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Office of the
Medicaid Inspector
General

2017-2018
Work Plan

Protecting the Integrity of the Medicaid Program

State of New York

Andrew M. Cuomo, Governor

Office of the Medicaid Inspector General

Dennis Rosen, Medicaid Inspector General

You can help stop Medicaid fraud. Call the Medicaid Fraud Hotline:

1-877-87 FRAUD (1-877-873-7283)

A Message from the Inspector General

I am pleased to present the New York State Office of the Medicaid Inspector General (OMIG) Work Plan for State Fiscal Year (SFY) 2018, (April 1, 2017 to March 31, 2018).

The Work Plan serves as a blueprint for OMIG's activities across each operational division. As the health care delivery system continues to transform and evolve on both the state and federal level, OMIG will continue to adapt to conduct and coordinate fraud, waste, and abuse control activities for all Medicaid-funded services.

The Work Plan is informed by OMIG's SFY 2018-2020 Strategic Plan, which focuses on three over-arching goals:

- Enhancing Compliance
- Fighting Fraud, Waste, and Abuse
- Promoting Innovative Analytics

As OMIG achieves the deliverables set forth in this Work Plan, program integrity in the New York State Medicaid program will be enhanced and taxpayer dollars will be protected and improper payments recovered.

Dennis Rosen,

Medicaid Inspector General

Executive Summary

The Office of the Medicaid Inspector General (OMIG) is an independent entity created within the New York State Department of Health (DOH) to promote and protect the integrity of the Medicaid program in New York State.

New York State's Medicaid program is the state's largest payer of health care and long-term care. Over six million New Yorkers receive Medicaid-eligible services through a network of more than 80,000 health care providers and over 90 managed care plans. The total federal, state and local Medicaid spending for SFY 2018 is expected to be $65 billion.

Health care fraud, waste, and abuse can involve physicians, pharmacists, nurses and aides, recipients, medical equipment companies, managed care organizations (MCO), and transportation providers, among others. In carrying out its mission, OMIG oversees the investigation, detection, audit, and review of Medicaid providers and recipients to ensure they are complying with the laws and regulations governing the Medicaid program.

OMIG works closely with the federal Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, Office of the Inspector General (OIG), the New York State Attorney General's Medicaid Fraud Control Unit (MFCU), the Bureau of Narcotic Enforcement (BNE), and other federal, state, and local agencies.

OMIG has the authority to pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, waste, and abuse. Information and evidence relating to suspected criminal acts are referred to MFCU.

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Introduction

The OMIG Work Plan provides a roadmap for taxpayers, policymakers, providers, and managed care organizations (MCO) to follow regarding activities OMIG has planned for SFY 2018 to fight fraud, improve program integrity and quality, and save taxpayer dollars.

OMIG consists of eight units (in alphabetical order):

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

These units direct OMIG's work within the three over-arching goals outlined in the Strategic Plan. It is important to note that the goals are not presented in order of priority - each goal has equal significance and weight in helping OMIG achieve its mission.

The first goal focuses on provider compliance and the work OMIG does to monitor compliance programs in the Medicaid program.

The second goal focuses on identifying and addressing fraud, waste, and abuse within the Medicaid program. Within this goal, OMIG will direct its efforts in areas including, but not limited to: prescription drug and opioid abuse; home health and community-based care services; transportation; long-term care services; and Medicaid managed care (MMC). This is in addition to ongoing program integrity activities.

The third goal focuses on OMIG's efforts to develop and employ innovative analytic capabilities to detect fraudulent or wasteful activities. This includes data mining and analysis, cost savings measures, and pre-payment reviews.

OMIG Strategic Plan

Mission

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.

Vision

To be the national leader in promoting and protecting the integrity of the Medicaid program

Goal 1

Collaborate with Providers to Enhance Compliance

Objectives

- Promulgate provider outreach and education through engagement and participation efforts
- Generate policy based on provider collaboration efforts

Goal 2

Coordinate with partners, including law enforcement and managed care SIUs, to identify and address fraud, waste, and abuse in the Medicaid program

Objectives

- Referring and supporting prosecution of cases related to suspected or confirmed allegations of fraud in program integrity partnership with the Attorney General's Medicaid Fraud Control Unit
- The Managed Care Plan Review, Network Provider Review and the Pharmacy Project Teams will focus on developing efficient and effective audit processes to enhance the integrity of the managed care environment.

Goal 3

Develop innovative analytic capabilities to extract high-level data on fraudulent or wasteful Medicaid activities

Objectives

- Enhance multidisciplinary activities, including improved data access, storage and mining capabilities
- Utilize multidisciplinary activities to improve upon audit and investigation efforts to recovery and save Medicaid funds

Goal #1: Collaborate with providers to enhance compliance

Compliance Program General Guidance and Assistance

OMIG maintains dedicated telephone and email connections to the public to respond to and address questions related to the implementation and operation of compliance programs required of Medicaid providers by Social Services Law (SSL) § 363-d and 18 New York Codes, Rules and Regulations (NYCRR) Part 521.

These connections supplement the compliance publications (e.g., alerts, guidance, Medicaid Updates) and webinars that are available on OMIG's website, as well as OMIG's compliance presentations that are offered across the state. Subject matter for the publications and presentations is identified by OMIG based upon input received from Medicaid providers, issues identified by OMIG during compliance program reviews, and changes in state and federal laws and regulations. OMIG will continue to update and publish the procedures and forms used in conducting reviews of providers' mandatory compliance programs.

Compliance Program Reviews

Compliance program reviews are conducted by OMIG to analyze whether a Medicaid provider's compliance program is implemented and operating as required by SSL § 363-d and NYCRR Part 521. Most reviews are initiated due to a Medicaid provider's failure to meet the annual compliance program certification obligation. Compliance program reviews were expanded in 2016-2017 to include MCOs. Reviews of providers and MCOs will continue under the SFY 2018 Work Plan.

OMIG will also continue monitoring annual certification performance obligations required of Medicaid providers under the False Claims Act requirements of the federal Deficit Reduction Act (DRA) of 2005.

Corporate Integrity Agreement Monitoring and Enforcement

A corporate integrity agreement (CIA) is a contract between OMIG and a provider which serves as an option that may be considered as an alternative to termination or exclusion from the Medicaid program when a provider has committed an act of Medicaid fraud, waste, or abuse. The CIA defines provider-specific obligations and allows for strict oversight of the provider.

OMIG will closely monitor providers under CIAs and take appropriate action in the event of a breach of the terms of the CIA.

Goal #2: Coordinate with stakeholders to identify and address fraud, waste, and abuse in the Medicaid program

In addition to ongoing program integrity endeavors, the activities in this section are centered on several priority areas: fighting prescription drug and opioid abuse; home health and community-based care; long-term care; transportation; and managed care.

In pursuing cases of Medicaid fraud, OMIG will continue to engage in collaborative efforts with federal, state, and local law enforcement agencies; and with local Departments of Social Services (LDSS). OMIG will continue to participate in the Federal Bureau of Investigation-directed Health Care Fraud Strike Forces throughout the state. OMIG will continue to participate in the U.S. Department of Justice (DOJ) Medicare Fraud Strike Force, based in the Eastern District of New York, and will assist in health care fraud investigations they conduct. OMIG will continue to work with MFCU and will also work collaboratively with District Attorneys across the state to identify those individuals attempting to defraud New York State taxpayers and the Medicaid program.

• Combatting Prescription Drug and Opioid Abuse

Recipient Restriction Program

The Recipient Restriction Program (RRP) is a medical review and administrative mechanism under the authority of NYCRR Title 18 § 360-6.4 whereby a recipient's access to Medicaid care and services can be restricted if it is found that they have received duplicative, excessive, contraindicated or conflicting health care services, drugs, or supplies. Access can also be restricted if the recipient has engaged in fraudulent or abusive practices such as forgery, selling drugs obtained through Medicaid, or loaning their Medicaid card to another person. Under the program, patients suspected of overuse or abuse are restricted to a single designated provider, pharmacy, or both.

Since RRP's inception, over 100,000 cases have been reviewed and those recipients found culpable recommended for restriction to ensure better care for the recipient, and eliminate excessive cost to the Medicaid program for unnecessary services.

All MCOs are required to have a restriction program. The MCOs coordinate and partner with OMIG to restrict recipients. These partnerships allow for the coordination of care for high-risk recipients. OMIG will continue its efforts to identify and restrict recipients who abuse Medicaid benefits and will increase its oversight of MCO restriction plans to ensure compliance with the Managed Care Model Contract.

Drug Diversion

OMIG continues to ensure the integrity of the Medicaid program by working to reduce drug misuse, prescription opioid abuse, and drug diversion. OMIG's partnerships with federal, state,

and local law enforcement continue to strengthen, while new initiatives are being developed to combat drug addiction and abuse of the Medicaid program. This past year OMIG was invited to present at the National Association of Medicaid Program Integrity (NAMPI) annual training conference in Baltimore, Maryland on its efforts to combat drug diversion in New York State. NAMPI brings together Medicaid program integrity experts from around the country to discuss best practices related to preventing fraud and abuse to the program. OMIG also teamed up with representatives from CMS, DOJ, the FBI and national health insurance companies to author a Healthcare Fraud Prevention Partnership (HFPP) white paper on marketplace fraud and opioid abuse. OMIG continues to share the information in the white paper with LDSSs and other local, state and federal entities to enhance collaboration on best practices for further combatting drug diversion in the Medicaid program.

Prescription Forgery Investigations

OMIG's Recipient Investigation Unit's (RIU) Forged Prescription Project will continue to identify fraudulent prescriptions being billed to Medicaid. While electronic prescribing has led to a downward trend in the number of forged paper prescriptions, the unit continues to detect forged prescriptions being filled and billed to Medicaid. The unit has uncovered fraudulent electronic prescriptions and will continue to monitor the system and take actions against wrongdoers. The data collected from forgeries is also used to identify trends where recipients are "doctor shopping" for narcotics. A recipient filling forged prescriptions or found to be doctor shopping is referred to the RRP, and may be criminally charged.

Physician Excessive Ordering

The RIU also uses reviews of recipient data to identify physicians prescribing excessive amounts of controlled substances or providing unnecessary services. Identified providers are then referred for investigation to the Provider Investigations Unit (PIU). RIU also tracks recipients who travel great distances, e.g., from upstate counties to New York City, in order to obtain prescriptions. The unit uses this information to identify possible "pill mills" and physicians who freely prescribe addictive narcotics without following accepted prescribing practices. OMIG will continue to identify these providers, perform investigations and refer them to MFCU, if appropriate, for prosecution.

• Home Health and Community-Based Care Services

Home and community-based care services (HCBS) cover the following program areas: certified home health agencies (CHHA), long-term home health care programs (LTHHCP), personal care aides (PCA), traumatic brain injury (TBI), and private duty nursing (PDN) services.

These services continue to grow as the population ages and as the Medicaid program moves away from hospitalization and long-term care placements under the value-based payment system.

The need for oversight of the home care services (HCS) workers providing these services to this vulnerable population is critical. This population often does not have the capability or family members available to advocate or to monitor and ensure that the services are: necessary; are

provided by qualified individuals; are provided as ordered; are provided at all; that the caregivers show up as assigned; and that the beneficiary is not at risk.

Home Health Verification Project

Verification Organizations (VO) are Medicaid-enrolled entities that utilize electronic means to review and verify all services or items provided by a participating provider to a Medicaid-eligible recipient prior to submission of a claim to DOH or an MCO.

Certain CHHAs, LTHHCPs or personal care providers who receive Medicaid reimbursement exceeding $15 million per calendar year through Medicaid, including fee-for-service (FFS) and/or managed care are required to utilize a VO. The VO must electronically capture, at minimum, the identity of the recipient, the identity of the caregiver, the location of the service, and the date, time, duration, and type of service. OMIG will continue to work with the VOs to standardize the reports in the VO portals and to identify areas of potential improvement.

Long-Term Home Health Care Program

LTHHCP providers deliver a coordinated plan of services to eligible enrollees in their homes, the home of a responsible adult, or an adult care facility (other than a shelter for adults). The LTHHCP began a transition from FFS to Managed Long-Term Care (MLTC) or MMC payments on April 1, 2013. OMIG continues to audit LTHHCP FFS Medicaid claims to verify per-visit and hourly rates calculated for the various ancillary services provided, with a focus on LTHHCPs with both high Medicaid utilization and rate capitations. OMIG will also review rate add-ons, including funds dedicated to worker recruitment, training, and retention.

Duplicative Billing of Home Care Services

Medicaid skilled nursing facility patients and hospital inpatients are provided a full range of patient services during their stay, and the facilities are paid all-inclusive Medicaid rates. Home health care and/or personal care FFS claims to Medicaid, with certain exceptions, are not necessary during these stays as they are duplicative. Medicaid reimbursement may not be made for services which duplicate or substitute for services that are required to be provided by another entity. OMIG will review and recover billings for claims identified as duplicative.

Certified Home Health Agencies

CHHAs provide part-time, intermittent health care and support services to individuals who need intermediate and skilled health care. CHHAs can also provide long-term nursing and home health aide services, can help patients determine the level of services they need, and can either provide or arrange for other services including physical, occupational and speech therapy, medical supplies and equipment, and social worker and nutrition services. Effective May 1, 2012, the payment process for CHHA services changed from an FFS payment to a 60-day episodic payment. CHHAs can be paid for a full episode (when the episode of care is 60 days) or for a partial episode (when the episode of care is less than 60 days), with adjustments for patient acuity (Case Mix Index) and regional wage differences. Payments for a partial episode may be pro-rated based on the number of days of care on the claim or may be a full payment for certain circumstances – such as when the patient is transferred to hospice, a hospital, or home self-care or in the event of the patient's death. OMIG will continue to conduct CHHA FFS audits and will initiate CHHA Episodic Payment System (EPS) audits.

Private Duty Nursing – Independent and Licensed

PDN services are medically necessary, skilled nursing services provided to eligible individuals, residing in their homes. These services are limited to licensed home care service agencies (LHCSA) and to private practicing licensed practical nurses (LPN) and registered professional nurses (RN) who are individually enrolled as Medicaid providers. These services are for clients who require more individual and continuous nursing care than is available from a CHHA and the majority of the recipients consist of medically fragile children. OMIG will conduct reviews of the recipients' medical charts to ensure services have been rendered for the hours billed. Data analysis will be performed to ensure there are no duplicate claims or overlapping services that have been provided by multiple service providers. Program oversight will be provided and overpayments recouped from providers.

Personal Care Services

Personal Care Services (PCS) include assistance with personal hygiene, dressing, feeding, the performance of incidental household tasks, and environmental and nutritional support services. These services may be provided by persons with the title of homemaker, homemaker-health aide, home health aide, or PCA. PCS are based on a comprehensive assessment of each patient, with a written plan of care, a written order from the treating physician and the prior authorization or reauthorization from the LDSS. PCS are provided by a PCA under the supervision of an RN. The PCS program began a transition from FFS to MMC payments on August 1, 2011. OMIG will continue to audit PCS FFS Medicaid claims.

Traumatic Brain Injury Waiver Services

The TBI Waiver is a HCBS waiver program that allows for the provision of alternative services for individuals who would otherwise require care in nursing homes. The TBI waiver program will be transitioning to managed care effective January 1, 2018. OMIG will focus on both FFS claims and MMC services. OMIG will continue to examine TBI FFS claims to determine compliance with program requirements. Reviews will primarily focus on verification that services were provided, that services billed were included in the service plan, that service plans were updated in a timely manner, and that services were provided by qualified staff. OMIG will also develop an audit plan to examine TBI in the managed care environment.

Nursing Home Transition and Diversion Waiver

The Nursing Home Transition and Diversion (NHTD) Waiver is also a HCBS waiver program. The NHTD waiver provides support and services to assist seniors and individuals with disabilities toward successful inclusion in the community. Waiver participants may come from a nursing facility or other institution (transition) or choose to participate in the waiver to prevent institutionalization (diversion). The NHTD waiver program will be transitioning to managed care effective January 1, 2018. OMIG will continue to examine NHTD FFS claims to determine compliance with program requirements. Reviews will primarily focus on verification that services were provided, that services billed were included in the service plan, that service plans were updated in a timely manner, and that services were provided by qualified staff.

Wage Parity/Minimum Wage

OMIG, DOH, and Department of Labor will work collaboratively to ensure compliance pertaining to Minimum Wage and Wage Parity laws. OMIG will audit MCOs and contracted network providers' records and reports to ensure that funds provided for employee wage increases are properly distributed to health care workers in accordance with statutory requirements and the procedures established by DOH.

• Long-Term Care Services

Residential Health Care Facilities

OMIG reviews nursing facilities and assisted living programs (ALP). Residential health care facilities (RHCF) are reimbursed for covered services provided to eligible consumers based on pre-determined rates. ALPs provide long-term residential care, room, board, housekeeping, personal care, supervision, and also provide or arrange for home health services for five or more eligible residents unrelated to the operator.

Assisted Living Program

Resident Care Audits

OMIG conducts field audits to validate payments for services and ensure the documented needs of patients are being met. OMIG reviews the patient records for up-coding and overbilling for services rendered to ALP residents, as well as to ensure patient records reflect the required authorizing documents. Additionally, OMIG will provide oversight of ALP resident care audits that are conducted as part of the County Demonstration program.

Coordination of Oversight

OMIG and DOH Division of Adult Care Facilities and Assisted Living Surveillance coordinate efforts to monitor ALP provider's compliance with Medicaid regulations. In the event OMIG identifies a potential quality of care or patient endangerment issue, DOH is contacted immediately and remedial activities are coordinated. Quality of service and fiscal issues of entities are addressed to ensure that the population serviced by the program is safe and adequately served while maintaining claiming accuracy.

Nursing Home Audits

Rate Audits

DOH's Bureau of Long-Term Care Reimbursement (BLTCR) has changed the rate setting process, including streamlining the capital portion of the nursing home rate by relying on the facility's confirmation and certification of the proposed capital reimbursement rate. Facilities are required to certify that requested revisions conform to BLTCR's policy and reimbursement regulations and further recognize that the capital calculation will be subject to audit by OMIG. OMIG audits will be conducted based on information from DOH BLTCR, and OMIG will work with BLTCR to ensure facilities are adhering to Medicaid program regulations.

Minimum Data Set

Since 2013, OMIG has coordinated with BLTCR to review the accuracy of nursing home Minimum Data Set (MDS) submissions. MDS is the tool that nursing homes use to evaluate each resident and develop a plan to provide the services that best meet the resident's needs. MDS data submissions to BLTCR are used to calculate each facility's Case Mix Index (CMI) which is used to determine the direct cost portion of each facility's Medicaid rate. OMIG will review the MDS submissions impacting the July 1, 2015 through June 30, 2016 Medicaid nursing home rates.

Managed Long-Term Care

Social Adult Day Care Centers

OMIG will continue to independently investigate social adult day care centers (SADC), and will work jointly with MFCU, DOH, the New York City Buildings Department, the New York City Department for the Aging (DFTA) and the State Office for the Aging (SOFA). OMIG will continue to meet bimonthly with MLTC plans, DOH, DFTA, and SOFA to review complaints, and discuss investigations and new initiatives.

Partial Capitation

The MLTC Partial Capitation program is designed to allow Medicaid enrollees who require high acuity attention to receive care in their homes and communities. OMIG audits MLTCs to ensure enrollees are eligible to qualify for the program and that appropriate care management is being provided by the MLTC plans. To qualify for the MLTC program, enrollees must receive 120 days of community-based long-term care services. The MLTC plan is responsible for the care management of their enrollees. They must ensure the care is medically necessary and actually received by their enrollees. Through OMIG's efforts and in collaboration with DOH, enrollees are now assessed by a third party – which was originally a responsibility of the MLTC plans - to determine if they are eligible to qualify for this program.

Enrollment and Eligibility Reviews

OMIG reviews the enrollment records, recipient Plans of Care and claims data to determine if the MLTC plans are providing the specific services deemed medically necessary by those MLTC plans for its recipients. Additionally, OMIG examines Case/Care Management system notations to confirm that appropriate care management is also being rendered to its members. OMIG will continue to access MLTC plans to ensure that their contractual obligations in serving their recipient population are being met.

• Medicaid Managed Care

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 MMC, including health maintenance organizations, prepaid health service plans, and HIV special needs plans. OMIG's 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. As more service areas are rolled into managed care, OMIG continues to pursue initiatives that significantly enhance the detection of fraud, waste, and abuse in the MMC environment.

OMIG's executive staff launched a new project team approach to guide the agency's program integrity efforts in MMC. OMIG established a project management office (PMO) with a dedicated project manager and created five teams with specific areas of focus.

Managed Care Contract and Policy Relationship Management Project Team

The Managed Care Contract and Policy Relationship Management Project Team will focus on developing amendments to the New York State Medicaid Managed Care Model Contract (Mainstream and Managed Long-Term Care) to address the CMS final rulemaking on managed care (CMS-2390-F). In order to comply with federal law, there are a number of provisions under the final rule concerning program integrity in MMC which must be implemented in the coming year. These amendments include changes to compliance program requirements for MCOs; referrals of fraud, waste, and abuse; MCO self-disclosure programs; MCO payment suspensions for credible allegations of fraud; MCO record retention and audit periods; and how MCO recoveries are treated and retained.

Additionally, the team will work to develop and advance new amendments to address current and future Medicaid program integrity challenges and support the work of the other project teams.

Finally, the team will work in conjunction with DOH, to continue implementation of provisions included in prior contract amendments. These include a quarterly report of all overpayments identified and recovered by MCOs; a clearance process for OMIG and MCO audits or reviews of network providers; and referrals by MCOs to OMIG of reasonably suspected or confirmed cases of fraud, waste, and abuse.

Managed Care Plan Review Project Team

The Managed Care Plan Review Project Team will focus on enhancing OMIG program integrity efforts in MMC through collaborative efforts across all OMIG divisions. The team will conduct audits of Medicaid managed care operating reports (MMCOR). OMIG will determine the accuracy of certain aspects of the MMCOR through data submitted by MCOs to substantiate reported information. OMIG will also perform detailed testing of the data submitted by MCOs to ensure costs were reported appropriately. Additionally, the team will work to identify initiatives through data mining techniques designed to detect fraud, waste, and abuse.

Network Provider Review Project Team

The Network Provider Review Project Team continues to hone the process of conducting audits of network providers in MCOs.

Benefits for managed care recipients are included in the services provided by MCOs, their network providers, and any subcontractors The team will perform audits of providers within MCOs' networks to ensure the accuracy of encounter claim submissions and confirm that provider records are in regulatory and contractual compliance. OMIG will identify improper encounter

claims that contribute to inflated capitation payments. OMIG will coordinate with MCOs and their Special Investigation Units (SIU) in its audit efforts.

Pharmacy Review Project Team

The Pharmacy Review Project Team will shift its focus from FFS pharmacy audits to managed care network pharmacy audits in order to ensure compliance in the pharmacy benefit component of MMC. Auditing for contract compliance and regulatory compliance at the pharmacy level will aid in the detection of fraudulent, wasteful, and abusive practices. OMIG will review for accurate formulary and benefit administration, as well as financial and pricing arrangements. Network pharmacy audits will verify that prescriptions were ordered by a qualified practitioner; the pharmacy has sufficient documentation to substantiate billed services and meet regulatory requirements; appropriate formulary codes were billed; and reimbursements were made in accordance with contracted pricing methodologies.

Managed care network pharmacy providers receive payments from pharmacy benefits managers (PBM) and/or MCOs. OMIG's Pharmacy Project Team will request and review pricing methodologies from MCOs and PBMs. The team will compare pharmacy encounter data reimbursements to the contracted pricing methodologies to verify accuracy in billing and payment. of encounter claims.

DSRIP Value-Based Payments and Program Integrity

The Medicaid Redesign Team (MRT) Waiver Amendment required DOH to submit a multiyear roadmap for comprehensive Medicaid payment reform with payouts based upon Performing Provider Systems (PPS), which are networks of providers created under Delivery System Reform Incentive Payment (DSRIP). The roadmap outlines a path toward a value-based payment (VBP) system with a goal of 80 to 90 percent of total MCO-PPS/provider payments to be paid through some form of VBP arrangement within the next few years. Since MCOs must encourage their network providers to enter into a VBP arrangement, the way MMC dollars are spent is rapidly changing.

OMIG will evaluate VBP reimbursements from a program integrity perspective, make recommendations and update audit processes accordingly.

MCO Incentive Program

In an effort to provide meaningful incentives for MCOs to pursue fraud, waste, and abuse, DOH's Office of Health Insurance Programs (OHIP) and OMIG proposed a joint initiative establishing recovery targets that are designed to incentivize MCOs in their recovery efforts. A framework of the plan has been developed, and industry targets set. Once the plan is launched, OMIG will continue to work closely with DOH to monitor each MCO and provide support as needed.

MCO-Specific Clinical Risk Group Rate Adjustment

The MCO-specific Clinical Risk Group (CRG) adjustment modifies each MCO's rate to recognize differences in the health status of enrollees. OMIG analyzed significant encounter data attributes and will be working to confirm the validity of these various encounters to take appropriate action on any improperly reported encounter data that resulted in an inaccurate calculation of the MCO-specific CRG rate adjustment.

MC Investigations

OMIG will continue to utilize a wide array of techniques to investigate fraud, waste, and abuse. OMIG continues to strengthen the MCO referral process for all allegations and will be establishing a regional effort to work on a closer, more individual basis with MCO SIUs to address program integrity concerns and better coordinate activities related to fraud investigations.

Retroactive Disenrollment Monitoring/Recovery

When a managed care monthly premium payment is inappropriately made to an MCO due to eligibility errors or untimely eligibility file updates (i.e., death, incarceration, institutionalization, enrollees assigned more than one client identification number, enrollees who have moved out of state, etc.), NY State of Health (NYSoH), LDSSs, and the New York City Human Resources Administration (NYC HRA) retroactively adjust the enrollee eligibility file, notify OMIG and the MCO of the retroactive disenrollment, and request that the MCO void the premium payments during the period of disenrollment. OMIG will continue to maintain and update the database file used to monitor the retroactive disenrollment of enrollees.

In addition, OMIG performs a secondary review of the other agencies' activities and issues retroactive disenrollment audit reports to MCOs that fail to void the premium payments following the request to do so by the NYSoH, LDSS, and/or NYC HRA. OMIG works with all parties on an ongoing basis to identify issues, provide educational materials, and modify retroactive disenrollment procedures to accommodate the dynamic managed care environment.

• Transportation

OMIG will continue to work with the New York State Department of Motor Vehicles, MFCU, DOH, and New York State Department of Transportation, as well as individual counties, to determine whether services were provided in accordance with Medicaid requirements.

OMIG will conduct reviews of providers of Medicaid ambulette and taxi services. Reviews will determine if services were properly ordered, if paid services were provided, if Medicaid claims were accurately submitted to eMedNY, and if drivers were qualified to drive the vehicles used to provide the service.

OMIG will review claims for transportation services to identify whether services were provided, to determine whether services were provided using disqualified drivers. Random field inspections of transportation providers will also be conducted to assess compliance with Medicaid rules and regulations.

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

• Ongoing Program Integrity Activities

County Demonstration Program

Under the Medicaid Fraud, Waste, and Abuse County Demonstration Program, OMIG partners with counties and New York City to detect Medicaid provider fraud, waste, and abuse and to recoup overpayments. OMIG will continue working with LDSS and NYC-HRA to conduct reviews of pharmacy, durable medical equipment, transportation (ambulette, taxi and livery), long-term home healthcare and ALPs.

OMIG will meet regularly with representatives from the counties and NYC-HRA to discuss current audit activities, potential new audit activities, and improvements to the audit process. These meetings will also provide the counties and NYC-HRA with the ability to share knowledge and experience with each other. Many of the counties use contract audit staff and OMIG also coordinates the audit activities of those contract staff. OMIG will continue to provide training and technical assistance as needed.

OMIG will continue its oversight of the County Demonstration Program's FFS pharmacy audits that are performed by program participants. The purpose of these audits is to determine whether pharmacy claims for Medicaid reimbursement complied with applicable federal and state laws, regulations, rules and policies governing the Medicaid program. These audits will verify that prescriptions were properly ordered by a qualified practitioner; the pharmacy has sufficient documentation to substantiate billed services; appropriate formulary codes were billed; patient-related records contain the documentation required by the regulations; and claims for payment were submitted in accordance with Department regulations and the appropriate Provider Manual.

Enrollment and Reinstatement

The Enrollment and Reinstatement Unit (EAR) serves as a secondary review to more thoroughly reviews provider enrollment applications in selected categories such as pharmacies, durable medical equipment suppliers and transportation providers to determine if applicants should be enrolled in the Medicaid program. EAR also reviews all reinstatement applications and requests for removal from the OMIG Exclusion List. These front-end reviews help ensure that potentially abusive providers and those unable to provide high-quality care are identified before they are enrolled or reinstated, resulting in cost avoidance. In addition, front-end denials may deter other providers from even attempting to enroll.

External Audits

OMIG will respond to external audits from other government entities such as the Office of the New York State Comptroller, and CMS. OMIG will analyze the external audit data, searching for and providing documentation not found during the course of the audit, researching applicable regulations, contract language and policy, and recovering inappropriately paid claims.

Fee-for-Service Audits

OMIG will conduct audits of various FFS providers in areas of concern or to meet federal waiver requirements. Programs that will be audited include, but not limited to:

- Diagnostic and Treatment Centers
- Hospice
- Ordered Ambulatory (Other Than Laboratory Services)
- Office of Alcohol and Substance Abuse Services
    - Outpatient Services
    - Inpatient Rehabilitation Services
- Office of Mental Health
    - Clinic Treatment
    - Continuing Day Treatment
    - Children's Day Treatment
    - Partial Hospitalization
    - Intensive Psychiatric Rehabilitation Program
    - Rehabilitation Services for Adults
    - Comprehensive Psychiatric Emergency Services
    - Children with Serious Emotional Disturbances
- Office for Persons With Developmental Disabilities
    - Clinical and Medical Services
    - Day and Residential Habilitation
    - Prevocational and Supported Employment Services
    - Medicaid Service Coordination
- Pre-School and School Supportive Health Services

Investigations - Provider

As part of their investigations, OMIG's 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 are conducted to identify quality-of-care issues, billing problems, systemic fraud, such as paying recipients to undergo unnecessary medical tests, as well as gather important intelligence on how organizations operate and the types of drugs/services being abused. OMIG will continue to use undercover investigators to identify these issues and assist other investigators in in the course of their program integrity efforts.

Investigations – Recipient Eligibility

OMIG's RIU investigates Medicaid recipients who submit fraudulent information and documentation in order to qualify for Medicaid benefits. RIU also investigates complaints received on OMIG's Medicaid Fraud Hotline and conducts data mining to identify potential fraudulent or inappropriate activities on the part of individual Medicaid recipients and organized groups. The data includes but is not limited to multiple Client Identification Number reports, recent real estate sales matches, rental properties owned by Medicaid recipients, and information regarding self-employed individuals. These are all used to discover eligibility schemes and other fraudulent activities. The main focus of this effort is to identify recipients who do not disclose their actual incomes and income sources during the application process. The unit collaborates with DOH, LDSSs, and law enforcement agencies throughout the state to take actions against these individuals. OMIG will continue to expand its efforts in this area and develop initiatives to increase

our investigative efforts to identify those who abuse the Medicaid program in order to seek restitution and save taxpayer dollars.

Medicaid Electronic Health Records Incentive Payment Program

The Medicaid Electronic Health Record (EHR) Incentive Payment program provides financial incentives to qualified hospitals and eligible providers in New York State that adopt, implement, or upgrade certified EHR technology, and subsequently become meaningful users of the EHR technology. As the Medicaid EHR Incentive program continues to receive guidance from CMS, OMIG will update its responsibilities and audit guidance accordingly. In this capacity, OMIG will continue to provide oversight and conduct reviews to ensure that the CMS eligibility requirements of the Medicaid EHR Incentive program are met. In addition, the post-payment audit team will continue to conduct knowledge-sharing and collaboration sessions with stakeholders throughout the state in an effort to keep providers informed of changes in audit requirements and provide updates to the post-payment audit section of the program website as necessary.

Recovery Audit Contractor

The Affordable Care Act expanded the federal Recovery Audit Contractor (RAC) program to Medicaid. The Medicaid RAC reviews claims that providers submit for services rendered to Medicaid recipients either through FFS or MMC. The RAC is tasked with identifying both overpayments and underpayments. The Medicaid RAC contractor in New York State is Health Management Systems Inc. (HMS).

OMIG and HMS will collaborate and coordinate their recovery initiatives with several entities including other state agencies and CMS contractors. Examples of potential projects include review and recovery of findings noted in OSC audits, reviews involving claims submitted on behalf of recipients that are dually eligible for Medicare and Medicaid, and retroactive member disenrollment and recovery of capitation payments made after a beneficiary is no longer enrolled or eligible for MMC coverage.

Self-Disclosure

The Self-Disclosure program presents providers with a penalty-free way to return self-identified Medicaid overpayments. Providers are encouraged to maintain active internal review and audit programs of their own so that overpayments are self-identified quickly and refunded to Medicaid. OMIG staff will continue to work closely with providers through each step of the disclosure process and will be available to address any questions or concerns that they may have.

The Self-Disclosure Unit is working to restructure its section of the OMIG website devoted to assisting providers with self-disclosing. Standard forms and guidance are available in a user-friendly format where providers can disclose to the OMIG Self-Disclosure Unit or to the online web-based portal maintained by OMIG's contractor HMS. OMIG staff will be available to answer provider questions via a main phone line, as well as a general email address.

Unified Program Integrity Contract

The Unified Program Integrity Contract (UPIC) is a collaborative effort between CMS and the state Medicaid agencies. This contract combines the previous Medi-Medi and Medicaid Integrity Contracts into one contract. Safeguard Services (SGS) has been awarded this contract to work

with New York State, as well as other Northeastern states. OMIG and SGS will combine efforts to perform data analytics, and investigations and audits of both Medicare and Medicaid providers. SGS will have access to all federal and state databases, giving a more complete picture of each provider, and thereby allowing for the identification of issues that may not appear when looking at either program in isolation. Additionally, SGS will have the ability to scrutinize providers who may be conducting business in contiguous states in both Medicare and Medicaid.

Goal #3: Develop innovative analytic capabilities to detect fraudulent or wasteful activities

Data Review Project Team

The Data Review Project Team is focused on various sources of data which are of importance to Medicaid program integrity. The team seeks to ensure the availability and usability of data from these sources, including the Medicaid Data Warehouse (MDW), Salient Data Mining Solution, All Payer Database, Data Mart, and Encounter Intake System. The team will collaborate with DOH to improve the completeness and accuracy of MCO-submitted encounter data. Team members will also look to inform and educate OMIG staff who rely on this information.

Encounter Analysis

Encounter records compiled by MCOs are the primary source of information about services being provided under MMC. Encounter data integrity is critical to OMIG's reliance on encounters for effective program integrity oversight activities. Bureau of Business Intelligence (BBI) staff will continue to analyze and evaluate the integrity of encounter data. Staff will perform comparative analyses of encounters and other plan-submitted data to evaluate the consistency and completeness of MCO encounter reporting. These other sources include individual MCO paid claim files, MMCORs, comprehensive provider reports and PBM data. OMIG analysts will also collaborate with DOH to improve data reporting by plans and facilitate data availability in the MDW.

System Match Recovery

Using analytical tools and techniques, as well as knowledge of Medicaid program rules, to data mine Medicaid claims and identify improper claim conditions, OMIG identifies potential recoveries of inappropriate Medicaid expenditures. In SFY 2018, OMIG will focus on partial hospitalization, an intensive outpatient treatment program licensed by OMH designed to provide patients with profound or disabling mental conditions individualized, coordinated, comprehensive, and multidisciplinary treatment in an outpatient setting. This program serves as an alternative to admission to or a continued stay at an inpatient hospital. Partial hospitalization treatment is not to exceed six calendar weeks, unless during the course of treatment, the recipient is admitted to an inpatient psychiatric facility. Such course of treatment may be extended to include the number of inpatient days, up to a maximum of 30 days. Each course of treatment is a new admission. OMIG will recover for any service that exceeds the six-week regulatory limit, unless extended due to a psychiatric inpatient admission.

Third Party Liability Match and Recovery Services

The Bureau of Third Party Liability and Contract Review is responsible for maximizing cost avoidance and third-party recoveries from all sources to ensure Medicaid is the payer of last resort. To achieve this goal, the Third-Party Liability (TPL) Unit oversees the activities of OMIG's contractor, HMS, which is responsible for fulfilling the requirements of the TPL contract. The contract's three main components are:

Prepayment Insurance Verification (PPIV)

Third-party file matches including commercial insurance, Medicare, and the Military are conducted to identify third-party coverage on Medicaid recipients. All newly identified segments of insurance coverage are verified prior to delivery and upload to the eMedNY third-party file. 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. This cost avoidance process will result in claims being denied by Medicaid until the third-party resources are utilized.

Third Party Retroactive Projects

The recovery process utilizes the eMedNY third-party subsystem that is updated from various resources, including LDSS/NYSoH input, CMS data, and the contracted third-party file match/verification process described above under PPIV. The updated third-party file is matched against the eMedNY claims extract file to identify claims for which potential or verifiable third-party liability exists but has not yet paid. Inpatient and clinic rate-based claims will be primarily recovered from a provider review process. Fee-based claims (i.e., practitioner, laboratory, and pharmacy claims) with potential third-party coverage will be billed directly to the insurance carriers. Third-party recoveries for managed care encounter claims will be pursued via the direct bill and provider review process noted above. The policies of the Medicaid managed care model contract provide guidance for this recovery process.

Estate and Casualty Recovery

Estate and casualty recovery seeks to recover Medicaid expenditures either from the estate of a deceased Medicaid beneficiary and/or from the award of a settlement to a Medicaid beneficiary who was injured, incurred Medicaid expenses related to that injury, and subsequently was awarded a settlement due to that injury. The process is centralized and administered at the state level with participation and coordination with LDSSs, NYC HRA, and NYSoH. These activities encompass all Medicaid enrollees in FFS or managed care programs. OMIG will continue to support HMS' efforts to maximize cost avoidance and recovery of Medicaid funds through the various recovery efforts described above.

Medicare Home Health Maximization

OMIG contracts with the University of Massachusetts Medical School (UMass) to maximize Medicare coverage for dual-eligible Medicare/Medicaid recipients who have received home health care services paid by Medicaid. OMIG will work collaboratively with UMass to improve upon current processes for collection of monies from Medicare for identified dual-eligible recipients for home health services that should have been paid by Medicare rather than Medicaid. OMIG will continue to work with CMS and the Office of Medicare Hearings and Appeals to achieve favorable outcomes of hearings and appeals for Medicaid cases.

Acronyms and Abbreviations

ALP	Assisted Living Program
BBI	Bureau of Business Intelligence
BLTCR	Bureau of Long-Term Care Reimbursement
BNE	New York State Bureau of Narcotic Enforcement
CHHA	Certified Home Health Agency
CIA	Corporate Integrity Agreement
CMI	Case Mix Index
CMS	Centers for Medicare and Medicaid Services
CRG	Clinical Risk Group
DFTA	New York City Dept. for the Aging
DOH	New York State Department of Health
DOJ	U.S. Department of Justice
DRA	Deficit Reduction Act
DSRIP	Delivery System Reform Incentive Payment
EAR	Enrollment and Reinstatement Unit
EHR	Electronic Health Record
eMedNY	Electronic Medicaid of New York
EPS	Episodic Payment System
FFS	Fee For Service
HCBS	Home and Community-Based Care Services
HCS	Home Care Services
HFPP	Healthcare Fraud Prevention Partnership
HMS	Health Management Systems, Inc.
LDSS	Local Department of Social Services
LHCSA	Licensed Home Care Services Agency
LPN	Licensed Practical Nurse
LTHHCP	Long-Term Home Health Care Program
MCO	Managed Care Organization
MDS	Minimum Data Set
MDW	Medicaid Data Warehouse
MFCU	New York State Attorney General Medicaid Fraud Control Unit
MLTC	Managed Long-Term Care
MMC	Medicaid Managed Care
MMCOR	Medicaid Managed Care Operating Report
MRT	Medicaid Redesign Team
NAMPI	National Association of Medicaid Program Integrity
NHTD	Nursing Home Transition and Diversion Waiver
NYCRR	New York Codes, Rules and Regulations
NYSoH	New York State of Health
OHIP	Office of Health Insurance Programs
OIG	Dept. of Health and Human Services Office of the Inspector General
OMIG	New York State Office of the Medicaid Inspector General
PBM	Pharmacy Benefits Manager
PCA	Personal Care Aide
PCS	Personal Care Services
PDN	Private Duty Nursing
PIU	Provider Investigations Unit
PMO	Project Management Office

PPIV	Prepayment Insurance Verification
RAC	Recovery Audit Contractor
RHCF	Residential Health Care Facility
RIU	Recipient Investigations Unit
RN	Registered Nurse
RRP	Recipient Restriction Program
SADC	Social Adult Day Care
SGS	Safeguard Services
SIU	Special Investigation Unit
SOFA	New York State Office for the Aging
SSL	Social Services Law
TBI	Traumatic Brain Injury
TPL	Third-Party Liability
UMass	University of Massachusetts
UPIC	Unified Program Integrity Contact
VBP	Value-Based Payment
VO	Verification Organization