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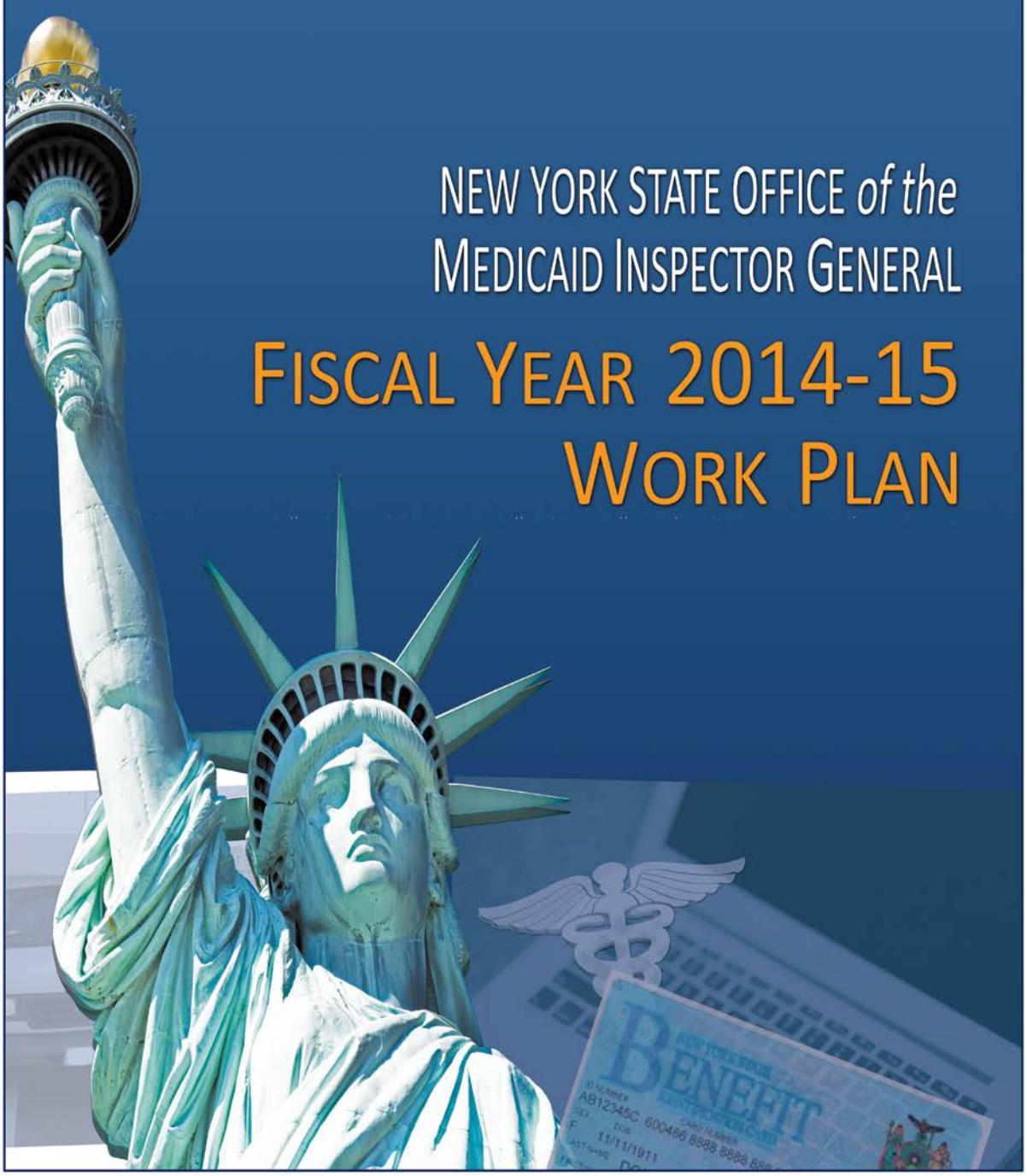
NEW YORK STATE OFFICE *of the* MEDICAID INSPECTOR GENERAL

FISCAL YEAR 2014-15 WORK PLAN



EXECUTIVE SUMMARY

New York State's Medicaid program provides important health care services to people across the State. The New York State Office of the Medicaid Inspector General's (OMIG) role in the program is fighting fraud and abuse by overseeing accuracy in payment and service provision. This Work Plan covers the period of April 1, 2014 to March 31, 2015.

The Work Plan, just like the rest of OMIG's work, is largely organized into Business Line Teams (BLTs). These specialized, multi-disciplinary teams within OMIG help coordinate program integrity activities with other federal, state, and local partners. The 2014-15 Work Plan is a roadmap to review activities OMIG plans to carry out during this fiscal year. As we move into the third year of BLT-based coordination, the focus will be on completing the work coordinated by each BLT and starting the process of analyzing the need to create new teams.

Managed care plays an increasing role in the Medicaid program. OMIG's work in managed care will expand this year and for the foreseeable future. In light of this, OMIG will continue the process of transitioning the focus of its reviews and personnel into managed care program integrity. OMIG will expand its activities in other areas during State fiscal year 2014-15, including certified home health agencies, personal care services, as well as supported employment services.

During the next year, OMIG will work with local governments to dramatically improve recoveries in the County Demonstration program. Quarterly meetings will be held with representatives from social service districts to improve upon past efforts. We will also seek budgets and work plans from local participants. OMIG will continue to bring expanded guidance to this program and start the process of bringing in additional local social service districts. OMIG will complete the process of integrating County Demonstration participant work into the BLTs.

OMIG is dedicated to program integrity efforts and recognizes the value in assisting providers to improve their practices. To that end, New York is the national leader in compliance efforts and was the first state in the nation to require providers to adopt effective compliance program elements. OMIG also offers instruction to providers on how to meet the Medicaid requirements. In 2014-15, OMIG will expand its compliance and education activities to further improve upon New York's nation-leading model.

OMIG values the importance of partnerships. OMIG was the first state-level entity to participate in the federal Fraud Prevention Partnership, which is a national effort to create best practices in healthcare program integrity. OMIG also maintains a close working relationship with 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. OMIG will continue these efforts in 2014-15.

Table of Contents

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 regarding activities planned for State Fiscal Year 2014-15, intended to fight fraud, improve integrity and quality, and save taxpayer dollars.

While review work is coordinated on a business line basis, OMIG consists of nine core components (in alphabetical order):

- Agency Coordination and Communications
- Bureau of Compliance
- Bureau of Risk Management
- Bureau of Quality Assurance
- Division of Administration
- Division of Medicaid Audit
- Division of Medicaid Investigations
- Division of System Utilization and Review
- Office of Counsel

Each of these core components helps to staff multidisciplinary teams known as Business Line Teams. These teams look at specific categories of services that are listed below (in alphabetical order):

- Home and Community Care Services
- Hospital and Outpatient Services
- Managed Care
- Medical Services in an Educational Setting
- 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

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.

Home Health

The Office of the Medicaid Inspector General (OMIG) will conduct reviews of CHHA, LTHHCP, PCA, TBI, and PDN services that will include the following components:

- *Provision of Services*: OMIG will analyze claims to determine if services that require supervision were provided, 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 the home care provider processes the spend down requirements correctly in cases where 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 Payments*: 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.

Home Health Verification Project

CHHA, LTHHC and Personal Care providers are required to utilize a verification organization to incorporate automated controls to verify the actual services provided, arrival time, departure time, PC worker identity proofing, etc. OMIG will continue to evaluate verification organization data and reports and refine our operational activities for monitoring home health data.

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

OMIG will review 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 review rate add-ons, including funds dedicated to worker recruitment, training, and retention.

HOSPITAL AND OUTPATIENT SERVICES

The Hospital and Outpatient Services Business Line Team includes services provided by hospitals, clinics, and diagnostic and treatment centers (D&TCs).

Diagnostic and Treatment Centers

The Office of the Medicaid Inspector General (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 Ambulatory Patient Groups (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 actually provided at a non-FQHC-approved location.

Inpatient Crossover to Emergency Room/Clinic Visits

Emergency visits, clinic visits, and related ancillary services 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 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 documentation to support both the initial emergency room service as well as any resulting paid claims for hospital or long-term care costs.

Outpatient Department Services

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

MANAGED CARE

The Managed Care Business Line Team includes all services provided by a managed care organization (MCO). MCOs coordinate the provision, quality, and cost of care for their enrolled consumers. 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 (MLTC) plans, and Human Immunodeficiency Virus (HIV) special needs plans. Historically, the Office of the Medicaid Inspector General (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. OMIG has identified a series of robust initiatives to significantly strengthen the detection of fraud, waste, and abuse in the Medicaid managed care environment.

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. Consumers have the option of securing family planning and reproductive health services from out-of-network providers. When this occurs, OMIG identifies these services, and the MCO may be requested to repay Medicaid for fee-for-service (FFS) costs.

Duplicate Billing

OMIG will review FFS payments made for managed care consumers to determine if the services were already included in the managed care benefit package.

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.

Managed Care Coding

OMIG will work with representatives from the Department of Health to examine MCO coding policies for completing patient encounter forms. This coding is used to determine clinical risk groups and ultimately risk scores for managed care reimbursement.

Managed Care Cost Reporting

New York is now paying MCOs a capitation rate that includes consumer services that have not traditionally been included in Medicaid managed care. OMIG plans to review various aspects of the cost reports. OMIG will examine the underlying data to identify whether unallowed costs are included in the report.

Managed Long-Term Care

OMIG will review the enrollment records to determine if the MLTC plans properly determined eligibility for enrollment and provided proper care management to selected members.

Medicaid Systems Controls

OMIG will review managed care edits that validate encounter records, and work with MCOs to strengthen systems controls, as well as share best practice edits.

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 DOH, local social service districts, and other regulating agencies.

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 or abuse by OMIG's RRP staff specifically assigned to each managed care plan. OMIG staff will continue to attend statewide managed care meetings. OMIG staff will also continue to identify and support consumer fraud or abuse medical and non-medical FFS restrictions in partnership with local districts.

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. In addition, OMIG will assume the responsibility for tracking consumers who are retroactively disenrolled from managed care.

Social Adult Day Care Centers

OMIG, the Medicaid Fraud Control Unit, and the New York City Buildings Department will continue joint investigations of several social adult day care centers (SADCs). Specifically, we will investigate and/or audit complaints of overcrowding, inappropriate solicitation of Medicaid clients, and the enrollment of unqualified clients in the MLTC program. In addition, OMIG will conduct credential verification reviews and record reviews of the documentation provided in response to the subpoenas.

Special Investigation Information

OMIG will coordinate with special investigative units (SIUs) of MCOs. This will enable MCOs to learn of cross-plan issues and take appropriate action. This will also create a much more efficient and effective investigative force.

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 the appropriateness of the payment.

MEDICAL SERVICES IN AN EDUCATIONAL SETTING

The Medical Services in an Educational Setting Business Line Team focuses on school supportive health services provided to special education students between the ages of 3 and 21.

Intermediate Care Facility School Supportive Health Services Program

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

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 review school districts and county preschool providers who received reimbursement.

MENTAL HEALTH, CHEMICAL DEPENDENCE, AND DEVELOPMENTAL DISABILITIES SERVICES

The Mental Health, Chemical Dependence, and Developmental Disabilities Services Business Line Team works in close collaboration with the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH), and the Office for People with Developmental Disabilities (OPWDD) to promote program integrity among the service providers under their regulatory purview.

Chemical Dependence Inpatient Rehabilitation Services

The Office of the Medicaid Inspector General (OMIG) will review payments for inpatient chemical dependence rehabilitation services to determine whether services were provided in accordance with Medicaid requirements.

Community Residence Rehabilitation Services

OMIG will review payments made for rehabilitative adult and family-based treatment services provided to individuals living in community-based residential programs to determine whether mental health services were provided in accordance with Medicaid requirements.

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. Working in conjunction with OMH, OMIG will review those providers whose COPS reimbursements exceeded the threshold amounts.

Day Habilitation

Day habilitation services provide various supports and services that assist individuals to work at their jobs and participate in the community, and are delivered primarily outside of the individual'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.

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 individuals with developmental disabilities. Individuals 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.

Medicaid Service Coordination

Medicaid service coordination (MSC) assists individuals 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.

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.

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 include clinic, continuing day treatment, children's day treatment, partial hospitalization, and intensive psychiatric rehabilitation program.

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.

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 habilitation services to determine whether developmental disability services were provided in accordance with Medicaid requirements.

Supported Employment

Supported employment offers various 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.

PHARMACY AND DURABLE MEDICAL EQUIPMENT

The Pharmacy and Durable Medical Equipment (DME) Business Line Team includes drug and durable medical equipment services.

Drug Diversion

The Office of the Medicaid Inspector General (OMIG) aims to decrease the amount of Medicaid wasteful expenditures by reducing drug diversion and drug misuse. The most commonly diverted drugs are high-cost medications and drugs with abuse potential, including narcotics and related pain relievers, high-cost antipsychotics, high-cost atypical antidepressants, and antiretroviral drugs used in the treatment of Human Immunodeficiency virus or Acquired Immune Deficiency Syndrome. OMIG will review complicit and non-complicit overprescribing of drugs as well as intentional and unintentional overuse. In addition, OMIG will investigate the resale of drugs and the proper authorization of written prescriptions.

Durable Medical Equipment Reviews

OMIG will determine whether claims were submitted by DME providers in accordance with Medicaid rules and regulations. In addition, OMIG will determine whether 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.

Using various data collection systems, OMIG will conduct prepayment reviews of selected DME providers dispensing orthopedic shoes. Documentation will be requested for submitted claims and will be reviewed for appropriateness of the dispensed shoes as well as the adequacy of the supporting documentation.

OMIG will also provide oversight of DME reviews that are conducted by the County Demonstration program.

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 coordinate with MCOs on inventory reviews to develop a comprehensive billing picture for pharmacies and DME providers servicing Medicaid consumers.

Medicare Part D Duplication

OMIG will collaborate with the federal Department of Health and Human Services (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.

Pharmacy Reviews

OMIG will conduct pharmacy reviews 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 regulations and appropriate provider manuals. OMIG will review various types of pharmacies, including retail pharmacies, long-term care pharmacies, and infusion/specialty pharmacies.

OMIG will also provide oversight of pharmacy reviews that are conducted by the County Demonstration program.

PHYSICIANS, DENTISTS, AND LABORATORIES

The Physicians, Dentists, and Laboratories Business Line Team encompasses those health practitioners who submit Medicaid claims within these categories of service. 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.

Clinical Psychologists and Social Workers Medicare Crossover Analysis

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

Dental Reviews

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

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

Excluded provider lists received from the US Department of Health and Human Services Office of Inspector General 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 will review controlled substance prescribing patterns to determine if the ordering was medically necessary.

RESIDENTIAL HEALTH CARE FACILITIES

The Residential Health Care Facilities (RHCF) Business Line Team reviews nursing facilities and assisted living programs (ALP). RHCFs are reimbursed for covered services to eligible consumers based on determined rates. An ALP 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.

Assisted Living Program Resident Care

OMIG will conduct reviews centered around the documentation of care given to ALP residents. These reviews will focus on timely medical evaluations, interim assessments, plans of care, functional assessments, and the presence of relevant evidence of service provision.

OMIG will also provide oversight of ALP resident care reviews that are conducted by the County Demonstration program.

Base Year Audits

RHCFs use the same reported costs, with appropriate trend factors, for multiple years of reimbursement. The Office of the Medicaid Inspector General (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.

Bed Reservations

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

Capital

Reported RHCF capital costs are used as a basis for the capital component of the RHCF Medicaid rate. OMIG will audit underlining costs included within the capital component and if necessary, make appropriate adjustments to the rates

Goods or Services Included in the Assisted Living Program Rate

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, which were also included in the ALP payment rates.

OMIG will also provide oversight of these ALP rate reviews that are conducted by the County Demonstration program.

Medicaid Rate Part B Offset

Medicaid rates for nursing facilities include billable rates for Medicaid consumers who may or may not be eligible for Medicare Part B service reimbursement. 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 consumers 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 and will also review any appeals processed by DOH.

Minimum Data Set

OMIG will review Minimum Data Set submissions from nursing facilities. During State Fiscal Year 2014-2015, OMIG will collaborate with DOH to initiate reviews of data submissions.

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 and adjust rates accordingly.

Rate Appeals

RHCFs may file rate appeals with DOH 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.

TRANSPORTATION

The Transportation Business Line Team will work with the New York State Department of Motor Vehicles (DMV), the New York State Attorney General's Medicaid Fraud Control Unit, Department of Health (DOH), and individual counties to determine whether services were provided in accordance with Medicaid requirements.

19-A Stop Project

This project is a cooperative effort between the Office of the Medicaid Inspector General (OMIG) and various law enforcement agencies, including the New York City Taxi and Limousine Commission. OMIG will work to identify high-ordering Medicaid transportation providers for field review.

Claim Review and Investigation

Using information from a variety of sources to select transportation providers, 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. Random field inspections of transportation providers will be conducted to assess compliance with Medicaid rules and regulations.

OMIG will provide oversight of transportation reviews that are conducted by the County Demonstration program.

Transportation Provider Prepayment Review

OMIG will review providers using inactive National Provider Identifiers as the prescribing provider, or failing to document the driver's license of the driver and/or plate number of the vehicle. OMIG will also review required trip records and backup documentation.

Transportation System Match

OMIG will continue to review transportation providers who use disqualified drivers. DMV maintains a database of 19-A qualified drivers. DMV data will be matched with Medicaid transportation claims to identify drivers who are not 19-A qualified on the date of service. This project will also examine transportation claims billed while the consumer was a hospital inpatient. In addition, this project will identify claims billed with incorrect driver's license numbers or vehicle plate numbers, which are required fields on a transportation ambulette claim.

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.

AIDS-Related Issues

The Office of the Medicaid Inspector General (OMIG) will continue working in conjunction with the AIDS Institute to complete 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 that are in the process of converting to medical health homes.

Ambulatory Patient Groups

As part of the overall effort to reform Medicaid reimbursement and reconsider service delivery, the outpatient Medicaid payment system now uses an APG methodology. OMIG will work closely with the regulating agencies to ensure that provider reimbursement is made in accordance with Medicaid APG requirements.

Collaborative Efforts with Law Enforcement/Medicare Fraud Strike Force

OMIG will continue to engage in collaborative efforts with local, state, and federal law enforcement agencies, local, state, and federal prosecutorial agencies, and with local and county department of social service agencies, in pursuing cases of Medicaid fraud. OMIG investigative staff will be represented on the FBI-directed Health Care Fraud Strike Forces operating out of the Southern District of New York and throughout the State. OMIG will also be represented on the U.S. Department of Justice Medicare Fraud Strike Force and will aid and assist in health care fraud investigations they conduct. OMIG will continue to work collaboratively with New York City Human Resources Administration (HRA) and with the local NYC District Attorneys' offices, as well as with local department of social service agencies and county prosecutors across the State to identify and prosecute those individuals attempting to defraud the taxpayers of the State of New York and the Medicaid program.

Collaborative Managed Care Surveys

OMIG will collaborate with the Department of Health (DOH) to conduct a review of managed care organizations (MCO) using an operational survey and onsite reviews. OMIG will lend investigative expertise to the project, providing DOH with trained investigative staff to determine whether MCO special investigation units are adequately performing their investigative functions to detect and prevent fraud, waste, and abuse in the Medicaid program.

Compliance Program General Guidance and Assistance

OMIG will continue its efforts to educate and assist providers in meeting requirements to implement and operate compliance programs that conform to statutory and regulatory requirements. OMIG will issue compliance publications, including *Compliance Alerts*, articles in *Medicaid Updates*, and other guidance that can be found on OMIG's Web site. OMIG will create and update forms used in compliance reviews and CIAs, update resources in the Compliance Library on OMIG's Web site, present compliance-focused webinars, and participate in 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 and produce educational materials to assist providers identify how they can improve and enhance their compliance programs.

Compliance Program Reviews

OMIG will conduct compliance program reviews of identified subjects. These reviews will focus on providers who do not meet annual certification requirements and those who have repeated issues with OMIG or other regulating agency metrics.

Corporate Integrity Agreement Enforcement

A corporate integrity agreement (CIA) is established when a provider would otherwise be excluded from continued participation in the Medicaid program as a result of provider noncompliance with program obligations. This includes participation in an unacceptable practice as defined in Medicaid regulations.

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.

County Demonstration Program

OMIG will work with county social service districts and HRA through its County Demonstration program. The program brings together OMIG's experience with county level intelligence and local understanding. The intent of the program is to partner with local districts to develop innovative approaches to fighting fraud, waste, and abuse at the local level.

OMIG will partner with local districts to conduct reviews in the areas of pharmacy, transportation, durable medical equipment, and assisted living. Evidence of this effort can be seen in the Transportation, Pharmacy and Durable Medical Equipment, and Residential Health Care Facilities Business Line Team sections for this year. Reviews will be conducted to ascertain whether providers are adhering to applicable federal and State laws, regulations, rules, and policies governing the New York State Medicaid program. OMIG will introduce new areas to audit.

County Demonstration Program (Continued)

Consistent with State law, OMIG will also seek budgets and work plans and conduct quarterly meetings with representatives from local social service districts to improve results. 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 continue to align training resources to match local needs, provide expanded guidance to this program, and discuss participation with non-participating counties.

Enrollment and Reinstatement

OMIG will review selected new provider enrollment applications to determine if providers should be allowed to enroll in the Medicaid program. OMIG will review reinstatement applications to determine whether the circumstances that led to the exclusion or termination may 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.

Estate and Casualty Recovery

Medicaid Redesign Team Initiative 102 (MRT 102) calls for the centralization of management and reporting of Medicaid casualty and estate recovery. OMIG requires local departments of social services, to use a centralized case management system to administer these recovery programs. Prior to assuming such responsibility from a social services district, a scope of services will be defined. In some cases, OMIG will undertake a full assumption of estate, casualty, and lien recovery.

As of January 2014, 27 New York counties, including some components of New York City HRA, have been implemented through the MRT 102 efforts. During the coming year, implementations for 10 additional counties and other components of HRA will be in progress.

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 that has been identified through various means, including local district input, matching with the Social Security Administration and the contracted third-party file matches (e.g., commercial insurance companies, military carriers, state and federal files, and input from employers, etc.). The updated third-party file will be matched against the eMedNY claims extract file to identify claims for which potential or verifiable third-party liability exists.

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 Medicaid consumer. OMIG will work to identify providers who have engaged in kickbacks and inducements.

Location of Services Unknown to New York State Department of Health

Medicaid providers are required to inform DOH of any new service location and newly closed locations. OMIG will identify providers with service locations that have not been disclosed and upon identification, report this information to DOH.

Managed Care Third-Party Retroactive Recovery Projects

New York State and Medicaid managed care plans now share responsibility for the collection of third-party revenues pursuant to respective managed care contracts. The process for this initiative mirror fee-for-service (FFS) protocols and use encounter reporting data as the operational base instead of FFS paid claims data. Reviews of the encounter data will be undertaken to ascertain the correct payer.

Medicaid Consumer Investigations

OMIG will proactively investigate allegations related to Medicaid consumer eligibility issues involving the misuse of benefit cards. OMIG will also coordinate with local, county, state, and federal law enforcement agencies, as well as with local and county department of social service agencies, to identify high-income Medicaid consumers who are defrauding the Medicaid program and refer such consumers to the appropriate prosecutorial agencies.

OMIG also investigates allegations of recipients involved in drug diversions through doctor shopping and forgeries. OMIG will coordinate with local, county, state, and federal law enforcement agencies to pursue prosecution of consumers found to be diverting drugs. In some cases, consumers will also be referred for administrative action.

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 Centers for Medicare and Medicaid Services (CMS) eligibility requirements of the New York State Medicaid EHR Incentive program were met.

Medicaid Integrity Contract Audits

Audit Medicaid Integrity Contractors (MICs) are entities with which CMS has contracted to conduct post-payment audits of Medicaid providers. The overall goal of the provider audits is to identify overpayments and to ultimately decrease the payment of inappropriate Medicaid claims. At the direction of CMS, the MICs audit Medicaid providers throughout the country. The audits ensure that Medicaid payments are for covered services that were actually provided and properly billed and documented. Audit MICs perform field audits and desk audits. CMS has contracted with IPRO to conduct MIC audits throughout New York State. OMIG has been working with IPRO and CMS to identify areas and providers to review. OMIG will coordinate IPROs audit work.

Medicaid Recovery Audit Contractor

In 2011 CMS mandated that all states will have a Medicaid Recovery Audit Contractor (RAC). CMS has given states discretion to tailor their RAC program to their respective state program. New York has contracted with HMS to function in this capacity.

RAC projects will continue in the coming year in the form of credit balance reviews and payment integrity reviews. RAC credit balance reviews identify overpayments in hospital and long-term care settings through both onsite and desk reviews. In hospitals, the RAC will review Provider Aged Trial Balance reports to identify and verify overpayments for Medicaid accounts in a credit status. Long-Term Care Credit Balance Reviews will include analysis of Net Available Monthly Income, Coordination of Benefits, bed-reserve days, and rate code billing.

RAC Payment Integrity reviews will cover a broad array of projects resulting from data mining activities, reports by the Office of the State Comptroller, as well as issues identified by providers and field office staff.

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, and
- request additional enhancements to payment system edits as additional system weaknesses are identified.

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. OMIG will also work with DOH, the Office for People with Developmental Disabilities, the Office of Alcoholism and Substance Abuse Services, the Office of Mental Health, and the Justice Center for the Protection of People with Special Needs Commission to develop controls to prevent excluded or terminated contractors or staff from participating in the Medicaid program.

Payment Error Rate Measurement Project

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).

OMIG will be responsible for the Medicaid FFS and Medicaid managed care universe submission. In addition, OMIG will mirror the medical review portion of the Medicaid FFS sample that will be completed by the federal contractor for CMS to verify that the sampled providers submitted complete documentation to justify the claim.

Pre-Enrollment Review

OMIG will conduct provider pre-enrollment reviews on all applications for enrollment from pharmacies and DME providers, and has also added pre-enrollment reviews on physical therapist and portable X-ray enrollment applications.

Prepayment Insurance Verification

OMIG will identify third-party coverage of Medicaid consumers and update the third-party file on eMedNY prior to payments being made by Medicaid. This will result in claims being 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 will be provided to the front-end of the State payment system for categories of service, including major medical, dental, prescription drug, and optical claims.

Prepayment Review

OMIG will conduct prepayment review activities by assessing claims submitted by providers. This capability allows for the monitoring and reviewing of claiming practices before payment is made. Areas of activity include:

- Transportation
- Pharmacy
- Private-duty nurses
- Certified home health agencies and home health agencies
- Misuse of National Provider Identifiers as a prescribing, referring, or servicing provider
- DME claims submitted with no diagnostic code

Prior Findings

OMIG will assist external agencies in their audits of the Medicaid program, and assure that the appropriate corrective action is taken on any audit findings. OMIG will conduct follow-up audits and verification of corrective actions associated with prior findings by all agencies, including OMIG. This approach will assist providers in reducing future risks of the occurrence of inappropriate or fraudulent billing.

Self-Disclosure Efforts

The federal Affordable Care Act of 2010 requires providers to report and return overpayments within 60 days of when the overpayment was identified. In order to assist providers in complying with this law, OMIG will maintain a Self-Disclosure Unit and provide Web-based guidance on how to return Medicaid overpayments. Maintenance of this function will allow providers to manually submit information directly to OMIG. These submissions will continue to be enhanced through the use of a web based portal.

The self-disclosure function will be supplemented by utilizing the OMIG/HMS PORTal. The PORTal is an online mechanism used to issue various projects and process recoveries in a simple, effective, and user-friendly electronic medium.

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 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. OMIG will work with liable third-party insurance carriers to ensure that retroactive claims processing are being performed in accordance with the federal Deficit Reduction Act (DRA) of 2005 and subsequent passage of State legislation in 2009 (Social Services Law, Section 367-A and Insurance Law, Section 320).

These efforts have also supported the expansion of third-party recovery initiatives on benefits paid by the managed care plans.

Undercover Operations

Undercover investigators receive services from a Medicaid provider and record the provider's conduct during the undercover operation. The provider's subsequent claims are reconciled with the investigator's written report and evidence obtained by the undercover investigator. Undercover operations discover quality-of-care issues, billing problems, systemic fraud, as well as gather important intelligence on how organizations operate and the types of drugs being abused. OMIG will use undercover investigators to identify fraud and assist other investigators in confirming the existence of fraud.