HINMAN STRAUB PC
ATTORNEYS AT LAW

121 State Street
Albany, New York 12207-1693
Tel: 518-436-0751
Fax: 518-436-4751

TO: **Memo Distribution List**

LeadingAge New York

FROM: Hinman Straub P.C.

RE: New York State Office of the Medicaid Inspector General 2016-17 Work Plan

DATE: May 4, 2016

NATURE OF THIS INFORMATION: This is information recently published or distributed which may be a useful resource to you.

DATE FOR RESPONSE OR IMPLEMENTATION: None – this is for your information.

HINMAN STRAUB CONTACT PEOPLE: Raymond Kolarsey, Stephanie Piel and Jonathan Gillerman

THE FOLLOWING INFORMATION IS FOR YOUR FILING OR ELECTRONIC RECORDS:
Category: #2 Providers and payments to them; and #9 Medicaid and Medicare
Suggested Key Word(s): OMIG

The New York State Office of the Medicaid Inspector General (OMIG) recently released its Work Plan for fiscal year 2016-2017 (the "2016-17 OMIG Work Plan"), available **here**. The 2016-17 OMIG Work Plan describes activities that OMIG plans to initiate or continue during 2016 and 2017, and has important implications for plans and providers participating in New York's Medicaid program. Medicaid participating providers and health plans are required, pursuant to Social Services Law § 363-d, to adopt and implement effective compliance programs that include systems for conducting internal audits of high risk areas. OMIG expects participating providers to incorporate in these internal audit plans high risk areas identified through a number of sources, including OMIG's annual work plan.

As such, plans and providers participating in New York's Medicaid Program should review the 2016-17 OMIG Work Plan and make any necessary revisions to their compliance programs by incorporating applicable high risk areas into their internal audit plans.

The 2016-17 OMIG Work Plan is organized according to its eleven "business line teams" (BLTs) comprised of OMIG personnel with a range of experience in OMIG functions (e.g. audit, investigations, legal, clinical and technical). Each BLT is charged with focusing on a specific area of Medicaid health care service delivery (i.e. provider type) and oversees the various OMIG initiatives for that provider type. Last year, two new BLTs were introduced that focus on the Delivery System Reform Incentive Payment (DSRIP) program, and Managed Long Term Care (MLTC), which was previously included in the "Managed Care" BLT but has its own business line team. Both areas were identified as "emerging areas of interest in the Medicaid program" in the 2015-16 OMIG Work Plan.

The 2016-17 OMIG Work Plan is organized according to its eleven BLTs, and also includes a twelfth section introducing the new Project Management Office and a thirteen section outlining activities applicable to all business lines. The eleven BLTs include:

- DSRIP
- 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 Disability Services
- Pharmacy and Durable Medical Equipment
- Physicians, Dentists and Laboratories
- Residential Health Care Facilities
- Transportation

New this year, OMIG has established a Project Management Office (PMO) that will focus exclusively on managed care. The PMO is comprised of five project teams that will oversee the following five areas that relate to managed care: Data, Managed Care Plan Review, Managed Care Network Provider Review, Pharmacy, and Managed Care Contract and Policy/Relationship Management.

This memorandum summarizes the high risk areas for each business line, including both new initiatives as well as important ongoing areas of focus, and also summarizes the new PMO, its project teams, and those compliance activities that apply to all line items.

While the particular initiatives described in the 2016-17 OMIG Work Plan are of primary importance, there are also general themes common across the initiatives that highlight general areas of concern to OMIG. These include:

- Continued expansion of the focus on managed care organizations in response to the growth of managed care in New York's Medicaid program, with particular focus on pharmacy as a major cost driver within the program;
- Continued focus on addressing fraud, waste, and abuse;
- Emphasis on ensuring that services provided were necessary and met all Medicaid requirements, including several new OMIG initiatives (among others, Hospice, Consumer Directed Personal Assistance, NHTD Waiver, Article 16 clinic);
- Emphasis on the data and risk adjustment processes that drive managed care plan premiums, with particular focus on managed care plan encounter data, risk adjustment, and member assessment tools (e.g., CRGs, UAS-NY, PRI); and
- Emphasis on preventing duplicative billing and maximizing Medicare.

The 2016-17 OMIG Work Plan makes special mention of its efforts to provide outreach and education to providers to ensure they have proactive compliance programs in place. These include compliance webinars, guidance materials, self-assessment tools, presentations, and a dedicated compliance email address and phone number. We recommend that plans and providers review their compliance plans in light of the high risk areas identified in the 2016-17 OMIG Work Plan and this memorandum, and incorporate any necessary updates/revisions.

OMIG INITIATIVES BY BUSINESS LINE

The following is a summary of the initiatives included within the 2016-17 OMIG Work Plan. The initiatives are organized by business line.

A. DSRIP

New Initiatives

- OMIG will monitor the implementation of Value Based Payment (VBP) Reform and will adapt its oversight activities accordingly to account for new integrity issues related to value based forms of reimbursement. OMIG was a participant in the VBP Regulatory Impact Subcommittee and will participate in the Program Integrity and HIPAA and Privacy Act Subcommittees throughout 2016-17.

- A requirement under DSRIP was that each Performing Provider System (PPS) obtain attestations from all of their provider entities by December 1, 2014. Last year, OMIG conducted reviews to ensure all attestations were obtained by the PPS. As this review

process is now complete, this compliance initiative is not included in the 2016-17 OMIG Work Plan.

Continuing Initiatives

- OMIG will continue to work with DOH to identify compliance risk areas associated with the functions of PPS Leads and help PPS Leads determine if their compliance programs meet the compliance program obligations. Last year, OMIG provided guidance to PPSs that they must dedicate resources and develop systems to take all reasonable steps to ensure the Medicaid funds distributed as part of the DSRIP program are not connected with fraud, waste or abuse ("DSRIP Compliance Guidance 2015-01"). In that publication, OMIG advised PPS Leads to focus their compliance program risk assessments on those risks specifically associated with the current phase of the DSRIP program and payments made pursuant to it(i.e., pay for reporting vs. pay for performance). While PPS Leads are not responsible for how network providers use DSRIP incentive funds, they must have adequate processes in place, such as, an effective compliance program, to allow them to identify when a network provider obtains DSRIP incentive funds in a way that is inconsistent with approved DSRIP project plans.

  OMIG maintains a dedicated website specifically for DSRIP Compliance Guidance, which is available at: https://www.omig.ny.gov/dsrip-compliance-guidance

B. Home and Community Care Services

The 2016-17 OMIG Work Plan includes some notable new initiatives under this line of business, including audits of hospice care providers, Nursing Home Transition and Diversion (NHTD) Waiver services, and Consumer-Directed Personal Assistance Program (CDPAP) providers and services.

New Initiatives

- The hospice benefit is available in the Medicaid program to individuals with a medical prognosis of 12 months or less to live. This is different than Medicare, where the benefit is only available for people with a life expectancy of 6 months or less. OMIG will review hospice payments to (1) determine whether hospice care was voluntarily elected by the patient and/or family member; (2) a verify that a certification of terminal illness was obtained; (3) qualifying services were authorized on the plan of care; and (4) all required documentation supporting continued hospice care are included in the patient's file. OMIG currently does not have audit protocols for hospice care providers. Audit protocols assist providers in developing compliance programs related to a specific category of service and are applied by the OMIG during the course of an audit. As a result of the inclusion of hospice care services within the 2016-17 Work Plan, we would expect that OMIG will develop audit protocols for hospice providers.

- OMIG will review Medicaid payments for CDPAP services claimed by selected providers to determine adherence to criteria set forth in 18 NYCRR § 505.28, which establish program eligibility requirements for the individual, requirements related to assessments and service authorizations, and set forth responsibilities of the consumer, the CDPAP aide, and the CDPAP Fiscal Intermediary. The 2016-17 Work Plan specifically mentions that OMIG will conduct audits to verify that services billed to Medicaid were actually delivered to the CDPAP participant and that CDPAP assistants comply with personnel requirements set forth in the regulation. OMIG currently does not have audit protocols governing the CDPAP program, and thus, we would expect OMIG to develop such protocols.

- OMIG will examine claims made pursuant to the 1915(c) Nursing Home Transition and Diversion (NHTD) Waiver, with reviews primarily focusing 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.

Continuing Initiatives

- OMIG will continue to audit claims of certified home health agencies (CHHAs) and long-term home health care programs (LTHHCPs), and claims for personal care aides (PCAs), traumatic brain injury (TBI) services, and private duty nursing (PDN) services, to determine (i) if services were provided and supervised by appropriate qualified staff, (ii) if services were necessary and provided pursuant to an approved patient care of plan, (iii) if spend down requirements were properly processed, (iv) if the services were billed while the consumer was in a hospital or institutional setting, and (v) if Medicaid paid an excessive amount for consumers eligible for both Medicare and Medicaid.

- OMIG will continue to review home health claims for dual eligibles to determine whether Medicaid reimbursed services should have been paid for by Medicare. This Medicare maximization review will be conducted by OMIG in conjunction with its subcontractor, the University of Massachusetts Medical School.

- OMIG will continue to evaluate verification organization (VO) data and reports as a means to monitor home health organizations; Pursuant to statutory changes that went into effect in 2014, only CHHAs, LTHHCPs, or personal care aide providers (i.e., LHCSAs) receiving total Medicaid reimbursements exceeding $15 million on a calendar year basis are required to use a VO to perform a pre-claim review of health care claims before such claims are submitted to FFS or a managed care plan. OMIG has been working with VOs (providers are required to select a pre-approved OMIG VO) and participating providers to standardize information that is reported in the VO portal. The 2016-17 OMIG Work Plan notes that the exception, reason, and resolution code report standardization will be fully implemented this year.

- OMIG will also continue to audit LTHHCP and CHHA cost reports to verify per-visit and hourly rates for ancillary services, as well as rate add-ons (e.g. for worker recruitment).

C. Hospitals, Clinics, and Diagnostic and Treatment Centers

The Hospital and Outpatient Services business line covers hospitals, clinics, and freestanding diagnostic and treatment centers (D&TCs). Relevant initiatives include:

New Initiatives

None.

Continuing Initiatives

- With respect to D&TCs, OMIG will continue to monitor D&TC payments for periods prior to the full implementation of APGs (i.e. prior to January 1, 2012) to determine whether services were provided, appropriate coding was used, and whether services were medically necessary. OMIG will continue to focus these reviews on payments for physical, speech, and occupational therapy services and HIV primary care services.

- With respect to hospitals and clinics, OMIG will continue to review (i) claims to determine whether ineligible emergency visits and clinic visits were billed during a hospital inpatient stay, (ii) payments and supporting documentation for selected hospital outpatient, emergency room, clinic and ordered ambulatory services, and (iii) payments and supporting documentation for hospital emergency room services provided to non-U.S. residents that led to inpatient stays.

  Noticeably absent from the 2016-17 OMIG Work Plan are reviews of payments to Federally Qualified Healthcare Centers (FQHCs) to ensure that services for which FQHCs received enhanced rates were provided at an approved FQHC location. This had been included in recent years' Work Plans.

D. Managed Care (Mainstream Medicaid Managed Care)

In response to the growing role of managed care organizations ("MCOs") within the New York Medicaid Program, the 2016-17 OMIG Work Plan reflects a continued emphasis on MCOs by OMIG, and specifically includes three new focus initiatives in addition to the continuation of preexisting oversight initiatives. The Managed Care BLT continues to add new focus areas every year to adapt to Managed Care program developments, and within the Work Plan, Managed Care has become the most comprehensive section.

In addition to the initiatives described, please note that OMIG has instituted a new Project Management Office (PMO) that will oversee five teams focused exclusively on managed care related topics. These teams and topics are identified in the penultimate section of this memo.

New Initiatives

- OMIG and DOH have collaborated on a new MCO Incentive Program. The program incentivizes MCOs to pursue fraud, waste and abuse by deducting recovery targets from

MCO premiums up front for anticipated fraud, waste, and abuse recoveries against their providers. The framework of the program is still under development. The cumulative target has been set at $30 million; specific MCO targets have not yet been established. OMIG will monitor plan activity and provide support.

- MCO premiums are risk adjusted using the 3M Clinical Risk Groups (CRGs) to account for the acuity of each plan's enrolled population. As part of its efforts to better acclimate to a Medicaid environment that operates predominantly through managed care, OMIG auditors recently attended training on CRGs conducted by 3M, the company that developed the CRG proprietary software that is used to develop risk adjustments. New for this year, OMIG will develop and begin audits of plan encounter data that is used in the determination of the MCO-specific CRG risk adjustment.

- Continuing the trend of oversight and review of managed care plan reporting, OMIG will perform comparative analytics of MCO encounter data and other plan-submitted data sources to assess the consistency and completeness of encounter data reporting by MCOs. This appears to be, in part, somewhat similar to the long-standing DOH initiative that compares encounter data against Medicaid Managed Care Operating Reports (MMCORs). OMIG will compare encounters submitted to the State against MCO-paid claims files, MMCORs, and comprehensive provider reports, pharmacy benefit manager (PBM) data, and other data sources.

Continuing Initiatives

- OMIG will continue to work with DOH to provide oversight of MCO's restricted recipient program and to coordinate with plan SIUs. OMIG will also continue working with DOH to review MCOs using an operational survey and onsite reviews, with a focus on determining whether special investigation units are adequately performing investigative functions to detect and prevent fraud, waste and abuse.[1]

- Additionally, OMIG plans to continue with the following initiatives and collaborate with DOH on strengthening provisions under the Medicaid Managed Care Model Contract to facilitate OMIG's ability to make recoveries regarding:

    - (i) supplemental maternity and newborn kick payments and associated inpatient delivery costs, with OMIG working to identify instances where hospitals inappropriately received a FFS Medicaid payment for newborns enrolled in managed care; (ii) whether MCOs are returning monthly capitation payments when consumers are retroactively disenrolled by local social service districts; (iii) identifying out-of-network claims made to Medicaid fee-for-service for family planning and reproductive services and seek payment from MCOs; iv) MCO cost report review to identify cost data improperly included in cost reports; (v) FFS payments made for MCO enrollees to identify services that should have been billed to the MCO; (vi) MCO claims that have dates of service after date of death or during a period of

[1] This initiative is listed in the Multiple Business Lines section of the 2016-17 OMIG Work Plan.

incarceration or institutionalization; and, (vii) Medicaid payments made for the same consumer with multiple client identification numbers (CIN numbers).

E. Managed Long Term Care

New Initiatives

None.

Continuing Initiatives

- In conjunction with the Medicaid Fraud Control Unit and the New York City Buildings Department, OMIG will continue its investigations of social adult day care centers. OMIG will also coordinate with DOH and the New York State Office for the Aging (NYSOFA) to implement the state certification process and align this process with the existing registration process that exists for New York City facilities. Additionally, OMIG will continue to verify that social adult day care centers have documentation required to maintain certification, and will continue to meet quarterly with Managed Long term Care plans and the New York City Department for the Aging to coordinate efforts to identify ongoing issues.

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

F. Medical Services in an Educational Setting

The Medical Services in an Educational Setting business line focuses on special education services and early intervention services. Relevant initiatives under this business line include:

New Initiatives

None.

Continuing Initiatives

- OMIG will continue to identify duplicate payments for School Supportive Health Services program services resulting from claims from both school districts and Office for People with Developmental Disabilities (OPWDD) intermediate care facilities, and will continue to audit school districts and preschool programs to ensure that services were provided in accordance with individualized education plans.

- Additionally, OMIG will continue to review individualized family service plans to determine whether early intervention providers who receive Medicaid reimbursement are providing services in accordance with such plans.

G. Mental Health, Chemical Dependence, and Developmental Disability Services

Relevant initiatives are described below:

New Initiatives

- Article 16 clinics provide an array of clinical and medical services to individuals with Developmental Disabilities to allow them to remain in residential settings, including physical therapy, occupational therapy, speech language pathology, social work, medical/dental services, and health care services such as nursing, dietetics and nutrition, audiology and podiatry. OMIG will begin reviewing these facilities to determine whether services are provided in accordance with Medicaid program requirements, including for periods prior to the full implementation of APGs (i.e. prior to January 1, 2014).

- As part of its review of OMH providers' comprehensive outpatient program supplemental (COPS) payments, OMIG will also review providers' community support program (CSP) reimbursements that exceeded threshold amounts.

- OMIG will review Supported Employment Providers (SEMP). SEMP providers provide job coaching services to individuals with development disabilities.

Continuing Initiatives

- OMIG will continue to review payments for inpatient chemical dependence rehabilitation services, outpatient chemical dependence services, rehabilitative services provided to enrollees in community-based residential programs, outpatient mental health services, Medicaid service coordination services, residential habilitation services, services provided by OPWDD day treatment facilities, and services provided by day habilitation providers, for compliance with Medicaid requirements. In addition, OMIG will continue to identify comprehensive outpatient program supplemental (COPS) reimbursements that exceed threshold amounts, issue COPS reports, and facilitate the collection of overpayments.

F. Pharmacy (including Infusion Pharmacies) and Durable Medical Equipment

The Pharmacy and Durable Medical Equipment business line includes prescription drugs and durable medical equipment. Relevant initiatives are discussed below.

New Initiatives

- OMIG will work with the DOH Bureau of Narcotics Enforcement (BNE) to ensure provider compliance with the Internet System for Tracking Over-Prescribing (I-STOP), New York State's prescription monitoring program registry.

- OMIG will also monitor compliance with the e-prescribing mandate for providers to prescribe medications electronically and identify possible weaknesses in the system.

Continuing Initiatives

- OMIG will continue to (i) monitor whether pharmacies have ordered the volume of items needed to fill claimed prescriptions; (ii) monitor drug diversion among pharmacies, orderers, providers, and enrollees, and seek prosecutions and administrative actions against recipients involved in these activities; and (iii) work to identify duplicate claims to both Medicare Part D and Medicaid by identifying pharmacies that are double billing Medicaid by directly billing Medicaid through a national drug code (NDC) for pharmacy claims in addition to being paid by Medicaid for Medicare crossover claims coded with a J-Code for the same drug. In addition, OMIG will continue to audit pharmacies, including infusion/specialty pharmacies, for compliance with federal and state laws, rules, and regulations, including whether prescriptions were ordered by a qualified practitioner and are supported by sufficient documentation, whether appropriate formulary codes were billed, and whether claims were submitted in accordance with rules and regulations.

- In addition, OMIG will continue to review DME provider claims to verify compliance with Medicaid rules and regulations, and ensure that equipment and supplies were authorized by a licensed provider, rendered for the dates billed, and appropriate procedure codes were used.

G. Physicians, Dentists and Laboratories

Relevant initiatives in this business line are described below:

New Initiatives

- OMIG will review APG claims submitted by dental clinics to identify instances of double billing, where a claim has been submitted by the attending dentist FFS and the same service was paid through an APG.

Continuing Initiatives

- OMIG will continue to review and identify orthodontic dental services that exceed age limitations or the limitations on the number of treatment quarters, excessive preventive dental services, clinic services ordered or referred by excluded providers, and physicians with high orders for controlled substances.

H. Residential Health Care Facilities

The Residential Health Care Facilities (RHCF) business line includes skilled nursing facilities and assisted living programs (ALPs). Relevant initiatives in this business line include:

New Initiatives

- As part of its existing focus on the ALP (summarized below) OMIG will review nurse's assessments and rate setting tools such as the interim assessment nurses section, functional

assessment, patient review instrument (PRI), the uniform assessment system for New York (UAS-NY).

Continuing Initiatives

- OMIG will continue to review (i) new base year rates for RHCFs with a focus on inappropriate and unallowable costs and appropriate calculation of add-ons, (ii) rate appeals by RHCFs and in some cases audit underlying costs associated with those appeals, (iii) nursing home reserve bed payments; (iv) RHCF capital cost component of RHCF rates, audit underlying costs, and make rate appropriate rate adjustments; and (vii) conduct risk assessment and performance reviews on the Part B Offset for nursing facilities considered "high risk."; (viii) in collaboration with the Department of Health, Minimum Data Set submissions; and finally, OMIG will continue to carry forward base year operating cost audit findings and adjust rates accordingly.

- OMIG will review documentation of care given to residents of ALPs, with a focus on timely medical evaluations, interim assessments, plans of care, functional assessments, and proof of service provision. The 2016-17 OMIG Work Plan also includes as a focus area duplicate billing resulting from goods and services delivered to ALP residents by other providers that are included in the ALP payment rate.

I. Transportation

The initiatives in the Transportation business line include:

New Initiatives

None.

Continuing Initiatives

- OMIG will continue to review transportation providers using disqualified drivers and claims submitted using incorrect driver's license numbers or incorrect vehicle plate numbers, and will continue to review claims from transportation providers and conduct field inspections to determine if services were provided and the level of service was medically necessary. In addition, OMIG will continue to review Medicaid ambulette and taxi services claims, with a focus on services were properly ordered; paid services were provided; Medicaid claims were accurately submitted to eMedNY; and drivers were qualified to drive the vehicles used to provide the service. OMIG will also continue to work with DOH and OPWDD to require transportation providers of Medicaid recipients residing in OPWDD facilities to be enrolled in Medicaid.

ADDITIONAL PROGRAM INTEGRITY ACTIVITIES: NEW MANAGED CARE PROJECT MANAGEMENT OFFICE AND REVIEW TEAMS

OMIG has established a new Project Management Office (PMO) to oversee five new project review teams that will focus exclusively on managed care. The teams are: data, managed care

plan review, managed care network provider review, pharmacy, and managed care contract and policy/relationship management. In some respects team initiatives will build upon initiatives identified by OMIG's Managed Care BLT. However, some team focus areas are effectively new initiatives related to managed care oversight.

The PMO was established to guide the agency's efforts in managed care. Each of the five teams has been assigned a charter that outlines a specific purpose and goal. Team leaders identify and assign tasks with target completion dates. However, specific activities of the PMO are directed by OMIG's executive staff, who serve as the PMO steering committee. Each team's managed care focus is summarized below.

- Pharmacy Review Project Team: This team will, among other things, review MCO contracts with Pharmacy Benefit Managers (PBMs) to review pricing and other financial arrangements, including discounts and rebates, for accurate formulary and benefit administration.

- Managed Care Plan Review Project Team: This team will audit MMCORs, "assess CRGs", and analyze the annual fraud and abuse prevention plan reports submitted by MCOs. It is not clear what OMIG means by "assess CRGs" and what specific review activity is expected to occur in conjunction with CRGs, as the CRGs are a proprietary risk adjustment model. It is possible this refers to assistance with audits of plan encounter data to determine whether CRGs were appropriately assigned (a new Managed Care BLT identified focus area for 2016-17) or if the intent is for this project team to look more broadly at CRGs and whether it is an appropriate risk adjustment model. We intend to follow up with the OMIG on this to clarify their intent.

- Network Provider Review Project Team: This team will adapt OMIG's FFS audit protocols to audit providers participating in Medicaid managed care plan networks. network providers within managed care. Amendments were made to the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract several years ago to clarify that managed care participating providers were required to comply with Medicaid regulatory requirements and clarify that OMIG has the authority to audit managed care providers.

- Data Review Project Team: This team will evaluate the completeness and accuracy of various sources of data that are important to Medicaid program integrity. This includes, MCO submitted encounter data, vital statistics from BNE, DMV, and the State Department of Taxation and Finance (DTF), and data provided through various data repositories including the Medicaid Data Warehouse, Salient Data Mining Solution, and the All Payer Database. The purpose of the review is to ensure that data is available and usable to assist OMIG in program integrity efforts.

- Contracts Review Project Team: This team will work to develop amendments to the mainstream Medicaid and MLTC model contracts addressing program integrity issues.

OMIG INITIATIVES THAT APPLY TO ALL BUSINESS LINES

In addition to the initiatives applicable to individual provider types described above, OMIG has identified a number of initiatives in its 2016-17 Work Plan that apply across business lines. Relevant initiatives are summarized below.

- OMIG will continue collaborative efforts with Federal, State, and Local Authorities in identifying and prosecuting Medicaid fraud.

- OMIG will continue to focus on implementing the compliance program requirements of N.Y. Soc. Serv. Law § 363-d by conducting compliance program reviews, with a focus on providers who have not completed the annual certification under the Social Services Law and/or Deficit Reduction Act, or who have had repeated issues with OMIG or other regulating agencies. OMIG will also continue to develop and publish guidance documents to assist providers in complying with this new requirement.

- OMIG will continue to provide education and guidance to providers about meeting requirements to implement and operate compliance programs.

- OMIG will continue to monitor providers who have executed corporate integrity agreements (CIAs) to settle civil or administration actions with OMIG to ensure these providers are complying with the terms of the agreement.

- In partnership with local social service districts, OMIG will conduct reviews in the areas of pharmacy, transportation, durable medical equipment, long term home health care, and assisted living to determine whether providers are adhering to federal and State laws, regulations, rules and policies.

- OMIG will continue to pursue mechanisms for preventing excluded providers from participating in and/or obtaining reimbursement from the Medicaid program. These efforts include selective review of new provider enrollment applications and revalidations. Revalidation review will be directed to providers of DME, physical therapy and portable X-ray services. OMIG will also conduct pre-enrollment reviews of applications from pharmacies, physical therapists and physical therapy groups, labs, transportation providers, and portable X-ray providers. In addition, OMIG will review reinstatement applications to determine whether re-enrollment should be permitted, and will review ownership changes to determine whether (i) previously excluded individuals are attempting to purchase businesses, or if (ii) providers undergoing an audit or investigation are attempting to sell their business to affiliated individuals.

- OMIG will continue estate and casualty recovery efforts and will specifically work to implement the Health Management System, Inc. (HMS) Maestro Case Management System in all non-participating local districts to allow for a more coordinated and centralized system of tracking funds recovered from the estate of a Medicaid decedent.
- OMIG will continue to conduct follow-up audits and recoveries of, and will review and respond to, Medicaid audits conducted by State agencies.

- OMIG will continue to investigate illegal kickbacks and inducements, and to recoup overpayments from providers who accept such kickbacks and inducements and exclude them from participation in the Medicaid program and/or refer them for prosecution.

- OMIG will continue to investigate allegations of fraud conducted by Medicaid beneficiaries, including the misuse of benefit cards, fraudulent enrollment, and drug diversion.

- OMIG will continue to coordinate the work of IPRO, the CMS Medicaid Integrity Contractor (MIC) tasked with auditing and identifying overpayments in Medicaid claims. Similarly, OMIG will continue to collaborate with the CMS Medicaid Recovery Audit Contractor (RAC), HMS, as well as with the "Medi-Medi" contractors to streamline data match processes for dually eligible enrollees. The Medi-Medi project is a joint venture between CMS and New York that combines claims data from Medicare and Medicaid in order to increase the likelihood of auditing entities being able to detect aberrations indicative of fraud or abuse that may fall below the detection threshold in either program individually. OMIG collaborates with Safeguard Services (SGS) and the Medicare Medicaid Data Analysis Center (NMMDAC) on this project.

- OMIG will continue to encourage the use of its self-disclosure protocol to report and return overpayments.

- OMIG will identify providers who have established service locations not disclosed to the Department of Health.

- OMIG will continue to monitor the implementation of Medicare/Medicaid coordination of benefits and recover associated overpayments.

- OMIG will conduct reviews of providers participating in the Medicaid Electronic Health Record (EHR) Incentive Payment program to ensure that participating providers meet eligibility requirements.

- OMIG will oversee the state's participation in the Payment Error Rate Measurement review, and will coordinate the fee-for-service and managed care submissions.

- OMIG will conduct pre-payment review (PPR) activities by assessing claims submitted by providers to monitor and review claims before payment is made. The Work Plan does not specify how OMIG will conduct PPR, though it's likely they will use processing edits or pend claims while supporting information is requested, which could be onerous for providers. Areas of activity include reviews of transportation providers, dentists, and independently enrolled private-duty nurses. In addition, PPR will work collaboratively with other divisions and bureaus within OMIG to prevent additional Medicaid funds from being paid during the audit or investigative process, and will refer non-compliant providers to the appropriate OMIG division for further review or investigation. PPR will continue to respond to ad hoc issues as they arise, including any changes to departmental rules and regulations, policy, budget initiatives and CMS initiatives.

- OMIG will continue to focus on third-party recovery activities through a variety of initiatives, including pre-payment insurance verification, FFS retroactive third-party recovery, managed care third-party retroactive recovery, third-party liability and commercial direct billing to ensure retroactive claims processing are performed; Medicare Coordination of Benefits, and the Medi-Medi Project.

- OMIG will continue to use undercover investigators posed as Medicaid recipients to record provider conduct and unearth quality of care, billing, fraud, or other issues, as well as gather general intel for auditing planning purposes, including how organizations operate and the types of drugs/services being used/abused.

CONCLUSION

We recommend that Medicaid plans and providers carefully review the 2016-17 OMIG Work Plan, with particular attention to the high risk areas identified in this memorandum. The initiatives in the 2016-17 OMIG Work Plan represent likely areas of focus in future OMIG audits. In addition, we recommend plans and providers review and make any necessary changes to their compliance plans and incorporate relevant high risk areas into internal audit plans.

Please contact us with any questions.

NEW YORK
STATE OF
OPPORTUNITY.

Office of the
Medicaid Inspector
General

2016-2017
Work Plan

State of New York

Andrew M. Cuomo, Governor

Office of the Medicaid Inspector General

Dennis Rosen, Medicaid Inspector General

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Executive Summary

The New York State Office of the Medicaid Inspector General (OMIG) is nationally recognized for its commitment to protecting the integrity of New York State's Medicaid program. Through its investigative work and partnerships with other law enforcement agencies, innovative auditing techniques, and proactive outreach and compliance initiatives, OMIG has recovered billions of Medicaid dollars and generated unparalleled cost savings. As such, OMIG plays a vital role in ensuring that Medicaid recipients throughout the New York State have access to a high-quality, cost-effective health care delivery system.

The following Work Plan, which details OMIG's areas of focus in the Medicaid program, covers the State Fiscal Year of April 1, 2016 to March 31, 2017.

This year's Work Plan continues a focus on organizing work according to categories of service. Building on the 2015-16 Work Plan, OMIG continues to utilize its Business Line Teams across a number of areas, including but not limited to the Delivery System Reform Incentive Payment Program (DSRIP), Managed Long Term Care, Transportation, Home and Community Care Services, and Managed Care. Further, OMIG will continue to emphasize provider outreach and education, particularly focusing on providers having proactive compliance programs that will prevent or, when necessary, detect and address abusive practices. Through its array of compliance webinars, guidance materials, self-assessment tools, presentations, and a dedicated compliance email address and phone number, OMIG's oversight activities and educational efforts increase provider accountability and contribute to improved quality of care.

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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 (MCO) to follow regarding activities OMIG has planned for State Fiscal Year 2016-17 to help fight fraud, improve program integrity and quality, and save taxpayer dollars.

Organizationally, OMIG consists of eight units (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 units direct OMIG's work in 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

Delivery System Reform Incentive Payment Program

Administered by the New York State Department of Health (DOH), the Delivery System Reform Incentive Payment (DSRIP) program is designed to fundamentally restructure and transform the state's Medicaid health care delivery system. Up to $6.42 billion dollars (federal share) have been allocated to DSRIP through a Waiver Amendment with the Centers for Medicare and Medicaid Services (CMS), and payouts are based upon Performing Provider Systems (PPS), which are networks of providers that have committed to work together in furtherance of DSRIP program initiatives. PPSs must achieve predefined results in system transformation, clinical management, and population health. DSRIP-eligible providers include major public general hospitals and safety net providers in collaboration with a designated lead provider ("PPS Lead") for the group. A primary goal of DSRIP is to reduce avoidable hospital use by 25 percent over five years.

Compliance Program Guidance and Reviews

Under the DSRIP program, PPS Leads are required to finalize a compliance plan consistent with New York State Social Services Law Section 363-d. Working closely with DOH, OMIG will continue to provide guidance on compliance risk areas associated with the functions of PPS Leads and help PPS Leads determine if their compliance programs meet the compliance program obligations.

Participation on Value-Based Payment Subcommittee and Workgroups

To help ensure the long-term sustainability of DSRIP investments, the Special Terms and Conditions (§39) of the Medicaid Redesign Team (MRT) Waiver Amendment require DOH to submit a multiyear roadmap for comprehensive Medicaid payment reform. The state's roadmap outlines a path toward a value-based payment (VBP) system. DOH convened a VBP Workgroup and subcommittees consisting of stakeholders to allow for input and to support the development of the VBP roadmap. OMIG was a member of the VBP Regulatory Impact Subcommittee and will participate on the additional Program Integrity and HIPAA and Privacy Act subcommittees throughout 2016-17. OMIG will continue to monitor DSRIP/VBP and will adapt accordingly as the program evolves.

Home and Community Care Services

Home and community care services 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.

Home Health Verification Project

Participating providers with total Medicaid reimbursements, including reimbursements through managed care programs, exceeding $15 million per calendar year, are required to utilize a verification organization (VO) and an electronic visit verification (EVV) vendor to verify home health aide (HHA) and personal care assistant/aide (PCA) services. This includes CHHA, LTHHCP, and personal care providers.

The VO's responsibilities include, but are not limited to, ensuring the EVV system(s) validates that all caregivers are properly registered, credentialed, and matched against exclusion and sanction lists; the recipient has proper authorization, both for enrollment and any utilization limits; the service scheduled is consistent with the plan of care and has had proper authorization; that each visit that occurs is scheduled; that an exception is created for late/missed visits; and an exception is created when the visit duration exceeds the authorized scheduled duration. The VO must also have the ability to identify any instances of caregiver location conflicts (caregiver is at two locations at the same time) across its entire customer base.

A VO must also ensure that a claim cannot be submitted when an exception and/or conflict exists and that all exceptions and/or conflicts have been resolved before claim submission.

OMIG is working with the VOs and participating providers to standardize information that is reported in the VO portals. The exception, reason, and resolution code report standardization will be fully implemented this year. OMIG will continue to work with the VOs and participating providers to standardize other reports in the VO portals.

OMIG will continue to monitor the data collected by the systems and the compliance reports produced by the VOs, identifying outlier behaviors and non-compliant providers and individual caregivers. Staff will also ensure that the VOs are conducting their annual reviews in a timely manner and will continue to work with the VOs to improve the quality and accessibility of the data in their systems.

Hospice Services

Hospice is a coordinated program of home and/or inpatient non-curative medical treatment and support services for terminally ill patients and their families. Care focuses on easing symptoms rather than treating diseases. The program provides the individual and family with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses that are experienced during the final stages of illness, dying and bereavement. Hospice is available to persons with a medical prognosis of 12 months or less to live if the terminal illness runs its normal course.

OMIG will review hospice payments to ascertain whether patients and/or family members voluntarily elected hospice care, a certification of terminal illness was obtained, qualifying services were authorized on the plan of care, and all required documentation supporting continued hospice care was in the patient file.

Consumer-Directed Personal Assistance Program

The purpose of the Consumer-Directed Personal Assistance Program (CDPAP) is to allow chronically ill or physically disabled individuals receiving home care services under the Medicaid program greater flexibility and freedom of choice in obtaining such services. OMIG will review Medicaid payments for CDPAP services claimed by selected providers to determine adherence to criteria set forth in 18 NYCRR § 505.28. Audits will verify that services billed to Medicaid were actually delivered to the CDPAP participant. OMIG will also ensure that consumer-directed personal assistants comply with personnel requirements.

Nursing Home Transition and Diversion Waiver

The Nursing Home Transition and Diversion (NHTD) Waiver is a Home and Community-based Services (HCBS) 1915c waiver program. The NHTD waiver provides support and services to assist individuals with disabilities and seniors 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). OMIG will examine NHTD 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.

Home Health

Home health services are provided in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include nursing care; speech, physical and occupational therapies; home health aide services and personal care services. OMIG will also conduct reviews that 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.

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 that were previously billed to Medicaid for dual-eligible recipients is sought retrospectively via the appeals process.

Hospital and Outpatient Services

Hospital and outpatient services include services provided by hospitals, clinics, and diagnostic and treatment centers (D&TC).

Diagnostic and Treatment Centers

OMIG will review payments for services provided by D&TCs to determine whether services were provided and appropriate coding was used. 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 (HIV) primary care services. These reviews will involve time periods preceding the implementation of Ambulatory Patient Groups (APG), which is the classification system for outpatient services reimbursement developed by the Health Care Financing Administration.

Non-Emergency Services to Non-U.S. 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 applicable documentation in order to ensure that the claims for payment were submitted in accordance with applicable federal and state regulations, rules and policies.

Managed Care

Managed Care Organizations (MCO) coordinate the provision, quality, and cost of care for its 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 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. OMIG continues to pursue initiatives that significantly enhance the detection of fraud, waste, and abuse in the Medicaid managed care environment as more service areas are rolled into managed care.

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 are proposing a joint initiative establishing recovery targets that are designed to incentivize MCOs in their recovery efforts. A framework of the plan is being developed, and industry targets will be set. Once the plan is launched, OMIG will 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 will develop and implement audits of the encounter data used in the determination of the MCO-specific CRG adjustment. OMIG auditors attended CRG training conducted by 3M®, the DOH contractor responsible for calculating enrollees' CRG weights. The training included an overview of how 3M® CRGs are used to administer care of a population and determine premium rates for managed care populations including those enrolled in New York State Medicaid.

Managed Care Cost Reporting

New York State 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 disallowed costs are included in the report.

Encounter Data Analysis

Recognizing that fee for service (FFS) and encounter claims are two different types of transactions, OMIG staff have been performing in-depth comparative analysis to understand differences in how data fields are reported for these transaction types.

OMIG will continue to perform comparative analytics of encounter data and other plan-submitted data sources to evaluate the consistency and completeness of reporting by MCOs. These other sources include individual MCO-paid claim files, Medicaid Managed Care Operating Reports (MMCOR), comprehensive provider reports and pharmacy benefit manager (PBM) data.

Managed Care Enrollment and Eligibility Reviews

These activities include continued collaboration with DOH to strengthen policy and contract language that will enable the state to recover inappropriately paid Medicaid managed care funds.

- **Match Base Audits** - Audits of claims for managed care enrollees who had a date of services following their date of death, or during a period of incarceration or institutionalization.

- **Multiple Client Identification Numbers** – OMIG will review Medicaid managed care payments for the same enrollee with multiple client identification numbers. OMIG will continue to work collaboratively with DOH, local social service districts, New York City Human Resources Administration (HRA) and the New York State of Health (NYSoH) to help prevent this from occurring.

- **Retroactive Disenrollment** – OMIG will continue to track enrollees who are retroactively disenrolled from managed care based on what is reported to OMIG by local social service districts, NYC HRA and DOH. OMIG will audit those MCOs who have received capitation payments to provide care to enrollees who were subsequently retroactively disenrolled.

- **Supplemental Newborn/Maternity Capitation Payments** – Supplemental capitation payments made in relation to the delivery of a newborn will be reviewed to determine the appropriateness of the payment. OMIG will identify instances where hospitals inappropriately receive a FFS Medicaid payment for newborns enrolled in managed care. As the managed care plan is responsible for the cost of these newborn births, inappropriate payments will be recovered.

In addition OMIG will review the appropriateness of supplemental low birth weight newborn capitation payments that MCOs 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.

- **Duplicate Billing** - OMIG will review FFS payments made for managed care consumers to determine if the services were already included in the managed care benefits package.

- **Chargeback for Family Planning Services** - OMIG will identify duplicate payments 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 FFS costs.

Oversight of Recipient Restriction Programs

In concert with DOH, OMIG will provide contractual, administrative, and medical utilization review oversight of MCOs' recipient restriction programs (RRP). This oversight will enhance MCOs' adherence with federal and state regulations while also monitoring program outcomes. OMIG will conduct focused reviews of RRPs to identify weaknesses and assist in creating corrective action plans to fix these weaknesses. OMIG will continue to attend statewide managed care meetings as well as share restriction information with MCOs, thereby allowing for a restriction to follow the recipient regardless of managed care enrollment or specific plan membership. In addition to these oversight functions, OMIG will continue to identify recipient fraud or abuse both medical and non-medical, and pursue FFS restrictions in partnership with local districts.

Special Investigation Information

OMIG will continue to work with and assist the MCO special investigative units (SIU), to facilitate the exchange of fraud and abuse allegation information among MCO SIUs. OMIG will hold regular meetings with MCO SIUs to exchange 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.

Managed Long-Term Care

Managed long-term care 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.

Social Adult Day Care Centers

In addition to the independent investigations of social adult day care centers (SADC), OMIG will continue to jointly investigate SADCs with the New York State Attorney General's Medicaid Fraud Control Unit (MFCU), the New York City Buildings Department and New York City Department for the Aging (DFTA). OMIG will also coordinate with DOH and the State Office for the Aging (SOFA) to improve system controls over SADCs, including implementing the state certification process and aligning with the DFTA's new registration process. OMIG will also continue to verify the documentation that SADCs are required to maintain for certification and continue to meet quarterly with MLTCs and DFTA to coordinate efforts to identify ongoing issues in SADCs.

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.

Medical Services in an Educational Setting

Medical services in an educational setting focus 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, from newborn to 3 years of age, 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 throughout New York State receive Medicaid reimbursement for services provided to special education students between the ages of 3 and 21 years of age. These services must be provided in accordance with the child's individualized education program (IEP) 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

OMIG 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

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

Clinic Treatment Facilities (Article 16)

Article 16 clinics are facilities that provide clinical and medical services to individuals with developmental disabilities enabling them to remain in their current residential setting and enhance their quality of life. Services may include physical therapy, occupational therapy, psychology, speech and language pathology, social work, medical/dental services, and health care services such as nursing, dietetics and nutrition, audiology and podiatry. OMIG will review Article 16 providers to determine whether services were provided in accordance with Medicaid requirements. Audits will include time periods involving pre- and post-APG reimbursement methodology implementation.

Community Residence Rehabilitation Services

OMIG will review payments made for rehabilitative adult 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/Community Support Program Reimbursement

The amount of comprehensive outpatient program supplemental (COPS) and community support program (CSP) 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/CSP reimbursements exceeded the threshold amounts.

Comprehensive Psychiatric Emergency Program

A comprehensive psychiatric emergency program (CPEP) is designed to provide or ensure the provision of a full range of psychiatric emergency services in a general hospital, seven days a week, in a defined geographic area. 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 skills, 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. Audits will include time periods involving pre- and post-APG reimbursement methodology implementation.

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 programs. Audits will include time periods involving pre- and post-APG reimbursement methodology implementation.

Prevocational Services

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

Residential Habilitation

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

Supported Employment

Supported employment (SEMP) provides the supports individuals with development disabilities need to obtain and maintain paid competitive jobs in the community. Generally, individuals will transition to SEMP after they have been trained on the job and only require limited job coaching. OMIG will review SEMP providers to determine whether services were provided in accordance with Medicaid requirements.

Pharmacy and Durable Medical Equipment

OMIG reviews pharmacies and durable medical equipment supplies for compliance with program requirements.

Drug Diversion

OMIG intends to deploy resources to reduce drug misuse in general and drug diversion in particular. 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 HIV and Acquired Immune Deficiency Syndrome (AIDS). OMIG will review the proper authorization of written prescriptions, the complicit and non-complicit overprescribing of drugs, as well as the resale of drugs. OMIG will continue its efforts to identify and investigate forged prescriptions and seek prosecutions and administrative actions against recipients involved in these activities. Additionally, OMIG will work collaboratively with the DOH Bureau of Narcotics Enforcement (BNE) to ensure provider compliance with the Internet System for Tracking Over-Prescribing (I-STOP), New York State's prescription monitoring program registry. OMIG will also monitor compliance with the mandate for providers to prescribe medications electronically and identify possible weaknesses in the system that could cause risks to the Medicaid program. OMIG and BNE will also work jointly to track cash payments for controlled substances to prevent recipients from obtaining unnecessary prescriptions which could be diverted for illegal use.

Duplicate Professional Medicare Crossover (J-Codes)/Pharmacy Claims

OMIG will identify pharmacies that are directly billing Medicaid through a national drug code (NDC) for pharmacy claims in addition to being paid by Medicaid for Medicare crossover claims coded with a J-Code for the same drug. Recoupment will be for the NDC-paid claim.

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 and with HRA to further investigate potential provider fraud and abuse.

Pharmacy Audits

OMIG will conduct audits of a variety of pharmacy types in order to determine whether pharmacy claims for Medicaid reimbursement complied with applicable federal and state laws, regulations, rules and policies governing the New York State 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 regulations and the appropriate provider manuals.

Durable Medical Equipment Reviews

OMIG will determine whether claims were submitted by Durable Medical Equipment (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 also provide oversight of DME reviews that are conducted as part of the County Demonstration program.

Duplicate Durable Medical Equipment Claims

OMIG will identify duplicate DME dual-eligible claims submitted directly from the provider to Medicaid, and a separate claim crossed over from Medicare to Medicaid, for the same provider, same recipient, same date of service, and same DME item, under two different categories of service. This project will also identify duplicate DME claims (both dual-eligible and Medicaid-only recipients) that have been submitted directly from the provider to Medicaid twice, consisting of the same provider, same recipient, same date of service, and same DME item.

Physicians, Dentists, and Laboratories

Health practitioners who submit Medicaid claims within these categories of service are subject to review by OMIG. 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.

Excessive Ordering of Controlled Substances

OMIG will perform analytics on the prescribing of controlled substances to identify providers 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 BNE as outlined in the Pharmacy and Durable Medical Equipment section of this work plan, and work to ensure provider compliance with I-STOP and the e-prescription mandate.

Dental Ambulatory Patient Group Payments for Duplicate Claims

OMIG will identify dental claims that were billed FFS by a dental provider who was also the attending provider in the dental clinic where the same service was paid through an APG visit. Recoupment of FFS claims will be sought.

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.

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. An ALP provides long-term residential care, room, board, housekeeping, personal care, supervision, and provides or arranges for home health services to five or more eligible residents unrelated to the operator.

Assisted Living Program Resident Care

OMIG conducts reviews to ensure that the documented needs of patients are being met and there is no overcharging for services rendered to ALP residents. These reviews will focus on medical evaluations, interim assessments, plans of care, along with the nurses' assessments and rate setting tools such as interim assessment nurses section, functional assessment, patient review instrument (PRI), the uniform assessment system for New York (UAS-NY), and the presence of relevant documentation of service provision.

OMIG will also provide oversight of ALP resident care reviews that are conducted by County Demonstration program participants and assist the medical integrity contractor (MIC) audits through the Centers for Medicare and Medicaid Services (CMS).

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 that 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.

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 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 underlying costs included within the capital component and, if necessary, make appropriate adjustments to the rates.

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. OMIG will review the MDS submissions impacting the 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

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

OMIG will also continue to work with DOH and OPWDD to require transportation providers to be enrolled in Medicaid when providing transportation to Medicaid recipients who are clients of a facility under the purview of OPWDD. This will serve to enhance both the protections afforded to Medicaid recipients, and OMIG's ability to monitor accountability and oversight of transportation providers receiving Medicaid reimbursement.

Claim Review

Using information from a variety of sources to select transportation providers, OMIG will review claims for transportation services to identify whether services were provided, whether services were provided using disqualified drivers and/or 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 conduct reviews of providers of Medicaid ambulette and taxi services. Reviews will determine if services were properly ordered; paid services were provided; Medicaid claims were accurately submitted to eMedNY; and drivers were qualified to drive the vehicles used to provide the service.

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

Additional Program Integrity Activities

OMIG's executive staff has sponsored a new project team approach to guide the agency's efforts during the transition to Managed Care (MC) in the Medicaid program. OMIG has established a project management office (PMO) with a dedicated project manager. OMIG executive staff collectively comprise the PMO Steering Committee and provide guidance and direction to the PMO. OMIG has developed five project teams to oversee the following focus areas: Data, MC Plan Review, MC Network Provider Review, Pharmacy, and MC Contract and Policy/Relationship Management. Teams have established charters to outline their specific team purpose and goals. Team leaders and members identify and assign tasks with target completion dates, regularly monitor their progress, and discuss upcoming deliverables. OMIG's project manager maintains an agency-wide portfolio of efforts.

Pharmacy Review Project Team

The Pharmacy Review Project Team was created to review and analyze the pharmacy benefit component of Medicaid managed care. For managed care recipients, pharmacy benefits are included in the services provided by MCOs, and subcontracted to Pharmacy Benefit Managers (PBM) and network pharmacies. OMIG will identify initiatives to ensure contract compliance and pharmacy compliance, which will aid in the detection of fraudulent, wasteful, and abusive practices in the Medicaid program.

OMIG efforts will include reviews of MCO and PBM contracts. PBMs develop and maintain drug formularies, contract with pharmacies, negotiate discounts and rebates with drug manufacturers, and process and pay prescription drug claims. Participating network pharmacies perform the dispensing of drugs and supplies. OMIG will review for accurate formulary and benefit administration, as well as financial and pricing arrangements. Program integrity efforts will rely on review of accurate encounter data.

Managed Care Plan Review Project Team

The Managed Care Plan Review Project Team will focus on further enhancing OMIG program integrity efforts in a continuously developing Medicaid managed care environment. Team resources will be devoted to auditing MMCORs, assessing CRGs, and analyzing the annual fraud and abuse prevention plan reports submitted by MCOs.

Network Provider Review Project Team

The Network Provider Review Project Team will develop an effective and efficient process to conduct audits of network providers in MCOs. The team will adapt OMIG's FFS audit protocols to include methodologies for auditing network providers in managed care, which will allow OMIG to recoup inappropriate Medicaid funds received by network providers.

Data Review Project Team

The Data Review Project Team is focused on various sources of data which are of importance to Medicaid program integrity, including vital statistics from BNE, DMV, and the State Department of Taxation and Finance (DTF). The data repositories include the Medicaid Data Warehouse, Salient Data Mining Solution, All Payer Database, Data Mart, and Encounter Intake System. The team seeks to ensure the availability and usability of data from these sources. The team will also evaluate the completeness and accuracy of MCO submitted encounter data. The team members will also look to inform and educate OMIG staff who rely on this information.

Contracts Review Project Team

The Managed Care Contract and Policy/Relationship Management Team works to develop amendments to the contracts between DOH and the MCOs to address current and future Medicaid program integrity challenges. The team will be examining the mainstream Medicaid managed care model contract and the managed long-term care model contracts.

The following activities help assess program integrity as it relates to any category of service within the Medicaid program. OMIG incorporates these activities into its overall strategy for holistically addressing fraud and abuse within the specific program area.

Collaborative Efforts with Federal, State and Local Authorities

In pursuing cases of Medicaid fraud, OMIG will continue to engage in collaborative efforts with federal, state, and local law enforcement agencies; local, state, and federal prosecutorial agencies; and with local social service districts. OMIG will participate in the Federal Bureau of Investigation-directed Health Care Fraud Strike Forces throughout the state. OMIG will also participate in the U.S. Department of Justice Medicare Fraud Strike Force, based in the Eastern District of New York, and will aid and assist in health care fraud investigations they conduct. OMIG will continue to work with the New York State Attorney General's Medicaid Fraud Control Unit and will also work collaboratively with District Attorneys and county prosecutors across the state to identify and prosecute those individuals attempting to defraud New York State taxpayers 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 website. OMIG will create and update resources in the Compliance Library on OMIG's website, 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 on how they may improve and enhance their compliance programs.

Compliance Program reviews

OMIG will conduct compliance program reviews of Medicaid providers. These reviews will include, but will not be limited to, 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 compliance program reviews of MCO compliance programs and reviews of MCOs' performance under New York State's mandatory compliance program requirements, as well as the program integrity requirements found in federal laws and regulations.

OMIG will also continue conducting reviews of Medicaid providers' performance 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 that defines provider-specific obligations and allows for strict oversight of the provider. CIAs may be offered as determined by OMIG to settle civil or administrative actions.

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

County Demonstration Program

OMIG will continue working with local social service districts through its County Demonstration program. The program brings together OMIG's experience with local-level intelligence and 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, long-term home healthcare, 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 Medicaid program.

Consistent with state law, OMIG will also review 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 local districts a continuing opportunity to discuss fraud, waste, and abuse efforts. It will also give local districts the opportunity to share knowledge and experience with each other. OMIG will continue to align training resources to match local needs, provide expanded guidance to this program, and discuss participation with non-participating districts.

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, labs, transportation providers, 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 DME, physical therapy and portable X-ray services.

Estate and Casualty Recovery

Estate and Casualty Recovery is the effort to recover Medicaid expenditures from Medicaid beneficiaries, 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. These efforts were previously undertaken by county staff, each having its own process. Medicaid Redesign Team 102 directed that the process be centralized and tracked in one statewide system. OMIG requires local social services districts, at a minimum, to use the Health Management System, Inc. (HMS) Maestro Case Management System to administer these recovery programs. There are 54 local districts that fully participate in the MRT 102 Medicaid Centralization efforts, including NYC HRA, Investigation, Revenue and Enforcement Administration (IREA), Division of Liens and Recovery Casualty Program. New York's health plan marketplace, NYSoH, is also included in the program. Efforts to implement the program in the remaining districts will continue this year.

External Audits

OMIG will review and respond to external agencies in their audits of the Medicaid program and assure that the appropriate action is taken on audit findings. OMIG will conduct follow-up audits and pursue recovery as appropriate.

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 Recipient Investigations

OMIG will investigate allegations related to Medicaid recipient 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 NYSoH, to identify Medicaid recipients who are defrauding the Medicaid program through fraudulent enrollment and refer such recipients to the appropriate prosecutorial agencies. OMIG will also investigate allegations of recipients involved in drug diversions through doctor shopping and forgeries. Working together with DOH and its I-STOP program,

OMIG will continue its efforts to identify and actively investigate Medicaid recipients who forge prescriptions or seek unnecessary medications and will coordinate with local, county, state, and federal law enforcement agencies to pursue prosecution of recipients found to be diverting drugs.

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. As the Medicaid EHR Incentive program continues to receive guidance from CMS, OMIG will respond as appropriate and update its responsibilities 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 were met.

Medicaid Integrity Contractor Audits

Medicaid Integrity Contractors (MIC) 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, properly billed, and documented. Audit MICs perform field audits and desk audits. CMS has contracted with Island Peer Review Organization (IPRO) to conduct MIC audits throughout New York State. OMIG has been working with IPRO and CMS to identify areas and providers to review. OMIG will coordinate IPRO’s audit work.

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.

The RAC will continue the payment integrity reviews that encompass multiple provider types as a result of data mining activities and based upon input from multiple sources. In addition, OMIG is collaborating with the RAC and Medi-Medi contractors to streamline a Medicare-Medicaid data match process that will enhance the RAC's projects involving payments made for beneficiaries that are dually eligible for Medicare and Medicaid.

Payment Error Rate Measurement Review

New York State will participate in the federal fiscal year 2017 Payment Error Rate Measurement (PERM) review. The PERM program developed by CMS measures improper payments in Medicaid and Child Health Insurance Program (CHIP) and produces error rates for each. 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, and that the contractor applied the correct laws, regulations, rules, policies and rates when reviewing the claims.

Pre-Payment Review

OMIG will conduct pre-payment review (PPR) activities by assessing claims submitted by providers. This functionality allows for the monitoring and reviewing of claiming practices before payment is made. Areas of activity include reviews of transportation providers, dentists, and independently enrolled private-duty nurses. In addition, PPR will work collaboratively with other divisions and bureaus within OMIG to prevent additional Medicaid funds from being paid during the audit or investigative process, and will refer non-compliant providers to the appropriate OMIG division for further review or investigation. PPR will continue to respond to ad hoc issues as they arise, including any changes to departmental rules and regulations, policy, budget initiatives and CMS initiatives.

Self-Disclosure Efforts

The federal Affordable Care Act of 2010 requires providers to report and return overpayments within 60 days from when the overpayment was identified. In order to assist providers in complying with this law, OMIG will continue to maintain a Self-Disclosure Unit and provide web-based guidance on how to return Medicaid overpayments. Maintenance of this function will allow providers to 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 CMS, its program safeguard contractors and participating states. The New York Medicare Medicaid Data Analysis Center (NMMDAC) team, consisting of data analysts and investigators, performs matching and analysis of Medicare and Medicaid data. SafeGuard Services (SGS) is the NMMDAC prime contractor.

  Combining claims data from two major payers for health care services, Medicare and Medicaid, increases the likelihood of detecting aberrancies indicative of fraud or abuse that may fall below the detection threshold in either program individually.

  OMIG will continue its collaboration with SGS on pre-payment reviews for select providers that appear to have suspicious billing patterns. In addition, OMIG is coordinating a collaborative review of certain providers between SGS and the MIC, and facilitating a collaboration between the Medi-Medi and RAC contractors to streamline a Medicare-Medicaid data match process.

- **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 (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.

- **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 NYSoH 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). 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.
- **Pre-Payment 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

OMIG will use undercover investigators to identify fraud and work collaboratively with other agencies. 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/services being abused.