, to verify that the sampled providers submitted complete documentation to justify the claim and to pursue additional documentation from the sampled provider when the documentation is incomplete.

AIDS-Related Issues

OMIG will continue working in conjunction with the AIDS Institute on active fee-for-service billing audits using the seven-tier and five-tier rate systems, before the implementation of ambulatory patient groups (APGs) in hospitals and diagnostic and treatment centers. Additionally, OMIG will complete work on Medicaid-financed targeted case management providers in the HIV system that are in the process of converting to medical health homes.

External Audits by Outside Agencies

The OMIG will continue to assist external agencies in their audits of the Medicaid program, and assure that the proper corrective action is taken on any audit findings. OMIG will conduct follow-up audits and verification of corrective actions associated with prior findings, not only by external agencies, but also those previously conducted by OMIG. This approach will assist providers in reducing future risks of the occurrence of inappropriate or fraudulent claims.

Cost Saving Activities

Cost saving activities reflects those initiatives and actions that result in reducing and/or avoiding future costs to the Medicaid program.

Prepayment Review

OMIG will conduct pre-payment review activities and review claims for providers and claiming subjects of interest. This capability allows for the monitoring and reviewing of claiming practices. Areas of activity include:

- Dual-Eligible Providers (Medicaid/Medicare) - Collaborate with the federal Medicare contractor in performing prepayment reviews of providers that render services to dual-eligible beneficiaries to prevent fraud and aberrant claim submission in the Medicare and Medicaid programs.
- Transportation - Providers using inactive National Provider Identifiers (NPI) as the prescribing provider, or failing to document the driver's license of the driver and plate number of the vehicle will be targeted.
- Pharmacy managed care carve outs.
- Consumers receiving family planning services.
- Consumers in the cancer treatment program.
- Private duty nurses.
- Certified home health agencies (CHHAs) and home health agencies.
- Misuse of NPI as a prescribing, referring, or servicing provider.
- DME claims submitted with no diagnostic code.

Point-of-Service Controls

Providers on the Cardswipe (landline terminals) program who continue to meet the statutory billing threshold of $75,000 per year will continue to be reviewed by OMIG in accordance with program rules.

For the Mobile Cardswipe program, OMIG staff will continue to review the activities of selected private duty nurses who are required to use a wireless card swipe terminal.

Medicaid Systems Controls

OMIG will lead a newly implemented project team to review managed care edits that validate encounter records; and, work with managed care organizations to strengthen their systems controls and share best practice edits.

Third-Party Activities

Third-party recovery activities are related to payments received by other insurers to cover the costs that they should have paid.

Pre-Payment Insurance Verification

This activity is the foundation of our cost avoidance efforts. By identifying third-party coverage and updating the third-party file on eMedNY prior to payments made by Medicaid, claims are rejected until third-party resources are utilized.

Liable third parties are added to the eMedNY database after matching Medicaid consumer files with commercial insurance, Medicare, military, and any other available third-party files. Identified and verified third-party client/carrier, specific eligibility information is provided to the front-end of the state payment system for categories of service, including major medical, dental, prescription drug, and optical claims.

Fee-for-Service Third-Party Retroactive Recovery Projects

A comprehensive periodic retroactive recovery process is in place as the primary part of OMIG's efforts for recovery of Medicaid expenditures. The recovery process utilizes many sources such as known third-party liability (eMedNY) that has been identified through various means, including local district input, matching with the Social Security Administration and the contracted third-party file matches (commercial insurance companies, military carriers, state and federal files, and input from employers, etc.). The updated third-party file is matched against the eMedNY claims extract file to identify claims for which potential or verifiable third-party liability exists.

Managed Care Third-Party Retroactive Recovery Projects

The state and managed care plans now share responsibility for the collection of third- party revenues pursuant to respective managed care contracts. The protocols for this initiative mirror the FFS protocols and use encounter reporting data as the operational base instead of FFS paid claims data.

Third-Party Liability and Commercial Direct Billing

Insurance carriers must process claims and remit payment for covered services directly to the state. They are not permitted to deny the claims submitted by the state Medicaid agency for being outside of the insurer's timely filing period, or for lack of documentation at the point of service.

These efforts have also supported the expansion of third-party recovery initiatives on benefits paid by the managed care plans. OMIG has seen success in performing third-party recovery work on certain encounter claims reported by the plans. In the past year, the OMIG initiated pharmacy third-party direct billing recovery work on the Medicaid managed care population.

Estate and Casualty Recovery

OMIG will work with counties and the Department of Health to centralize estate and casualty recovery as specified in Medicaid Redesign Team initiative 102.

COUNTY DEMONSTRATION PROGRAM

OMIG has worked with county social service districts since 2006 through its County Demonstration program. The program brings together OMIG's audit experience with county level expertise and data with county level intelligence and local understanding of fraud, waste, and abuse. The intent of the program is to partner with local districts to collectively intensify these efforts and develop innovative approaches to fighting fraud, waste and abuse at the local level.

OMIG will increase its efforts in improve recoveries in the coming year. With the introduction of an increased number of audit protocols and the alignment of training resources to match local needs, OMIG intends to finalize outstanding audits and initiate new audit targets.

The 2013-14 budget introduces some improvements to the program. First, the budget incentivizes the participation of counties by increasing the savings attributable to the counties efforts from 10 percent to 20 percent. Also, OMIG will conduct quarterly meetings with representatives from local social service districts to improve upon past efforts. These meetings will provide OMIG and the social service districts a continuing opportunity to discuss fraud, waste, and abuse efforts. It will also give counties the opportunity to share knowledge and experience with other counties. OMIG will also provide expanded guidance to this program and discuss participation with non-participating counties.

Consistent with state law, OMIG will also seek local budgets and work plans. These work plans will then be integrated into OMIG work plans as an addendum.

OMIG will continue to partner with the local districts to conduct audits in the areas of pharmacy, transportation, and durable medical equipment. The reviews are conducted to ascertain whether providers are adhering to applicable federal and state laws, regulations, rules, and policies governing the New York Stet Medicaid program.

COMPLIANCE-RELATED ACTIVITIES

Mandatory Compliance Program General Guidance and Assistance

OMIG's compliance efforts educate and assist providers in meeting requirements to implement and operate compliance programs that meet the statutory and regulatory requirements. 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 continue to update and publish the procedures and forms used in conducting reviews of providers' mandatory compliance programs, including identification of best practices in compliance and how providers can enhance their compliance programs. OMIG will begin collecting data on how observed compliance programs interact with providers' activities related to billing, payment, medical necessity and quality of care, governance, mandatory reporting, credentialing, and provider-specific risk areas. Once the data is collected, it is expected that it will be published in a de-identified way on OMIG's Web site.

The Bureau of Compliance will develop at least 12 guidance documents per year that will be publishable on OMIG's Web site. The guidance documents will be in various forms and formats but will include *Compliance Alerts*, *Medicaid Updates*, creation and updates of forms used in compliance reviews and corporate integrity agreements (CIAs), webinars, additions to the Compliance Library, and presentations given to various provider groups.

Compliance Program Reviews

OMIG desk and onsite compliance program reviews will initially focus on providers who do not meet the annual certification requirements under the New York State Social Services Law and the federal Deficit Reduction Act of 2005. In addition, that focus will be augmented by including providers identified to have repeated issues associated with claims submissions.

Corporate Integrity Agreement Enforcement

Corporate integrity agreements 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 provider's compliance program to determine if the provider has sufficient resources and has established its compliance program to meet the program integrity obligations that would be required by a CIA. OMIG will monitor provider performance under the terms of CIAs and will impose penalties which are identified in CIAs when providers fail to comply with their CIAs. Guidance will be published related to specific issues to be addressed by providers under the terms of a New York State CIA.

INVESTIGATIVE ACTIVITIES

In addition to the normal internal and external referral process and follow up investigative actions by the Division of Medicaid Investigations, OMIG will perform the following reviews on an on-going basis.

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, a consumer. 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.

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.

Recipient Investigations

OMIG will investigate allegations related to consumer eligibility issues, issues involving misuse of benefits cards, and cases where consumers lend or rent their benefits cards to others to obtain medical benefits to which they are not entitled. OMIG will coordinate with local, state, and federal law enforcement to investigate consumers defrauding Medicaid and referring those consumers 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.