NEW YORK
STATE OF
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Office of the Medicaid Inspector General

2015-2016

WORK PLAN

State of New York

Andrew M. Cuomo, Governor

Office of the Medicaid Inspector General

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Executive Summary

Since its inception, the New York State Office of the Medicaid Inspector General (OMIG) has recovered billions of dollars in fraud and abuse and set new national records. One of the ways that OMIG manages its review activities is the creation of an agency Work Plan (Plan). This Plan is intended to detail OMIG's areas of focus in the Medicaid program. The Work Plan covers the State fiscal year of April 1, 2015 to March 31, 2016.

This year's Plan continues a focus on organizing work according to categories of service. Review items are grouped into Business Line Teams (BLT). While a detailed reading of individual BLT sections may be enough for some readers, we encourage review of the entire Plan to gain an overview of planned review activities.

There are some important changes to this year's Plan. First, while OMIG has continued the practice of organizing its work into BLTs, two new BLTs are appearing for the first time. One BLT is focused on reviews of the Delivery System Reform Incentive Payment (DSRIP) program and the second focuses on reviews of services transitioned into Managed Long Term Care. Both are emerging areas of interest in the Medicaid program.

New York State is the national leader in compliance efforts and was the first state in the nation to require providers to adopt effective compliance program elements. In 2015-16, OMIG will expand its compliance and education activities to further improve upon New York's nation-leading model.

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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 regarding activities OMIG has 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 eight core organizational components (in alphabetical order):

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

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

- Delivery System Reform Incentive Payment Program
- Home and Community Care Services
- Hospital and Outpatient Services
- Managed Care
- Managed Long Term 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

Delivery System Reform Incentive Payment Program

The Delivery System Reform Incentive Payment (DSRIP) program is a Department of Health (DOH) program and is the main mechanism by which New York State will implement the Medicaid Redesign Team (MRT) Waiver Amendment. The purpose of DSRIP is to fundamentally restructure the health care delivery system by reinvesting in the Medicaid program with the primary goal of reducing avoidable hospital use by 25% over 5 years. Up to $6.42 billion dollars have been allocated to this program, and payouts are based upon achieving predefined results in system transformation, clinical management, and population health. Performing Provider Systems (PPS) are entities responsible for performing DSRIP projects. DSRIP-eligible providers include major public general hospitals and safety net providers in collaboration with a designated lead provider ("PPS Lead") for the group.

Attestation reviews of Performing Provider System Networks

As part of DSRIP network finalization, the New York State Medicaid Director informed every Performing Provider System (PPS) Network that by December 1, 2014, that PPS Leads should have signed attestation forms for all PPSs in their network. An important first step in ensuring program integrity is to conduct attestation reviews of PPSs participating in the DSRIP program. OMIG will conduct these reviews. The results of the attestation reviews will be provided to DOH for consideration in connection to pending applications for DSRIP PPS Leads.

Compliance program guidance and reviews

As new corporations are formed and enrolled as PPS Leads, they will be subject to the State's mandatory compliance requirements. OMIG will provide guidance on the mandatory compliance obligations. Existing entities that may already be subject to these requirements may have to expand their compliance programs to account for their new functions as a PPS Lead. OMIG will provide guidance on compliance risk areas associated with organizational structure and functions of PPSs. OMIG will also conduct compliance program reviews of PPS Leads to assess their success in meeting these mandatory compliance obligations.

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, LTHHCP 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, personal care worker identity proofing, etc.

OMIG, in collaboration with the New York State Department of Health (DOH), has revised the New York State Medicaid requirements for Home Health providers and Verification Organizations (VO) that are detailed in State law. The statute now requires these automated controls for CHHA, LTHHC, or Personal Care providers receiving total Medicaid reimbursements exceeding $15 million per calendar year through fee for service or managed care. OMIG will identify and notify those providers who meet this threshold and work with the VOs to standardize data sets and develop reports.

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.

Medicare Home Health Maximization

OMIG and its contractor, the University of Massachusetts Medical School, will continue to work collaboratively to pursue reimbursement for dual eligible recipients who have received home health services paid for by Medicaid that should have been paid for by Medicare. Medicare coverage of home health claims which were previously billed to Medicaid for dually eligible recipients is sought retrospectively via the appeals process.

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 Human Immunodeficiency Virus 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-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. For ordered ambulatory services (other than laboratories) billed subsequent to the implementation of APG reimbursement methodology, OMIG will review Medicaid payments and the applicable documentation in order to ensure that the claims for payment were submitted in accordance with APG payment policy.

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, and Human Immunodeficiency Virus (HIV) special needs plans. The Office of the Medicaid Inspector General's (OMIG) ongoing efforts include performance of various match-based targeted reviews and other audits identified through data mining, analysis and other sources. These audits lead to the recovery of overpayments and implementation of corrective actions that address system and programmatic concerns. OMIG continues to identify robust initiatives to significantly strengthen the detection of fraud, waste, and abuse in the Medicaid managed care environment as more service areas are rolled into managed care.

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

Managed Care Third-Party retroactive recovery projects
New York State and Medicaid MCOs now share responsibility for the collection of third-party revenues pursuant to respective managed care contracts. The process for this initiative will 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 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 the New York State Department of Health (DOH), local social service districts, and other regulating agencies.

Oversight of Managed Care Organizations' Recipient Restriction Programs
In concert with DOH, OMIG will provide contractual, administrative, and medical utilization review oversight to MCOs' recipient restriction programs (RRPs). This oversight will enhance MCO's adherence with federal and state regulations while monitoring program outcomes. OMIG will designate specific staff to work with each managed care program to provide assistance in identifying managed care consumer fraud or abuse. OMIG will continue to attend statewide managed care meetings as well as share restriction information with MCO's allowing for a restriction to follow the member regardless of managed care enrollment or specific plan membership. In addition to these oversight functions, OMIG will continue to identify consumer fraud or abuse both medical and non-medical, and pursue 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' and New York State of Health retroactive disenrollment of consumers. In addition, OMIG continues to track consumers who are retroactively disenrolled from managed care.

Special investigation information
OMIG will continue to work with and assist the MCO special investigative units (SIUs), which facilitates the exchange of fraud and abuse allegation information among MCO SIUs. OMIG will hold regular meetings with MCO SIUs for the exchange of information; coordinate responses in identifying targets for investigation across the MCO provider universe; review the quarterly/biannual/annual reports from the MCOs as well as the functional assessments conducted by the DOH; and act as a coordination and de-confliction center for both internal and external investigations of fraud and abuse in the MCO environment.

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.

In addition to the Supplemental Newborn Capitation Payment, OMIG will review Supplemental Low Birth Weight Newborn Capitation Payments which the MCO's receive for each enrolled newborn weighing less than 1,200 grams at birth. These

supplemental low birth weight payments are intended to cover the high cost of care these newborns require and subsequently are paid at a much higher rate.

Managed Long Term Care

The Managed Long Term Care Business Line Team includes all services provided by a managed long term care organization (MLTC). MLTCs coordinate the provision, quality, and cost of care for their enrolled consumers.

Enrollment and Care Management reviews
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.

Social Adult Day Care Centers
OMIG will continue to independently investigate social adult day care centers (SADCs). When possible, OMIG will seek to jointly investigate SADCs with the Medicaid Fraud Control Unit and the New York City Buildings Department. OMIG will also coordinate with the State Department of Health and State Office for the Aging to improve system controls over SADC.

Medical Services In An Educational Setting

The Medical Services in an Educational Setting Business Line Team focuses on Early Intervention services as well as preschool and school supportive health services provided to children with special needs.

Early Intervention Services
Early Intervention Service providers receive Medicaid reimbursement for services provided to children with special needs, and their families. These services must be provided in accordance with the child's individualized family services plan in order to achieve desired outcomes. OMIG will review early intervention providers who received reimbursement from Medicaid.

School Supportive health services
Preschool programs, school districts, and many schools receive Medicaid reimbursement for services provided to special education students. 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 from Medicaid.

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.

Comprehensive Psychiatric Emergency Program (CPEP)
A 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. The CPEP also provides crisis intervention in the community, assessments, and links to other community-based mental health services. OMIG will review CPEP providers to determine whether services were provided in accordance with Medicaid requirements.

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.

Serious Emotional Disturbance (SED)
OMH's SED waiver services are designed to serve children and adolescents with complex and significant mental health needs in their homes and communities thus decreasing the need for placements in psychiatric inpatient levels of care, including residential treatment facilities. OMIG will review SED providers to determine whether services were provided in accordance with Medicaid requirements.

Supported Employment
Supported employment offers structured supports for individuals. 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 wasteful Medicaid expenditures by reducing drug diversion and drug misuse. Drugs that are commonly diverted are high-cost medications and drugs with abuse potential, including narcotics and related pain relievers, antipsychotics, antidepressants, and antiretroviral drugs used in the treatment of Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome. OMIG will review the complicit and non-complicit overprescribing of drugs as well as 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.

OMIG will conduct pre-payment reviews of selected DME providers who dispense orthopedic shoes. Documentation will be requested for submitted claims and will be reviewed for the 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 as part of the County Demonstration program.

Pharmacy Inventory reviews
Inventory reviews involve looking at payments made for prescriptions billed compared with pharmacy inventory purchases to determine whether the pharmacy ordered at least the volume of drugs necessary to fill the prescriptions that were billed. OMIG will continue to work on existing inventory reviews to probe provider fraud and abuse.

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 also verify that pharmacies meet basic Board of Pharmacy regulatory standards, which include cleanliness and keeping proper patient records. OMIG will review various types of

pharmacies, including retail pharmacies, long-term care pharmacies, and infusion/specialty pharmacies and continue to act accordingly when the public health and safety is at risk.

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

Physicians, Dentists, And Laboratories

The Physicians, Dentists, and Laboratories Business Line Team encompass 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.

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

Providers with excessive ordering of controlled substances
OMIG will perform analytics on prescribing of controlled substances in an effort to identify prescribers whose prescribing patterns are exceptional. OMIG will review the ordering for these providers to determine if the ordering was medically necessary. OMIG will coordinate its work with the Bureau of Narcotics Enforcement of the New York State Department of Health.

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
The Office of the Medicaid Inspector General (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 County Demonstration program participants.

Base Year audits
RHCFs use the same reported costs, with appropriate trend factors, for multiple years of reimbursement. 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 the facilities are eligible 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 County Demonstration program participants.

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
Minimum Data Set (MDS) is a comprehensive assessment of the functional abilities and needs of every Medicaid nursing home resident. DOH uses nursing home MDS submissions to determine the nursing home's Medicaid rate. OMIG is collaborating with DOH to review MDS data submissions to determine the accuracy of the information submitted. During 2015-2016, OMIG will review the MDS submissions impacting July 1, 2014 through June 30, 2015 Medicaid nursing home rates.

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, the New York State Attorney General's Medicaid Fraud Control Unit, The New York State Department of Health and the New York State Department of Transportation as well as individual counties to determine whether services were provided in accordance with Medicaid requirements.

Claim review

Using information from a variety of sources to select transportation providers, OMIG will review claims for transportation services not limited to identifying whether services were provided, whether services were provided using disqualified drivers and whether claims were submitted using incorrect driver's license numbers or incorrect vehicle plate numbers. Random field inspections of transportation providers will also be conducted to assess compliance with Medicaid rules and regulations.

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

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 may incorporate these activities into its overall strategy for holistically addressing fraud and abuse within the specific line of business.

Collaborative efforts with federal and local authorities
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 will participate in the Federal Bureau of Investigation-directed Health Care Fraud Strike Forces operating out of the Southern District of New York and throughout the State. OMIG will also participate in the U.S. Department of Justice Medicare Fraud Strike Force and will aid and assist in health care fraud investigations they conduct. OMIG will also work collaboratively with 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.

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 Guidance, 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 corporate integrity agreements (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. These publications will be supplemented by webinars posted on OMIG's Web site and by presentations.

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 requirements.

OMIG will continue conducting reviews of Medicaid providers' performance under the False Claims Act requirements of the federal Deficit Reduction Act of 2005.

Corporate Integrity Agreement monitoring and enforcement
A corporate integrity agreement (CIA) is a contract between OMIG and a provider that defines provider-specific obligations and allows for strict oversight of the provider. CIAs may be offered, in certain circumstances, when a provider has committed one or more unacceptable practices but it is not in the best interest of the Medicaid program to

exclude the provider.

OMIG will monitor provider performance under the terms of CIAs and will take appropriate actions, which may include imposing penalties, when providers fail to comply with the terms of the CIAs.

County Demonstration Program

OMIG will continue working with county social service districts and the New York City Human Resource Administration (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 continue partnering with local districts to conduct reviews in the areas of pharmacy, transportation, durable medical equipment, and assisted living. 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.

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 and revalidations to determine if providers should be allowed to enroll in the Medicaid program. OMIG will conduct provider pre-enrollment reviews on applications for enrollment from pharmacies, DME providers, physical therapists and physical therapy groups, and portable X-ray providers. 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. Selected revalidation visits will include providers of durable medical equipment (DME), physical therapy and portable X-ray services.

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.

Medicaid Consumer investigations
OMIG will proactively investigate allegations related to Medicaid consumer eligibility issues involving the misuse of benefit cards and fraudulent enrollment to obtain Medicaid Benefits. OMIG will coordinate with local, county, state, and federal law enforcement agencies, as well as the NYS Department of Health's health benefit exchange, known as the New York State of Health, to identify Medicaid consumers who are defrauding the Medicaid program through fraudulent enrollment and refer such consumers to the appropriate prosecutorial agencies. OMIG will also investigate allegations of recipients involved in drug diversions through doctor shopping and forgeries. OMIG will continue its efforts to identify and actively investigate Medicaid consumers who forge prescriptions or seek unnecessary medications and 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 Contractor 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 to review. OMIG will coordinate, review and issue IPRO's final audit reports.

Medicaid Recovery Audit Contractor
In 2011 CMS mandated that all states 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. RAC Payment Integrity reviews will cover a broad array of projects resulting from data mining activities, reports by other audit agencies, as well as issues identified by providers and field office staff.

Payment Error Rate Measurement project
New York State will participate in a Payment Error Rate Measurement (PERM) review. 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.

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 Certified Home Health Agencies and home health agencies' transportation billing, Dentists, DME claims submitted with no diagnostic code, misuse of National Provider Identifiers as a prescribing, referring, or servicing provider, pharmacy and private-duty nurses.

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.

Third Party recovery
Medicaid is the payer of last resort. OMIG's Third Party Recovery work reviews circumstances where other payers should have paid for services rendered to a Medicaid consumer. Where another payer is identified, Medicaid pursues recoveries from that payer. These reviews take several forms:

> **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. We will also 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.

Medi-Medi project. The Medi-Medi program is a joint venture between the Centers for Medicare and Medicaid (CMS), their program safeguard contractors and participating States. The New York Medicare Medicaid Data Analysis Center (NMMDAC) team consisting of data analysts and investigators perform matching and analysis of Medicare and Medicaid data. SafeGuard Services (SGS) is the NMMDAC prime contractor.

OMIG is collaborating with SGS to perform coordinated investigations and prepayment reviews on select providers that appear to have suspicious billing patterns. The providers are identified through CMS's Fraud Prevention System (FPS) which uses predictive modeling to identify providers for review.

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.

Estate and casualty recovery.
During the coming year, implementation of Estate recoveries for the final 15 counties and HRA Office of Legal Affairs will be completed per MRT 102 – Estate and Casualty Recoveries.

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 methods, including local district and New York State of Health 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.

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.

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.