

**New York State
Office of the Medicaid Inspector General**



**SFY 2008-2009
OMIG Medicaid
Work Plan**

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OMIG Medicaid Work Plan for SFY 2008-09

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Glossary of Abbreviations.....1

* Items in both the federal OIG and OMIG Work Plans are denoted with an asterisk

New York State Office of the Medicaid Inspector General Introduction

The Office of the Medicaid Inspector General (OMIG) in New York State has been a distinct entity since November 2006. This is the agency's first official work plan, reflecting a roadmap of where we plan to go in the future.

The OMIG coordinates Medicaid fraud, waste and abuse control activities of all state executive branch agencies and recommends legislative, policy and structural changes needed to strengthen the integrity of the Medicaid program. The OMIG, through audit, investigative, fraud detection and enforcement efforts, recovers state funds that have been inappropriately claimed by individuals and providers.

Assuring that providers meet program quality standards for Medicaid enrollees in a system free of waste, fraud and abuse is an important part of the OMIG's mission.

Federal law requires that the OMIG be structured within the single state agency that has the overall administrative responsibility for the Medicaid program. While OMIG is part of the New York State Department of Health, the Medicaid Inspector General reports directly to the Governor.

The functions of the OMIG include, and we are committed to:

- Conducting and supervising activities to prevent, detect and investigate Medicaid fraud, waste and abuse, and coordinating such activities with:
 - The Department of Health
 - The Offices of Mental Health (OMH), Mental Retardation and Developmental Disabilities (OMRDD), Alcoholism and Substance Abuse Services (OASAS), Temporary Disability Assistance, and Children and Family Services
 - The Commission on Quality of Care and Advocacy for Persons with Disabilities
 - The Department of Education
 - The fiscal agent—Computer Sciences Corporation (CSC)—employed to operate the Medicaid management information system
 - Local governments and entities

- Working in a coordinated and cooperative manner with, to the greatest extent possible:
 - The Attorney General's Medicaid Fraud Control Unit (MFCU)
 - The State Comptroller

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- Recovering overpayments and pursuing civil and administrative enforcement actions against those who engage in fraud, waste or abuse or other illegal or inappropriate acts perpetrated within the Medicaid program
- Keeping the Governor and the heads of agencies with responsibility for the administration of the Medicaid program apprised of efforts to prevent, detect, investigate, and prosecute fraud, waste and abuse within the Medicaid system
- Making information and evidence relating to potential criminal acts which may be obtained in carrying out duties available to appropriate law enforcement agencies
- Receiving and investigating complaints of alleged failures of state and local officials to prevent, detect and prosecute fraud, waste and abuse
- Performing any other functions deemed necessary or appropriate to fulfill the duties and responsibilities of the office

The work of OMIG is funded in significant part (more than 50 percent) by the Center for Medicare and Medicaid Services (CMS) of the Department of Health and Human Services. In 2006, the State of New York entered into an agreement with CMS requiring the state to identify fraud and abuse recoveries of \$215 million in Federal Fiscal Year 2008. This requirement has led to a significant expansion of OMIG's initiatives and resources.

The OMIG cannot achieve this goal alone. The Attorney General's Medicaid Fraud Control Unit, the Office of the State Controller, New York City's Human Resources Administration and 13 counties participating in OMIG's demonstration projects, the Office of Health Insurance Programs which manages Medicaid, and numerous private contractors have all committed themselves to this work, and will assist OMIG in making the recovery goals for New York. Additionally, OMIG will collaborate with the New York State Department of Health (DOH), the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC), the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH), the Office of Mental Retardation and Developmental Disabilities, (OMRDD), and the Office of Temporary and Disability Assistance (TDA).

The Fiscal 2008-09 State Budget provides support for the operations of the OMIG. The budget provides resources for up to 750 staff and funds the necessary investments in technology to significantly improve the state's ability to combat Medicaid fraud, waste and abuse. These technology investments will:

- Strengthen the prepayment identification and verification process to maximize third party recoveries;
- Enhance the state's ability to investigate fraud and ensure compliance with provider Medicaid standards;

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- Implement new technologies to maximize the capabilities of the eMedNY system for assisting in the detection of fraud, waste and abuse; and
- Increase the coordination of anti-fraud activities with other state agencies in order to improve the procedures and protocols for the detection and prevention of Medicaid fraud.

The Medicaid Inspector General is headquartered in Albany with offices in New York City, White Plains, Hauppauge, Syracuse, Rochester, and Buffalo.

Creation of the OMIG—and support for its work—has been a bipartisan effort, requiring the leadership and support of both the Governor and the Legislature, as well as the advice and assistance of both public servants and private citizens. We appreciate and acknowledge this help, and will rely on it going forward.

Finally, we recognize that the rules governing a \$48-billion program to provide effective care to four million New Yorkers can be complex. We appreciate the efforts of New York's health care providers, as well as their compliance officers, and billing and coding staff, to comply with the rules of the program. Through this multi-pronged approach to compliance, and with the support of policymakers and legislators, we will enhance protection for vulnerable Medicaid enrollees in all parts of New York State.

With this plan as a roadmap, we are committed to serving the people of New York by continuing those initiatives that have proven to be successful, as well as developing new and improved ways to uphold the integrity of the Medicaid system through fighting fraud, abuse and waste across the state.

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DIVISION OF AUDIT

Division of Audit staff conducts audits and reviews of Medicaid providers to ensure compliance with program requirements, including quality of care, and to determine the amount of any overpayments made. Field staff has experience in a broad range of health care programs, and has knowledge about various types of medical providers. This affords the division the opportunity to organize and coordinate statewide projects to address the broad spectrum of Medicaid-covered services and the various program initiatives of the Department of Health, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities, and the Office of Alcoholism and Substance Abuse Services. Audits and reviews of Medicaid providers are performed by state staff, augmented by outside contractors, and the local districts through the County Audit/Investigation Demonstration Project.

Pursuant to 42 USC § 1396(5), §§ 20, 34, and Article 5, Title 11 of the New York Social Services Law, and Chapter 436 of the Laws of 1997, DOH is the designated single state agency responsible for the administration and supervision of the Medical Assistance (Medicaid) program in New York. That responsibility includes setting the standards for, and ensuring the quality of, care within each facility, establishing the rates of payment to be paid to each facility for Medicaid-covered care (Public Health Law Article 28), validating the appropriateness of payments on delayed or denied claims, and the responsibility of assuring the accuracy of the promulgated rates of payment through the audit of cost reports (Social Services Law § 368-c). To carry out the latter responsibility, Health conducts audits and reviews of various providers of Medicaid-reimbursable services.

Medicaid program participation is a voluntary, contractual relationship between the provider of service and the state (Social Services Law § 365-a; 18 NYCRR Part 504). Continued participation by any provider of service is conditioned upon satisfactory compliance with the rules and regulations of the program.

By choosing to participate as a Medicaid provider, a participant assumes responsibility for meeting all requirements as a prerequisite to payment and continued status as an enrolled provider (18 NYCRR Parts 504, 515, 517 and 518). Enrollment as a provider, along with participation and submission of billings certifying compliance with those rules and regulations (18 NYCRR §§ 504.3 and 540.7(a)(8)), connotes acceptance of the contractual responsibilities.

The requirements for participation are set forth in the regulations of DOH (18 NYCRR Subchapter E) and the rules, regulations and statutes of general applicability to the provider type in question. The rules governing the establishment of Medicaid rates by Health are enumerated in 10 NYCRR Subpart 86-2.

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AUDIT PROCESS

All providers participating in the Medicaid program are required to maintain records to support their billings to the program. Cost-based providers must maintain all fiscal and statistical records and reports which are used for the purpose of establishing their rates of payment. This includes all underlying books, records and documentation that formed the basis for the fiscal and statistical reports filed by a provider with the state agency responsible for establishing the rates of payment.

The provider must keep and maintain these records for a period of not less than six years from the date of filing such reports, or the date upon which the fiscal and statistical records were required to be filed, or two years from the end of the last calendar year during any part of which a provider's rate or fee was based on the fiscal or statistical reports, whichever is later.

Fee-for-service providers, who are paid in accordance with the rates, fees and schedules established by the department, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. The provider must keep all records necessary to disclose the nature and extent of services furnished and the medical necessity of the service, including any prescription or fiscal order for the service or supply, for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later.

An on-site audit begins with an entrance conference, at which time OMIG representatives discuss the nature and extent of the audit with the provider. For rate-based providers, the audit period is no more than six years from the date that the provider filed the fiscal and statistical reports to be audited, or six years from the date the reports were required to be filed, whichever is later. For fee-based providers, the audit period is no more than six years from the date the care, services or supplies were furnished or billed, whichever is later.

Upon completion of a field audit, the OMIG will conduct an exit conference with the provider to discuss preliminary findings. Afterward, the OMIG will issue a draft audit report that will identify any proposed recoupments and the basis for the action. The provider has a 30-day response period to respond to the draft audit report. If the provider fails to reply within the time period, the OMIG will issue its final report. If the provider objects to the draft audit report, the OMIG will review the response, including and supporting documentation, and issue a final audit report.

The provider then has 60 days after receiving the final audit report to request an administrative hearing. If granted, the administrative hearing will be limited only to those matters contained in the provider's objection to the draft audit report. The provider has the option after the hearing decision, to undertake an Article 78 proceeding if the provider disagrees with the hearing decision.

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The OMIG has incorporated into its audit process a review of medical necessity for services rendered to eligible recipients and billed to the Medicaid program. The purpose of the medical necessity review is to determine if services are reasonable and necessary, and, therefore, reimbursable under the Medicaid program. The review focuses on clinical documentation. OMIG clinical staff has the requisite training needed to make clinical determinations as to the appropriateness of the services provided to Medicaid recipients, as defined in the Standards of Care NYCRR § 515.2(11) and (12).

ADULT DAY HEALTH CARE*

Currently, most adult day health care (ADHC) rates are based on a budget and are held to the ceiling (65 percent of the skilled nursing facility's January 1, 1990 rate plus trending). The OMIG will review ADHC billings for compliance with Medicaid billing requirements. We will also examine the education, certification and licensure of staff providing ADHC services. These audits will be directed at determining whether providers are in compliance with Medicaid billing and payment requirements for ADHC, as well as whether the provider's staff meet required educational, certification and licensure requirements. The rules governing ADHC audits and operations are contained in 10 NYCRR Parts 425, 713 and Subpart 86-2.

AMBULATORY SURGERY SERVICES

The OMIG will review ambulatory surgical services provided in freestanding ambulatory surgical centers. Reimbursement methodology for ambulatory surgery is found in 10 NYCRR § 86-4.40. Ambulatory surgery is defined in 10 NYCRR §§ 405.20, 709.5 and 755.1. The Medicaid program reimburses ambulatory surgery centers a higher payment rate than it does if the same service were to be performed in a physician's private office. If the services are performed in an ambulatory surgery center, it must be justifiable for reasons of patient safety and administration of anesthesia. The OMIG will review physician and ambulatory surgery center medical charts to ascertain if documentation demonstrates that the procedure needed to be performed in an ambulatory surgery setting.

ASSISTED LIVING FACILITIES*

The OMIG will review Medicaid payments for services provided to assisted living facility residents to determine whether claims were improperly reimbursed for items included in the assisted living facility's per diem rate. Per 18 NYCRR § 505.5(d)(1)(iii), Medicaid will not pay for any items furnished to a facility or organization when the cost of these items is included in the facility's rate.

In June 2007, the Commission on Quality of Care (CQC) issued a report on assisted living programs (ALP). New York State established the ALP by law in 1991 to provide a cost-effective alternative to individuals who might otherwise be eligible for nursing home placement. As of January 2006, operating certificates had been issued to 60 ALP facilities with a total capacity of 3,747 beds. In 2005, annual Medicaid charges for ALPs statewide totaled \$63 million. The CQC found that the established rate for an ALP bed

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(which is based on the regional nursing home rate) was excessive for the services provided. The CQC estimates that \$30 million could be saved if the rate reflected the cost of services actually provided. Additionally, the CQC reported numerous examples where Medicaid was being billed for excessive services that were inconsistent with an ALP resident's treatment plan.

COUNTY AUDIT/INVESTIGATION DEMONSTRATION PROVIDER

The OMIG has entered into agreements with 13 counties and the City of New York (collectively referred to as "the counties") to perform audits and/or investigations of Medicaid providers in selected ambulatory care areas. The OMIG anticipates that two additional counties will apply for the demonstration programs during fiscal 2009. Counties must identify providers and obtain clearance from the OMIG prior to initiating any field work. The OMIG must approve, in advance, the county's audit or investigation plan. OMIG staff work with the counties and/or their contractors to ensure the provider audit or investigation is conducted in a manner similar to that of the OMIG. It is anticipated that during the year more than 100 audits will be conducted by the various county entities.

DIAGNOSTIC AND TREATMENT CENTERS

The OMIG will review Medicaid payments for services provided by diagnostic and treatment centers (D&TC) to determine compliance with applicable rules and regulations found in 10 NYCRR. A key component of the review will be a determination of the appropriateness of payments for physical, speech, and occupational therapy services which the OMIG has found to be unnecessary and/or excessive in prior audits of D&TCs. This will be accomplished through a medical review. A determination will also be made if the service was rendered by an unqualified provider. The OMIG will also review audited D&TC compliance with Medicaid conditions of participation.

DURABLE MEDICAL EQUIPMENT*

The OMIG will review Medicaid payments for durable medical equipment for selected providers to determine compliance with 18 NYCRR § 505.5. A sample of payments will be reviewed to ensure that the equipment and/or supplies were properly authorized, the products were delivered, and the claim amount is within Medicaid payment guidelines. Particular attention will be paid to the propriety of items dispensed to institutional residents and to the accuracy of Medicare coinsurance claims. The OMIG will use system matches to identify such claims for institutional residents and for inappropriate claims for dual-eligible recipients.

FEE-FOR-SERVICE SYSTEMS MATCHES

OMIG staff performs numerous post-payment data matches which identify systemic behaviors which result in recoveries from multiple providers. OMIG will continue to perform existing matches for open time periods and will continue to develop and prepare

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new data matches. A key goal in this regard is to actively work with review staff (e.g., audit, investigative) and solicit new ideas for data matches based on field experience.

Specific matches planned for the coming year include:

- Identification of overlapping billing of all inclusive products of ambulatory care (PAC) clinic rates and related billings for procedures, ancillary testing and physician services.
- Identification of overlapping issues relating to dialysis treatment billing of monthly vs. home rates and daily session vs. monthly rate billings as well as instances where Epogen was billed separately when it should be included in the rate.
- Identification of overlapping issues relating to clinics billing all-inclusive clinic rates with servicing providers billing Medicaid for related procedures, ancillary testing and physician services that should be billed back to the clinic.

HOME HEALTH CARE DEMONSTRATION PROJECT

The federal Center for Medicare and Medicaid Services (CMS) has been working with Connecticut, Massachusetts, and New York under a five-year pilot demonstration project which has utilized a sampling approach to determine the Medicare share of the cost of home health services claims for dual-eligible beneficiaries that were inadvertently submitted to and paid by the Medicaid agencies. This demonstration project replaces previous third-party liability audit activities of individually gathering Medicare claims from home health agencies for every dual-eligible Medicaid claim the state has possibly paid in error. This represents an enormous savings in resources for home health agencies, as well as the regional home health intermediaries, and for the participating states.

The demonstration includes an educational component to improve the ability of all parties to make appropriate coverage determinations in the first instance; and an audit sample drawn from each project year's universe of dual-eligible home health claims paid by Medicaid that the state believes should have been paid by Medicare. The sample results are extrapolated to the universe of claims in determining a Medicare settlement payment for each FFY. Reconsideration appeals and arbitration procedures are included in the project to resolve cases where the states and CMS disagree on Medicare's denial of coverage. Subsequent payments are made after final determinations on disputed cases are resolved.

In addition, the OMIG is in the process of developing a review of the top providers with high utilization cost to the Medicaid program. A probe audit starting with FFY2004 will allow medical review of the home health care claims to determine the rationale for Medicaid payments to cases that involve a Medicare episode.

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HOME HEALTH SERVICES

Home Health Agency (HHA) Claims*

The OMIG will review HHA claims to determine whether the claims meet the criteria outlined in 18 NYCRR § 505.23 and in 10 NYCRR Article 7 including whether the services were properly authorized, the services were properly documented, third-party coverage was pursued, and the personnel met all regulatory requirements. The OMIG analyzes beneficiaries' payment histories to identify if patients are in institutions that are reimbursed for these services in their rates.

Payments for Personal Care Services*

The OMIG will review Medicaid payments for personal care services claimed by selected providers to determine adherence to criteria set forth in 18 NYCRR § 505.14. A sample of claims will be examined to ensure that the services are properly authorized, the claims are properly documented, that coverage for Medicare and all other third-party insurance is pursued, and that personnel meet all requirements established in regulation. Included in the pre-audit for all reviews is an analysis of the beneficiaries' payment history to ensure that they are not residents of an institution that is reimbursed for these services in their rate.

Home Health Care in Adult Home Settings

In November 2004, the state won an appeal in a home health care disallowance brought to its attention by the Commission on Quality of Care (CQC) (in the matter of First to Care Home Care, Inc.). In sum, CQC identified \$420,000 in overbillings to the Medicaid program provided by a certified home health care agency (CHHA) providing services to residents of an adult home. The overbillings occurred because personal care services were already being funded through the adult home rate and therefore should not have been billed to Medicaid. While this case involved the billings of one provider, numerous home health care services, costing Medicaid tens of millions of dollars, continue to be provided and billed in adult homes. The OMIG will be reviewing those billings.

HOSPICE SERVICES

The OMIG will review Medicaid payments to hospice providers to determine compliance with 10 NYCRR § 86-6, and Sections 792, 793, and 794. A data match analysis will be performed to identify duplicate billings for routine home care and general inpatient care days. A medical record review will be completed to determine whether the services were properly authorized, appropriately provided and documented, and if third-party coverage was pursued. A review of personnel records will be completed to verify provider staff met all regulatory, educational, medical and experience requirements. A documentation review will be identified, and a determination will be made whether the recipient met the criteria as terminally ill with a life expectancy of approximately six months or less.

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HOSPITALS

Inappropriate Upcoding of Diagnoses

The Medicaid program reimburses hospitals a prospective payment based on diagnosis-related groups (DRGs) and necessity. The rules governing these reviews are contained in 10 NYCRR Subpart 86-1. The OMIG will initiate reviews of Medicaid providers to assure that providers, in accordance with 18 NYCRR § 515.2, are not upcoding diagnoses to receive higher reimbursement.

Ambulatory Surgery Services

The OMIG will review ambulatory surgical services provided in hospitals. Reimbursement methodology for ambulatory surgery is found in 10 NYCRR § 86-4.40. Ambulatory surgery is defined in 10 NYCRR §§ 405.20, 709.5 and 755.1. The Medicaid program reimburses ambulatory surgery centers a higher payment rate than if the same service were performed in a private physician's office. If the services are performed in an ambulatory surgery center, it must be for reasons of patient safety and administration of anesthesia. The OMIG will review physician and ambulatory surgery center medical charts to ascertain if documentation justifies that the procedure was performed in an ambulatory surgery setting.

Credit Balances*

The OMIG will review hospitals' financial and patient accounts receivable records to identify Medicaid patient accounts records with credit balances. Pursuant to 18 NYCRR § 540.6, providers shall take reasonable measures necessary to assure that no claims are submitted to the medical assistance program that could be submitted to another source of reimbursement, and any reimbursement the provider recovers from liable third parties shall be applied to reduce any claims for medical assistance submitted for payment to the medical assistance program by such provider or shall be repaid to the medical assistance program within 30 days after third-party liability has been ascertained. Also, § 1902(a)(25) of the Social Security Act, 42 CFR 433 Subpart D, requires that Medicaid be the payor of last resort, and that providers identify and refund any overpayment received.

Disproportionate Share Hospital (DSH) Payments

The Medicaid program provides for disproportionate share hospital (DSH) payments to certain hospitals which serve a disproportionate share of low-income patients. These payments in New York are based upon reports submitted by hospitals showing, among other things, the volume and value of uncompensated care rendered by hospitals.

The OMIG will review trends in reporting by hospitals connected with claims for DSH payments. Based upon this review, among other factors, the OMIG will examine records relating to uncompensated care at specific hospitals to determine whether DSH payments were appropriately claimed and paid.

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Physician Compensation

The OMIG will review hospital-based physician compensation and supporting documentation with respect to direct patient care and administrative services. The OMIG reviews will focus on duplicate payments for direct patient care services and the purpose and reasonableness of the administrative services. 10 NYCRR Subpart 86-1 and 18 NYCRR Parts 504, 515, 517 and 518 provide authority to conduct these audits.

LABORATORY SERVICES*

The OMIG will review Medicaid payments for selected independent laboratories to assess compliance with 18 NYCRR § 505.7. A sample of claims will be reviewed to ensure that all tests were ordered, the test results were available and that all Medicaid billing regulations were followed. In all reviews, tests are done to ensure recipients were not residents of facilities where the lab tests would be included in the rate, the lab fees were not unbundled from a clinic rate, and the recipient did not have Medicare or another form of third-party insurance coverage.

MANAGED CARE/DATA MINING PROJECT

Managed care is a term used to describe a health insurance plan or health care system that coordinates the provision, quality and cost of care for its enrolled members. Many different types of managed care plans participate in Medicaid managed care in New York State, including: health maintenance organizations (11); prepaid health service plans (16); managed long-term care plans (17); primary care partial capitation providers (4); and HIV special need plans (3). Please note that Medicaid managed care policy and billing procedures are generally found and referenced to the contract sections found in the Medicaid Managed Care/Family Health Plus Contract. The contract is the primary document which is used to describe and outline the responsibilities and agreements established between the managed care organization and the New York State Department of Health (Medicaid).

Payments for Deceased Enrollees

The OMIG will identify and make fiscal recoveries of Medicaid managed care capitation payments for months subsequent to the enrollee's date of death where the local district (LDSS) has failed to facilitate the recovery. The fiscal recovery for deceased enrollees is described in the Medicaid Managed Care and Family Health Plus Model Contract, Section 3.6 (SDOH Right to Recover Premiums).

Payments for Incarcerated Enrollees

The OMIG will receive from the NYS Office of Temporary and Disability Assistance on an annual basis the *Prison Match Report*, which is produced through corroboration with

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the Department of Corrections and the Division of Criminal Justice Services. The match lists individuals who had been eligible for assistance under the Office of Temporary Disability Assistance (OTDA) and/or Medicaid at the time of their incarceration. We will determine which individuals were enrolled in Medicaid managed care at the time of incarceration where the monthly capitation payments continued after the member was incarcerated and the LDSS failed to facilitate the recovery. We will notify each managed care organization (MCO) of capitation payments made to them for incarcerated members for any time period following the month of incarceration. We will request that the MCO either void the claims or provide documentation supporting their right to the capitation payment. The fiscal recovery for incarcerated enrollees is described in the Medicaid Managed Care and Family Health Plus Model Contract, Section 3.6 (SDOH Right to Recover Premiums).

Payments for Enrollees Who Moved Out of State (PARIS Match)*

The NYS Office of Temporary and Disability Assistance (OTDA) receives from the federal government a report that lists individuals who are receiving benefits from either OTDA and/or Medicaid in more than one state. The OMIG receives a copy of that report and then determines from that information the names of individuals who were enrolled in managed care. Another copy of this report is sent by the Department of Health to the local district (LDSS) offices, which then verify if the individual is still residing in the district, in which case all benefits will continue. However, if the individual is no longer residing in the district, the LDSS is charged with removing that person from the state roster. Capitation payments made prior to the disenrollment of the individual by the LDSS are not recoverable pursuant to the Medicaid Managed Care and Family Health Plus Model Contract, Section 3.6 (SDOH Right to Recover Premiums). Section 3.6 states that capitation payments may be recovered for Medicaid managed care (MMC) enrollees who “have moved out of the contractor’s service area subject to any time remaining in the MMC enrollee’s guaranteed eligibility period” and if the contractor was not at risk for provision of benefit package services for any portion of the payment period. We will continue to monitor this project on an annual basis.

Stop Loss Payments

The OMIG is identifying and reviewing stop loss payments made to managed care organizations where payments were incurred by the plan exceeding certain threshold limits for rate codes related to general inpatient, inpatient mental health/alcohol and substance abuse, outpatient mental health, and RHCF (nursing home). Stop loss is a type of reinsurance, or risk protection, New York State offers to Medicaid managed care plans, intended to limit the plan's liability for individual enrollees. We are encompassing both fiscal and medical record reviews for these outlier payments. This review is described in the Medicaid Managed Care and Family Health Plus Model Contract, Section 19.

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Enrollees with No Encounter and No Fee-For-Service Payments for Immunizations During the First Year of Life

The OMIG will review data matches where there is no encounter data reported for newborns, ages 0 to 12 months, and Medicaid has paid monthly capitation payments. The purpose of the review is to identify and assess potentially incorrect payments, as well as quality-of-care issues. Immunizations are included in the benefit package as provided in the Medicaid Managed Care and Family Health Plus Model Contract, Appendix K.

Capitation Payments Made When Enrollees are Institutionalized in a Skilled Nursing Facility

The OMIG will review data matches where a monthly capitation payment was paid for a period following the month in which an enrollee was institutionalized in a skilled nursing facility. We will identify and make fiscal recoveries of Medicaid managed care capitation payments for months subsequent to the enrollee's date of institutionalization where the local social services district failed to facilitate the recovery. The fiscal recovery for institutionalized enrollees is described in the Medicaid Managed Care and Family Health Plus Model Contract, Section 3.6.

Family Planning Chargeback to Managed Care Organizations

The OMIG will identify claims in relation to family planning criteria as set forth by the Division of Managed Care pursuant to Managed Care Contract, Appendix C, Part I, Section 2a: "Free Access to Services for MMC Enrollees," specifically, free access to family planning and reproductive health services. The claims where the enrollee has chosen to go outside the health plan network for family planning services are identified on an annual basis and are recoverable from the managed care organizations as stated in the Managed Care Contract, Appendix C, Part II, Section 2b. A report of all claims for each MCO will be forwarded to the NYS Division of Managed Care for reconciliation with the managed care plans. When reconciliation is completed, we will then forward a remittance advice to each MCO for payment of the agreed upon amount.

Family Planning Chargeback to Managed Care Organization Network Providers

MCO network provider contracts outline services to MCO enrollees and the methodology to bill the MCO for such services. The OMIG has identified incidents where MCO network providers have billed Medicaid directly for MCO-covered services provided to MCO enrollees. The OMIG will determine if claims submitted by MCO network providers should have been paid by the MCO. This review is in compliance with 18 NYCRR § 540.6(e), which addresses the responsibility of providers to seek reimbursement from liable third parties before billing Medicaid directly for payment.

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Improper Retroactive Supplemental Security Income (SSI) Capitation Payments

The OMIG will review SSI-related enhanced capitation payments made to MCOs. Specifically, the review involves identifying instances in which these enhanced payments may have been inappropriately received by an MCO through the submission of billing adjustments for former Medicaid managed care enrollees whose enrollment status may have been changed retroactively to SSI or SSI-related. This billing is a violation of the Medicaid Managed Care Contract, Section 10.29, Prospective Benefit Package Change for Retroactive SSI Determinations (MMC Programs), which states that, despite the fact that enrollment status may be changed using retroactive dates, MCOs may not bill capitation payments retroactively to a listed date of SSI eligibility, only prospectively from the date the plan is notified via the roster of the status change.

Prior to Date of Birth Payments

The OMIG will review newborn six month rate capitation payments made to MCOs. Specifically, this involves identification of payments made for dates of service prior to a managed care newborn's month of birth. These payments violate the Medicaid Managed Care Contract Section 3.8c, Payments for Newborns, which states that the capitation rate for a newborn will begin as of the month following certification of the newborn's eligibility and enrollment, retroactive to the first day of the month in which the child was born.

Improper Crossover/Duplicate Payments*

The OMIG will review Medicaid payments made for fee-for-service (FFS) claims containing service dates that fall within months in which MCOs also received capitation payments. We will determine through this review whether and which payments may have been made inappropriately as authorized by Medicaid Managed Care Contract Section 10, Benefit Package, Covered and Non-Covered Services. Where the payments are determined to be inappropriate and recoverable, the FFS claims will be recovered from the provider.

Supplemental Capitation Payments Made Without Corresponding Encounter Data

MCOs are entitled to a supplemental newborn capitation payment (paid under the newborn's recipient ID) and a supplemental maternity capitation payment (paid under the mother's recipient ID) in instances where the MCO paid a hospital for the newborn/maternity hospital stay and/or birthing center delivery. The MCO must maintain on file evidence of such payments. Additionally, the MCO is expected to submit birth/delivery encounter data to the DOH. The OMIG will target supplemental newborn and maternity capitation payments to MCOs focusing on encounter data and other documentation to support payment. If the MCO cannot provide documentation to support the newborn/maternity billing, we will request repayment of the supplemental capitation payment. The policy is described in the Medicaid Managed Care and Family

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Health Plus Contract, Section 3.8 (Payments for Newborns) and Section 3.9 (Supplemental Maternity Capitation Payments).

Supplemental Newborn and Maternity Payment Errors

The OMIG will review newborn and maternity supplemental capitation payments and identify instances where incorrect payments appear to exist based on recipient file demographic information. In the past, some of these scenarios have included more than one newborn payment for the same enrollee, billing for both supplemental payments under the same recipient, and billing for a delivery when the enrollee is under 10 years of age or over 50 years old. The OMIG is developing claim edits to prevent these occurrences. The policy is described in the Medicaid Managed Care and Family Health Plus Contract, Section 3.8 (Payments for Newborns) and Section 3.9 (Supplemental Maternity Capitation Payments).

Improper Multiple Client Identification Numbers (CINs) for One Enrollee Payments

The OMIG will review and identify instances where an enrollee has incorrectly been assigned more than one client identification number (CIN) and is enrolled in Medicaid managed care. Where the same health plan is receiving multiple monthly capitation payments for the same enrollee, the OMIG will request the MCO to review the claim(s) in question and take the following action: reimburse Medicaid where the payment was not appropriate, or if the MCO believes the claim(s) to be correct, provide case record documentation to support the claim. The fiscal recovery for multiple CINs is described in the Medicaid Managed Care and Family Health Plus Model Contract, Section 3.6 (SDOH Right to Recover Premiums).

Graduate Medical Education (GME) Payments with No Encounter Data

The Medicaid program includes a GME component as part of the diagnosis related groups (DRG) payment to hospitals providing inpatient services. The MCO payment made to hospitals for inpatient services does not include a payment for GME. The hospital must bill Medicaid directly for the GME component. The OMIG will match MCO inpatient claim data with hospital GME payments in accordance with Title 18 § 515.2, to determine if inappropriate payments were made to hospitals for GME.

Supplemental Payments to Federally Qualified Health Centers (FQHC) with No Encounter Data

Federal Law 42 U.S.C. § 1396a (bb)(5)(A) requires states to make supplemental payments to an FQHC pursuant to a contract between the FQHC and the MCO for the amount, if any, that the FQHC's Prospective Payment System (PPS) rate exceeds the amount of payments provided under the managed care contract for the services rendered by the FQHC. The OMIG will review these supplemental payments made to FQHCs to assure that the FQHC had an executed contract with the Medicaid beneficiaries' MCO,

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the FQHC received a payment from the MCO for the services rendered prior to billing Medicaid, and the amount billed was correct.

Recovery of Capitation Payments for Retroactive Disenrollment Transactions

In accordance with the Medicaid Managed Care and Family Health Plus Model Contract, Section 8.2, MCO is required to void the premium claims for any months of retroactive disenrollment where the MCO was not at risk for the provision of benefit package services during that month. The OMIG will identify and review retroactive disenrollments of beneficiaries to assure that the MCO repays/voids capitation payments when the MCO was not at risk for the provision of benefit package services during any month.

Review of Reported Costs by MCO Plan Companies

The MCO final rate is determined using multiple factors, one of which is reported operational costs used by the plan. The OMIG will review the reported costs submitted by the plans and used by the DOH in finalizing a MCO rate, and determine the accuracy of the information reported.

Review of Reported Costs by Managed Long Term Care Organizations (MLTCs)

A MLTC final rate is determined using multiple factors. The OMIG will review the reported costs submitted by the MCOs that are used by the DOH in finalizing a MCO capitated rate, and determine the accuracy of the information reported. This review will include, but not be limited to, an analysis of related party costs and administrative expenses reported in the MCO cost report submission.

Review of Office of Mental Health (OMH) Prepaid Mental Health Plans*

Based on the type of services provided by OMH prepaid mental health plans, these managed care plans receive a high premium to deliver services to their enrollees. The OMIG intends to perform an overall review of this program including a review of the appropriateness of the beneficiaries being enrolled and the costs associated in the determination of the premiums.

Compliance Review of Medicaid Managed Care and Family Health Plus Contracts

The OMIG will review procedures and policies of two MCOs and their contracted network providers to assure the organization is in compliance with all provisions of the Medicaid Managed Care and Family Health Plus Contract, which the MCO entered into with the DOH.

MEDICAID IN EDUCATION

The Medicaid in Education Unit will continue to work with school districts and counties to ensure the integrity of their claims for Medicaid reimbursement by providing

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continuous guidance and monitoring of the programs through the use of memos, letters and regional training sessions. We anticipate completing pre-payment reviews and continuing post-payment reviews using both OMIG staff and outside contract audit staff.

CMS has issued rule changes that directly impact the Medicaid in Education claiming requirements. The OMIG will work with the New York State Education and Health Departments to implement coming changes, such as changes in requirements for professional credentials and reimbursement methodology.

As an extension of the rule changes and ongoing discussions with CMS, the OMIG is evaluating plans to implement both pre-payment and post-payment claim reviews. Pre-payment reviews will focus on early identification of potential claiming problems, as well as to target providers for post-payment review. Post-payment review includes monitoring all payments to providers, comparing billing trends among providers and scheduling on-site reviews.

MEDICARE PAYMENT RECOVERY

In late 2006, the OMIG sought resolution for outstanding paid claims that were a result of the Center for Medicaid Advocacy (CMA) review of dual-eligible claims for home care services rendered from FFY93 through FFY97. Notices of proposed agency action were sent to the three selected certified home health agencies. Initial letters will be sent to several more providers with activity in the coming year focusing on related recovery activities.

NURSING FACILITIES

Nursing Facility Rates

Residential health care facilities, including skilled nursing facilities (SNFs), are reimbursed for services by the Medicaid program through a prospective per diem payment rate system (Public Health Law §2808).

The Medicaid rate for a nursing facility is comprised of two components: an operating component and a property/capital component. The operating component is based on the 1983 reported costs of the nursing facility, or the first full year of operation, whichever is later, or on a more current basis to reflect, among other events, a change of ownership or construction of a new facility.

Currently, approximately 40 percent of the nursing facilities operating in New York State have reimbursement rates based on 1983 operating costs. The remaining 60 percent are based on more recent operating costs. The property/capital component is based on costs reported in each year with a two-year time lag, with the exception of mortgage expense, which is based on rate year costs.

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For the State Fiscal Year 2008-09, the OMIG plans to conduct Medicaid rate audits in the following areas:

Base Year

Since the same reported costs, with appropriate trend factors, are used for multiple years of reimbursement for the operating component until a new base year is set, the OMIG will review new base years approved by the Department of Health (DOH), Bureau of Long Term Care Reimbursement (BLTCR) and used as a basis for a promulgated nursing facility rate. OMIG audits will focus on inappropriate and unallowable costs included in the nursing facilities' rates. The rules governing the audits are 10 NYCRR Subpart 86-2 and 18 NYCRR Parts 504, 515, 517 and 518.

Rate Appeals

The OMIG will review rate appeals that have been approved by DOH's BLTCR and, where indicated, audit the underlying costs associated with those appeals. Nursing facilities file rate appeals regarding the addition of new services and for large renovation projects. OMIG audits will focus on inappropriate and unallowable costs from the rates and recover the Medicaid overpayments. 10 NYCRR Subpart 86-2 and 18 NYCRR Parts 504, 515, 517 and 518 provide authority to conduct these audits.

Property/Capital Cost Audits

The OMIG will review each nursing facility's property/capital cost component of their promulgated rate and, where appropriate, audit the underlying costs used to arrive at the capital component. Normally, each year's capital costs are used to set the capital portion of the nursing facilities' rates. OMIG audits will focus on inappropriate and unallowable costs from the rate and recover Medicaid overpayments. 10 NYCRR Subpart 86-2 and 18 NYCRR Parts 504, 515, 517 and 518 provide authority to conduct these audits.

Rollovers

Rollover audits are base year audit findings of the operating portion of the nursing facilities' Medicaid rates trended forward to subsequent years. The OMIG plans to issue rollover reports for the rate years 2005 and 2006 and collect Medicaid overpayments.

Dropped Ancillary Services

The OMIG will review whether nursing facilities are providing the ancillary service(s) included in their per diem rate. In cases where the nursing facilities have discontinued providing the service(s) included in their base rate, the OMIG will reduce their per diem rate accordingly and recover the related Medicaid overpayment. Nursing facilities' Medicaid rates include various ancillary costs in their base year costs. Pursuant to 10 NYCRR § 86-2.27, facilities are required to notify the Department of Health of the

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deletion of any previously offered service. OMIG audits will focus on Medicaid overpayments where, subsequent to the base year, the ancillary services are dropped, but the nursing facilities' Medicaid rates still include the cost of such ancillary services. 10 NYCRR Subpart 86-2 and 18 NYCRR Parts 504, 515, 517 and 518 provide authority to conduct these audits.

Patient Review Instrument (PRI)

The DOH's BLTCR utilizes PRIs to adjust a nursing facility's operating component per diem rate to recognize intensity of services. The OMIG will examine the propriety of the preparation of the PRIs as they affect the nursing facility's case-mix index portion of its per diem rate of reimbursement. The last case-mix index calculated by the DOH's BLTCR for 2006 will be used for the 2007 and 2008 rates, per PHL § 2808-2-b(a)(v).

Bed Reserve Payments

The OMIG will perform audits of nursing home reserved bed day billings. The audit scope includes a review of the nursing facility's chart documentation to support that the recipient's expected hospital stay was not to exceed 15 days, as required by 18 NYCRR § 505.9(d). Per 18 NYCRR § 505.9(d)(6)(i), when an institution reserves a recipient's bed, the nursing facility must notify the hospital by telephone and in writing that the recipient's bed has been reserved. The hospital discharge planning coordinator, in return, must notify the nursing facility of the recipient's planned discharge date by the morning of the fourth day of hospital care. If the hospital discharge planner estimates that the hospital stay will exceed 15 days from the hospital admission date, then the nursing facility is required to terminate the recipient's bed-hold.

OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES (OASAS)

The overriding goal of OASAS is to lead a premier system of addiction services. Programming efforts focus on putting patients first and on system and service reforms and performance improvements that ensure a strong return on taxpayer investments.

OASAS collaborates with counties, providers, and other state partners in developing a "gold standard" system of service provision that includes: full compliance with regulatory, ethical and quality-of-care standards; disciplined use of continuous performance improvement approaches; infusion of evidence-based practices; and deliberate attention to consumer outcomes. As an example of interagency collaboration, the OMIG will participate with OASAS during the coming year on a series of regional forums designed to promote audit readiness and compliance planning by chemical dependence providers.

Within this framework, OASAS actively supports the OMIG's efforts to enhance the state's ability to prevent and investigate Medicaid fraud, waste and abuse in the chemical

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dependence system and to improve the quality of chemical dependence care for all patients.

Chemical Dependence Inpatient Rehabilitation Services*

The OMIG will continue a statewide review of Medicaid payments for chemical dependence inpatient rehabilitation providers to determine if providers claimed reimbursement in accordance with 14 NYCRR § 818. Prior OMIG audits identified significant non-compliance with applicable regulations relating to missing progress notes and treatment plans.

Outpatient Chemical Dependence Services*

The OMIG will review Medicaid payments for outpatient chemical dependence services to determine if providers claimed reimbursement in accordance with 14 NYCRR § 822. Medicaid reimbursement is available for outpatient chemical dependence services provided in hospital-based or freestanding clinics. We will conduct reviews of providers that receive the largest amounts of Medicaid reimbursement for these services. Prior OMIG audits identified significant non-compliance with regulations, such as missing treatment plans and missing signatures on treatment plans. As part of the review, the OMIG will focus on the medical necessity of services rendered to Medicaid recipients, and also if the services were excessive. In addition, the OMIG will conduct an audit or investigation of OASAS providers who are found to be providing excessive services through OASAS reviews and are referred to the OMIG by OASAS.

Code 10—Administrative Delay in Prior Authorization Process

The OMIG will review Medicaid payments for claims that were submitted by OASAS providers 90 days after the date of service with a reason Code 10—Administrative Delay in the Prior Authorization Process. OASAS policies, rules and regulations, however, do not require prior authorization for services to Medicaid-eligible recipients. We will also review Medicaid payments for claims submitted by OASAS providers who utilized reason codes other than code 10 for the late submission of claims.

OFFICE OF MENTAL HEALTH (OMH)

The OMH's mission is to promote the mental health of New Yorkers. Of particular focus for OMH is mental health service provision for adults with serious mental illness and children with severe emotional disturbances.

OMH's policy is to refer all matters relating to suspected Medicaid fraud, waste and abuse to the OMIG as such cases are identified.

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Outpatient Services

The OMIG will review Medicaid payments for outpatient mental health services to determine if providers claimed reimbursement in accordance with 14 NYCRR §§ 587 and 588. The outpatient programs in our review will include clinic, continuing day treatment, partial hospitalization, and intensive psychiatric rehabilitation program. Prior OMIG audits identified significant non-compliance with regulations relating to treatment plans and program documentation requirements.

Community Residence Rehabilitation Services*

The OMIG will review payments made for rehabilitative services provided to residents, both child and adult, of community-based residential programs in accordance with 14 NYCRR § 593. These programs are licensed by the Office of Mental Health and are for adults with mental illness and children and adolescents with serious emotional disturbances. The OMIG will focus on whether the Medicaid recipients reside in the community residence.

Code 10—Administrative Delay in Prior Authorization Process

The OMIG will review Medicaid payments for claims that were submitted by OMH providers 90 days after the date of service with a reason Code 10 – Administrative Delay in the Prior Authorization Process. The OMIG is interested in Code 10, since the OMH policies, rules and regulations do not require prior authorization for services to Medicaid-eligible recipients. In addition, we will also review Medicaid payments for claims submitted by OMH providers who utilized reason codes other than code 10 for the late submission of claims.

Case Management Services*

Case management is a process which assists persons eligible for Medicaid to access necessary services in accordance with goals contained in a written case management plan. 18 NYCRR § 505.16 provides details of the regulatory requirements for case management services. The OMIG will review providers of case management services to ensure that the procedural requirements for the provision of services are met and that those services have been billed correctly and have supporting documentation for the claimed units of service.

OFFICE OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES (OMRDD)

OMRDD has been highly successful in implementing a comprehensive Medicaid accountability system which includes the establishment of clear billing standards, regular communication and training for providers on these standards, field reviews that audit

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against the standards, routine desk reviews of Medicaid-paid claims to identify inappropriate claims, and special targeted Medicaid field reviews based on eMedNY data analyses. OMRDD is also working on a series of governance recommendations to advance as part of our own agenda and as part of a workgroup formed with OMH, OASAS, CQCAPD and OMRDD. These recommendations are designed to create greater corporate accountability, improve program integrity and reduce the likelihood of fraud, overpayments and imprudent use of public funds.

OMRDD has extensive Medicaid auditing processes in place. The OMIG will work collaboratively with OMRDD on expanded reviews of Medicaid payments for selected OMRDD-licensed HCBS waiver providers, day treatment providers (14 NYCRR §§ 690), clinic providers (14 NYCRR §§ 679), and case management providers who fail the initial OMRDD review. These reviews are designed to determine if providers claimed reimbursement in accordance with applicable billing standards established by OMRDD.

OMRDD regularly makes referrals to the OMIG of voluntary provider agencies when there is suspected Medicaid waste, fraud, or other abuse involving Medicaid, or there is a lack of documentation to support Medicaid claims. OMRDD also refers to the OMIG providers who have self-disclosed Medicaid-related issues to OMRDD. OMRDD conducts a due diligence review to verify the information in the provider's written self-disclosure. The OMIG conducts an audit or investigation of providers referred by OMRDD pursuant to the circumstances described above. In addition to the above, the OMIG will conduct audits in the following areas.

Outpatient Services

The OMIG will review Medicaid payments for selected OMRDD providers to determine if providers claimed reimbursement in accordance with 14 NYCRR §§ 679 and 690. In addition, we will conduct an audit or investigation of OMRDD providers who were referred to the OMIG by OMRDD. The OMIG will conduct audits of OMRDD providers who did not pass the phase I audit conducted by OMRDD involving a small sample of claims.

Case Management Services*

Case management is a process which assists persons eligible for Medicaid to access necessary services in accordance with goals contained in a written case management plan. 18 NYCRR § 505.16 provides details of the regulatory requirements for case management services. The OMIG will review providers of case management services to ensure that the procedural requirements for the provision of services are met and that those services have been billed correctly and have supporting documentation for the units of service billed.

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Health Care Benefits Initiative

The Commission on Quality of Care (CQC) has received complaints about OMRDD's health care initiative. This initiative, in effect, helps to subsidize health care premiums for direct care staff in order to attract individuals into the system. Complaints have been received that the subsidy provided to provider agencies has not been used for its intended purpose. The OMIG will review the use of these payments.

PAYMENT ERROR RATE MEASUREMENT (PERM) PROJECT

New York State is part of the federal review to determine a national payment error rate for the Medicaid program, known as the Payment Error Rate Measurement (PERM) Project. Sixteen other states and the District of Columbia are working on this federal measure to determine the extent of improper payments of Medicaid monies.

New York State will mirror the federal review of 1,000 to 1,200 claims for fee-for-service payments and managed care capitation payments. New York State will contact providers with sample payments and encourage providers to submit the appropriate documentation for each claim sampled, follow-up with providers if additional documentation is needed and dispute any CMS review contractor findings with which the state disagrees.

The OMIG will use PERM samples to collect information that might not be required as part of the project, but which is useful to the OMIG in identifying potential threats to the integrity of the Medicaid program. OMIG staff will look at each sample payment as it relates to the overall billing pattern of the provider, the utilization pattern of Medicaid recipients and the health care relationships between the client, the provider and other health care providers dealing with the client and the sampled provider.

PERM review is scheduled for every three years. Between cycles, the OMIG will use the PERM model to continuously perform random sampling of Medicaid claims.

PHARMACY

18 NYCRR § 504.3 describes the duties of providers enrolled in the Medicaid program to include providing true, accurate and complete information in relation to any claim, as well as to comply with the rules, regulations and official directives of the department. It also permits the audit of all records relating to services furnished and payments received by enrolled providers.

Pharmacy audit findings generally include, but are not be limited to, the billing of excess quantities, missing prescription documentation, incomplete information on written and telephone orders, the prescriber on the Medicaid claim differing from the actual prescriber of the prescription, missing imprinted/stamped name of prescriber on the prescription, not crediting the Medicaid program for unused medications, and unauthorized refills.

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Claims

The OMIG will review fee-for-service claims and supporting documentation of selected pharmacy providers. The OMIG will review pharmacy compliance with regulations governing the program as stated in 18 NYCRR Section 505.3. We will review claim information as it compares to the actual prescription information. We will review for inappropriate payments as a result of missing prescription/fiscal orders, inaccurate claim submissions, unauthorized refills, and missing prescription/fiscal order information. In addition, the OMIG will review for duplicate prescription serial numbers.

The OMIG will also pursue reviews of selected out-of-state pharmacies that bill New York State Medicaid. Such reviews will examine compliance with the aforementioned Medicaid regulations, with an emphasis on proper dispensing of medications ordered and verification of delivery of medications, since these providers appear to be mail-order pharmacies.

Payments for Deceased Enrollees

The OMIG will identify fee-for-service pharmacy claims submitted subsequent to an enrollee's date of death. The OMIG will review these claims for automatic refills after death, new orders vs. refill orders after death, ordering physicians for dead enrollees, and claim denials for dead enrollees. The OMIG will recover payments made for abusive billing practices as allowed by 18 NYCRR § 515.3.

License Verification

In an effort to uncover potentially fraudulent practices, including stolen provider ID numbers, stolen prescription pads, unlicensed physicians prescribing drugs and Medicaid-excluded providers who are prescribing drugs, the OMIG will verify the licenses of all ordering providers during pharmacy reviews. This verification will require the assistance of the Bureau of Investigations and Enforcement staff to investigate those practitioners who are not properly licensed.

PHYSICIANS

Physician Ordering Practices for Controlled Substances

18 NYCRR Part 515 defines the furnishing of medical care, services or supplies as those being provided directly, or ordered or prescribed by a person. The OMIG will review physicians who have ordered a high volume of Medicaid-reimbursed drugs that fall into the category of controlled substances. We will review the physician's patient medical records to determine if there is documentation to support the medical necessity of the prescription ordered.

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PRE-PAYMENT REVIEW (EDIT 1141)

We will conduct pre-payment reviews on Medicaid providers submitting claims for medical services, equipment, and supplies furnished to Medicaid beneficiaries. Provider review will include, but not be limited to, pharmacies, outpatient and freestanding clinics, durable medical equipment and custom shoe dealers, transportation companies, dentists and physicians. Reviews will focus on the appropriateness and accuracy of submitted claims, evidence of fraudulent practices, and adequacy of supporting documentation. Goals include an increase of 50 percent in the number of providers under review, and in the number of referrals sent to Bureau of Medicaid Audit for recovery, as well as to Bureau of Investigations and Enforcement (BIE).

THIRD-PARTY MATCH AND RECOVERY*

This unit manages activity in accordance with the Medicaid Match and Recovery Contract requirements and state and federal laws and regulations. During the next state fiscal year, unit managers will continue to provide oversight for the four contract modules:

Retroactive Recovery

Recoveries are pursued subsequent to post-payment identification of third-party coverage through Medicare, commercial insurance or other third-party resources.

Data Matching

Nationwide data matches are conducted to identify third-party insurance coverage resulting in updates to eligibility information (for future claims) and pursuit of recoveries for previously paid claims.

Payment Integrity

This category covers data analysis used to identify overpayments that may exist in situations where Medicaid overpaid, e.g., credit balance, system overpayments and other questionable billing practices.

Pre-payment Insurance Verification

Verification includes proactive efforts at the time of enrollment and re-enrollment to maximize our ability to properly update eligibility information and avoid Medicaid billing by providers in the first instance.

TRANSPORTATION*

18 NYCRR § 504.3 describes the duties of providers enrolled in the Medicaid program to include providing true, accurate and complete information in relation to any claim, as

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well as to comply with the rules, regulations and official directives of the department. It also permits the audit of all records relating to services furnished and payments received by enrolled providers.

The OMIG will review fee-for-service claims and supporting documentation of selected transportation providers. We will examine transportation provider compliance with regulations governing the program as stated in 18 NYCRR § 505.10.

New areas being considered for audit:

- Ambulette tolls/EZ Pass matches
- Ambulette trip ticket information is complete and accurate
- New York City ordering providers giving out subway tokens and also ordering ambulette transportation for the same recipient
- Transportation services for inpatients
- Transportation services with no other services in the same day

VOLUNTARY DISCLOSURES

The OMIG has offered and continues to offer all Medicaid providers a voluntary disclosure program. Extensive outreach is made to communicate this to the various provider, medical and legal associations. Providers who identify internal billing or operational issues that might affect their right to Medicaid reimbursement are strongly encouraged to come forward and disclose the parameters of the problem and its potential Medicaid financial impact. The OMIG determines that the issue is a true disclosure (not the result of audit or investigation), validates the parameters described and works with the provider for repayment, which may include extended repayment terms and/or forgiveness of some accrued interest.

WAIVER PROGRAMS

Home and Community-Based Services (HCBS) – Long Term Home Health Care Program Waiver

The OMIG will review Medicaid payments made for services provided under the Long Term Health Care waiver to determine compliance with the *Long Term Care Program Reference Manual* and 18 NYCRR §§ 505.21(b)(4), 540.6(e) and Social Services Law § 367-c. HCBS waiver programs allow states to provide alternative services for individuals who would otherwise require care in a nursing home.

Home and Community-Based Services (HCBS) – Medicaid Waiver for Individuals with Traumatic Brain Injury (TBI)

The OMIG will review Medicaid payments for services provided to participants in the TBI program. Medicaid HCBS waiver programs allow states to provide alternative services for individuals who would otherwise require care in nursing homes. We will

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examine documentation in support of TBI claims to determine compliance with the *HCBS/TBI Waiver Provider Manual*. Prior audits have found significant problems with the lack of documentation for services billed, billing for services not included in the service plan, and billing for more hours than documented.

Services Provided Under § 1915(c) of the Social Security Act: Home and Community-Based Services Waiver*

The purpose of the waiver is to decrease the risk of institutionalization by providing such services as day habilitation, residential habilitation, respite, and family education and training. Any waiver service provided to a participant must be included in the participant's service plan and also the amount, frequency and duration of each service. The OMIG will review Medicaid payments to providers to determine if services provided to individuals with developmental disabilities were in accordance with § 1915(c) approved waiver agreements and 18 NYCRR Parts 624, 633, 635, 636, 686 and 671.

DIVISION OF INFORMATION TECHNOLOGY

BUSINESS INTELLIGENCE UNIT

The Business Intelligence Unit (BIU) will sponsor the procurement and implementation of commercial software products which enhance our ability to do sophisticated data mining and data analysis for identification of difficult-to-detect instances of Medicaid fraud and abuse. Specific initiatives will include identification of recipient duplicates, improvements in matching of recipients with vital statistics data, and a detailed analysis of active providers, sanctioned providers and identifying relationships between owners and associates. The group will also continue efforts to develop new data match algorithms for identifying systemic claiming for which recoupment is necessary.

CARDSWIPE/POST & CLEAR

The OMIG's Cardswipe/Post & Clear Unit oversees the designation of certain providers required to participate in the Cardswipe and/or the Post & Clear programs.

The Cardswipe program requires the installation of a device at the point of service for designated providers and is intended to ensure that the recipient is present by scanning their Medicaid card.

The Post & Clear program requires designated providers to identify patients for whom they prescribe medications or order lab tests, and indicate how many prescriptions and/or lab tests they ordered on a given day. When the patient goes to the pharmacy to pick up their medications, or when the lab sample arrives at the testing lab, the pharmacy or lab must "clear" that information and match it against what was prescribed (i.e., "posted") by the prescriber/orderer to obtain authorization and provide/be paid for the service. Cardswipe and Post & Clear are described in 18 NYCRR Part 514.

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During SFY 2008/2009, we will be identifying additional providers to post their prescription and laboratory orders. Our goal is to work closely with other state groups, such as Bureau of Narcotics Enforcement, Edit 1141, Preferred Drug Program and Recipient Restriction, to encourage referrals of potentially fraudulent activities that could be better controlled through the requirement of posting.

Cardswipe goals for the year include the addition of up to 2,000 providers designated to swipe their transactions. New provider areas for potential inclusion in the Cardswipe program include transportation, home health and dental.

For selected providers, we will focus on enforcing the standard that 85 percent of the providers' services are claimed using the Cardswipe technology.

DATA MINING

Quality data mining is a key enabler to enhance the overall efficiency and effectiveness of many of the activities outlined in the OMIG work plan. By performing effective data mining, the OMIG can direct its resources more accurately.

The OMIG is taking a number of steps to improve the quality and capacity of its data mining efforts, including:

1. Adding to the number of staff involved in data mining activities.
2. Organizing staff to create a focus on the disciplines involved in data mining and related targeting activities.
3. Procuring specialized, commercial data mining tools to enhance the capabilities of data mining.
4. Gathering data from new sources which can be effectively matched with Medicaid data to provide new perspective and leads on fraud, waste and abuse.
5. Hiring expert services and consultants to augment OMIG's own staff expertise.
6. Increasing use of point-of-service (POS) card swipe machines.
7. Increasing staff to review claims on a pre-payment basis.

Together, these steps allow us to continually improve the sophistication with which we identify providers who demonstrate aberrant behavior which demands a closer look through investigation and/or audit.

The OMIG has also increased our focus and capacity to perform data matches. Through data matches, the OMIG is often able to identify large-scale, systemic issues where claims are billed in error by numerous providers. There are a number of reasons why these types of errors are addressed after payment is made. For example:

1. Timing issues: In many instances, a given match revolves around duplicative claims from separate providers. Though we have numerous edits that detect duplicate claims on a real-time basis, there are many instances where the first

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- claim received is the one in error, but has already been paid by the time the second, correct claim is received.
2. Exceptions and complexity: In other instances, the degree of complexity involved in identifying a billing issue is too intricate or involves too many exceptions to be incorporated as part of the real-time edits in the claims processing system.
 3. Use of external data sources: A number of the matches used by the OMIG rely on outside data sources which cannot be applied in a real-time manner. Examples of outside data sources used by the OMIG include vital statistics, worker's compensation, and Medicare data.
 4. Non-claim-related matches: For some recoveries, the basis for claims recovery starts with conditions separate from the claims themselves. For example, the OMIG has recently performed data match analysis to identify duplicate enrollments for managed care recipients. Once the duplicates were identified, the corresponding claims for managed care capitation payments were recovered.

MEDICAID MANAGEMENT INFORMATION SYSTEMS (MMIS) UNIT (SYSTEM EDITS)

The OMIG will work with DOH-OHIP, OMH, OMRDD, OASAS and CSC, the Medicaid fiscal agent, to develop and refine new system edits to reduce fraud, waste and abuse within the Medicaid program. We will continue to work with our contractor to ensure that projects which the OMIG sponsored are addressed on a timely basis. We will begin a process for monitoring and testing existing FWA system edits to ensure that they are working as intended.

OMIG staff will identify opportunities to create system edits to prevent Medicaid overpayments during the claims payment process. We will also review audits of the Medicaid program performed by the Office of the State Comptroller and federal Office of the Inspector General—Health and Human Services to identify any deficiencies that could be corrected by the development of system edits.

MEDI-MEDI PROJECT

The OMIG will continue to be involved in this CMS-sponsored project, established to detect and prevent fraud and abuse in the Medicare and Medicaid programs. New York State is the tenth state to be added to the project. The New York Medicare Medicaid Data Analysis Center (NMMDAC) will be performing computerized matching and analysis of Medicare and Medicaid data. The primary goal is to supplement existing tools being used in the detection, pursuit, prosecution and elimination of aberrant practices.

Initial matching for duplicate payments will provide an opportunity to identify fraud, waste, and abuse cross-matching Medicare and Medicaid that would otherwise go undetected when reviewing each program. Given the breadth of Medi-Medi's mandate, programs have been able to identify a wide variety of billing exceptions. Examples

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include: fraudulent providers who intentionally overbill the programs; provider education issues that result in significant but unintentional abuse; and systematic problems that leave the programs vulnerable to overpayments.

The Medi-Medi Project supports initiatives in both the Audit and Investigations Divisions.

DIVISION OF INVESTIGATIONS AND ENFORCEMENT

INVESTIGATIONS AND ENFORCEMENT UNIT

The Bureau of Investigations and Enforcement (BIE) conducts and coordinates investigations of fraud and misconduct related to the New York State Medicaid programs, operations, and beneficiaries. With investigators working in all 56 counties, BIE leverages its resources by actively coordinating with the Bureau of Medicaid Audit (BMA) and outside agencies. This unit investigates complaints and identifies potential fraud and weaknesses that leave the New York State Medicaid program vulnerable to fraud and recovers damages and penalties through administrative proceedings.

BIE conducts investigations of fraud and misconduct to safeguard the New York State Medicaid program and to protect its beneficiaries. Investigative activities are designed to detect and prevent waste, fraud, and abuse in New York State Medicaid programs. Investigations result in administrative actions (e.g., exclusion from participating in the Medicaid program), recovery of overpayments, and the imposition of penalties through civil and administrative proceedings.

Each year, OMIG receives hundreds of complaints from various sources for development, investigation, and appropriate resolution. Such complaints cannot be predicted in advance; this work plan, however, identifies investigative focus areas in which we will concentrate our resources, subject to the demands of current complaint referrals.

In addition to meeting its programmatic requirements, BIE will continue to educate its own employees and insist on the highest level of integrity within the agency's investigators as they undertake their investigatory roles. BIE carries out this responsibility to ensure that OMIG personnel and contractors treat those whom they investigate with the utmost respect during the process.

Health Care Fraud

OMIG devotes resources to the investigation of fraud committed against the Medicaid program. Staff conducts numerous investigations in conjunction with other law enforcement agencies, such as the state Medicaid fraud control units (MFCUs) and the federal Department of Health and Human Services (HHS) Office of the Inspector General (OIG). BIE will investigate individuals, facilities, or entities that bill or are alleged to have billed Medicaid for services not rendered, claims that manipulate payment codes in

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an effort to inflate reimbursement amounts, and other false claims submitted to obtain program funds. It will also investigate business arrangements that allegedly violate the federal health care anti-kickback statute and the statutory limitation on self-referrals by physicians. BIE is investigating matters involving enrollment and marketing schemes, prescription shorting, kickbacks, factoring, and health care fraud.

Working jointly with other law enforcement partners at the local, state, and federal levels, BIE will continue to identify and investigate schemes designed to illegally obtain and distribute prescription drugs reimbursed by the New York State Medicaid program. BIE will leverage lessons learned through its work related to fraudulent pharmacies in the downstate areas of New York State. Applying these methods to additional high-risk areas in other locations in New York State could produce similar results.

BIE will examine quality-of-care issues for beneficiaries residing in nursing facilities and other care settings. With the continuing growth of the elderly population, nursing facilities and their residents have become common victims of fraudulent schemes. New York State Medicaid may be improperly billed for medically unnecessary services and for services either not rendered, not rendered as prescribed, or for substandard care that is so deficient that it constitutes a “failure of care.”

There are several areas that the OMIG BIE will proceed to leverage their expertise to investigate and recover inappropriately paid monies:

Beneficiary Fraud Unit

The Beneficiary Fraud Unit will continue to interface with LDs on the referral and tracking of Hotline complaints involving incidents of alleged recipient fraud.

The unit plans to formalize interaction with the 58 local social services districts (LDSSs) in the area of beneficiary fraud investigations, prosecutions and recoveries. To this end the unit has established a work group comprised of OMIG staff and selected LDSSs who have volunteered to participate.

Each of the participating districts will receive a questionnaire designed to garner an understanding of the level of beneficiary fraud activity that may be taking place in their respective area. Information will be gathered on the number of investigations, number of prosecutions, type of courts utilized (i.e., state, county, or courts of lower jurisdiction), number of civil prosecutions and judgments and by what methods (civil courts, lower courts of civil jurisdiction—i.e., small claims, or affidavits of confession of judgment).

The data will be collected and compiled, followed by meetings with the participating districts. The hope is to identify potential “best practices” that may be shared with the other districts, as well as identifying local concerns and needs in areas where OMIG may be able to lend technical support.

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A mechanism for disseminating general information, policies and procedures to local districts will be identified.

A statewide beneficiary fraud investigation, prosecution, and recovery reporting instrument will be evaluated for the purpose of quantifying recipient fraud activity and identifying areas where efforts may be enhanced. A baseline of LDSS beneficiary fraud activity can be established, against which growth in fraud control and recoveries can be measured.

Special Projects and Provider Exclusion/Termination

To protect the program and beneficiaries from providers who pose a risk, the OMIG has authority to exclude individuals and entities from participation in Medicaid. Providers are excluded for reasons that may include program-related convictions, patient abuse or neglect convictions, and licensing board disciplinary actions.

The OMIG uses referrals received from various federal, state and local agencies to determine as factors in determining whether or not to exclude a provider. It will continue to work with these agencies to ensure the timely referral of convictions, licensing board and administrative actions. OMIG excluded 657 individuals and entities from Medicaid in SFY 2006 and has implemented the exclusion of 668 individuals and entities in SFY 2007 as of February 6, 2008.

As appropriate, OMIG BIE staff has initiated an affirmative program to impose exclusions against individuals and entities that submitted false or fraudulent claims, failed to provide services that met professionally recognized standards of care, committed crimes or otherwise engaged in conduct actionable under NYCRR Title 18 or other statutes authorizing exclusions by OMIG.

This program uses several approaches, including letters sent in January 2008 to all district attorney offices in New York State requesting that they share any arrest or conviction information with the OMIG related to health care or health care providers. In addition, Internet searches have been developed which return Medicaid and health care-related arrest or investigation information. OMIG BIE staff peruses the major newspapers in New York State on a daily basis for news related to Medicaid and health care as well as related arrest or investigation information.

RECIPIENT CONTROL UNIT

The Recipient Controls Unit is comprised of four entities focusing on seven initiatives, responsible for evaluating the efficiency, effectiveness and utilization of Medicaid program services obtained by Medicaid beneficiaries and taking administrative remedial action where needed. They include:

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Recipient (Beneficiary) Surveillance and Utilization Review Subsystem (RSURS) Unit

Targets potentially excessive or suspect care by employing sophisticated software (J-SURS /DataWarehouse) that enables the linkage of medical services usage characteristics with demographic information to rank the highest risk outliers. These targets are referred for punitive administrative action. Goals for State Fiscal Year (SFY) 08-09 include the enhancement of outlier targeting for new categories of services and increasing the number of referrals for Recipient Restriction Program (RRP) actions.

Recipient Restriction Program (RRP) Unit

Nurses, pharmacists, and physicians perform medical and administrative claims/data analysis and review. Inappropriate utilization puts patients at risk as well as increasing program costs. This program is designed to monitor utilization patterns of patients to assure appropriate, medically necessary services, using output from RSURS, staff:

- Compares utilization against clinical, regulatory, and policy.
- Makes official recommendations for restriction packets and notices.
- Reduces the cost of health care by monitoring utilization behavior by Medicaid enrollees and ensuring that it is appropriate.
- Administers the federal lock-in program.

Specific goals for SFY 08-09 include: (1) continuing to provide RRP enrollees with coordinated medical services to improve the quality of their care; (2) monitoring and increasing medical review of enrollees who have been indentified through RSURS, Hotline or other referrals, based on inappropriate use of medical, pharmaceutical or other Medicaid reimbursed services, achieving cost avoidance and cost savings; and (3) pursuing enhanced regulations to track suspect patterns that may lead to additional RRP actions that may be appropriate for upstate local districts (LDs).

RRP Implementation and Outreach Unit

Staff is responsible for the functions referenced below, and compliance monitoring of RRP by local district departments of social services (LDSS). This unit maintains a program presence and a relationship with every LDSS to provide technical assistance, support and administrative expertise for the RRP. Functions include:

- Monitoring all RRP recommendations sent to the LDSS. Reconciling their restriction and no-restriction actions.
- Providing training to LD staff to achieve maximum program goals and cost savings.
- Monitoring LD use of administrative rules involving RRP Client Notices, continuations, lifts, delinquent lifts and unimplemented cases.
- Providing support for fair hearing issues.

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SFY 08-09 goals include working with BIE recipient fraud staff to collaborate on developing an improved support system so that LDs will be able to identify Medicaid recipients who should not be receiving benefits. Additionally, LDs need support for in finding ways to meet their restriction responsibilities. An ongoing goal is to complete all New York City Human Resources Administration (HRA) Medicaid Insurance Community Service Agency (MICSA) cases referred for RRP completed by the Recipient Controls Unit efficiently and fairly.

Medical Utilization Threshold Program (MUT) Unit

MUT is an administrative mechanism by which Medicaid limits the number of service units of a given provider service type which will be paid for within a beneficiary's "benefit" year (i.e., physician/clinic-10 visits; laboratory- 18 procedures; pharmacy-40 items; mental health clinic- 40 visits; dental clinic-3 visits) without prior authorization. A MUT service authorization (SA) is required prior to payment of claims for providing additional selected services. MUT staff is mandated to:

- Monitor the activities of vendor Computer Sciences Corp. (CSC) staff in the adjudication of MUT service authorization usage and threshold override application (TOA) requests by participating providers.
- Serve as a resource for providers experiencing claiming problems. Recipient Controls staff authorizes the special handling of MUT overrides, the submission of special forms, and reconciles disputes between providers and CSC.
- Evaluate TOAs for potential fraud or misuse and refer appropriate cases for either provider or beneficiary actions.

A major goal for SFY-08-09 is to assist the Office of Health Insurance Programs (OHIP) in the evolution of the current MUT program to a provider-specific service-authorization attribution format.

Duplicate Client Identification Number (CIN) Project

LDs must authenticate the identities of Medicaid applicants in order to prevent the possibility of eligibility fraud. Enrollees intending to commit fraud may attempt to open duplicate cases so that benefits may be obtained using multiple Medicaid cards. The goal of this initiative is to identify occurrences of multiple Medicaid client (beneficiary) identification numbers (CINs) issuance problems by LDSS, and assist them in closing inappropriate cases by using eMedNY Data Warehouse and the Welfare Management System. A major function of Recipient Controls staff is to find duplicate CINs in the RRP and determine if these numbers have been used fraudulently.

Goals for SFY-08-09 are to support LDS in the prevention of multiple CINs with expected savings by preventing duplicative managed care capitation payments, avoidance of excessive fee-for-service payments and closure of improperly opened Medicaid cases.

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Prescription Forgery Project

This project continues to be an effective method of identifying beneficiaries for both referrals to RRP and to fraud units when forgeries are authenticated. Forgeries are identified through attestation via outreach to providers or data mining prescription serial numbers on lost or stolen prescription blanks. Through this initiative, the issue of fraudulent Medicaid-reimbursable drugs can be prevented and expedited referrals for criminal investigation.

Goals for 08-09 are to continue to pursue a productive relationship with LDSS staff, other Office of the Medicaid Inspector General (OMIG) and other Department of Health (DOH) units, such as the Bureau of Narcotic Enforcement.

Provider-Beneficiary Intersect Special Projects

This initiative is the direct result of the collaboration between provider SURS and beneficiary SURS actions. Recipient Controls clinical and program staff work collegially to share and develop outlier targets to obtain maximum efficiency in the pursuit of fraud. A goal for SFY 08-09 is to integrate each other's existing SUR control files to profile targets from each unit's data mining actions.

PROVIDER SURVEILLANCE AND UTILIZATION REVIEW SYSTEM (SURS) UNIT

The Provider SURS unit is responsible for evaluating the efficiency, effectiveness and utilization of the Medicaid program by Medicaid providers. The unit identifies potentially duplicative, excessive or contraindicated care or services rendered to Medicaid beneficiaries. The Provider SURS unit also provides medical review support for central office (upstate) and metro-regional office (downstate) investigative staff.

The Provider SURS unit works closely with the New York State Attorney General's Medicaid Fraud Control Unit (MFCU), the Office of Professional Medical Conduct (OPMC), the State Board for Education, the Bureau of Controlled Substances, OMIG Bureau of Medicaid Audit and other government agencies when quality-of-care issues or aberrant billing practices are noted. Referrals are also sent to the Recipient SURS unit.

Examples of upcoming SURS activity are:

- Physicians who bill for the same service on both an individual and a group basis for the same beneficiary on the same date of service.
- Transportation providers who submit claims where the beneficiary does not have corresponding visits with Medicaid-enrolled providers.
- Nursing services and home health care—SURS works closely with the investigative staff to evaluate the appropriateness of claims submitted by Medicaid-enrolled nursing and home health agencies and individual nurses.

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- Pharmacy—BIE and SURS review claims submitted by enrolled pharmacies, developing targets utilizing formulary peer group quarterly/annual data.

ENROLLMENT AUDIT REVIEW UNIT (EAR)

The Enrollment Audit Review Unit (EAR) builds integrity in on the front end of the program by completing thorough, in-depth reviews of provider enrollment and reinstatement applications. The purpose of these reviews is to determine whether applicants should be enrolled or reinstated into the Medicaid program based on compliance with Department of Health policies and procedures.

EAR reviews enrollment applications in categories of service where a history of abuse in the Medicaid program has been demonstrated either statewide or in certain geographical areas within the state. Categories include pharmacies, laboratories, transportation and durable medical equipment (DME) providers, and physicians. EAR uses various databases, on-site investigations, undercover “shoppers,” information from the New York State Education Department and the Office of Professional Medical Conduct (OPMC) and other sources to gather information.

The unit works closely with the U.S. Department of Health and Human Services (HHS), the New York State Department of Transportation, OPMC, the Board of Pharmacy, the Medicaid Fraud Control Unit (MFCU) and other state and local agencies, as well as staff within the DOH and OMIG.

If potential or actual abuses are found during an EAR review, appropriate referrals are made to other units within OMIG for audits or further investigation, and, in some situations, EAR may terminate the ability of existing providers to participate in the Medicaid program.

The unit’s functions also include reviewing ownership changes, targeting physicians who have documented incidences of ordering high numbers of prescriptions or services, setting up and updating density criteria for providers, coordinating the provider appeals process, and preparing affidavits for Article 78 proceedings challenging applicant denials.

Within the next year, EAR expects to review approximately 700-1000 applications, which comprise 10-15 percent of all applications received by the Department of Health’s Provider Enrollment Unit. Approximately 15 percent of the applications reviewed and processed by EAR result in denials, netting an annual cost savings estimated to be between \$40-50 million.

OFFICE OF COUNSEL

The Office of Counsel (OOC) to the Inspector General provides day-to-day internal legal advice and representation to OMIG. OOC also coordinates OMIG’s role in the resolution

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of civil and administrative health care fraud and overpayment cases, including the litigation of recoupment of overpayments, program exclusions, and civil monetary penalties. DOC is responsible for drafting legislation and OMIG regulations and compliance guidance. Work planned in FY 2008 includes the following:

Creation and Revisions of Regulations

OOC will draft and work closely with the Governor's Office of Regulatory Reform to issue regulations implementing Social Services Law §363-d compliance program requirements. OMIG will also revise certain current regulations to strengthen and clarify OMIG's ability to effectuate its statutory mission.

Legislation

OMIG will work with the Legislature and other agency partners to suggest and support legislation that provide additional tools to support OMIG's ability to identify fraud, abuse, and waste in the medical assistance program and take effective action.

Industry Compliance Guidance

As part of OMIG's ongoing efforts to foster compliance efforts by providers, we will issue compliance program guidance specific to particular types of providers. We will periodically convene advisory committees comprised of key stakeholders in each industry for which compliance guidance will be drafted to provide suggestions about best practices for effective compliance programs.

Corporate Integrity Agreements

OOC will initiate the issuance of corporate integrity agreements (CIAs) as appropriate. We will, with the Bureau of Investigation and Enforcement, assess the compliance of providers with the terms of CIAs (and settlements with integrity provisions) into which they entered as part of the settlement of fraud and/or abuse allegations. Included in this monitoring process will be systems reviews to determine whether a provider's compliance mechanisms are appropriate and to identify any problem areas and establish a basis for corrective action. When warranted, we will work with the Bureau of Investigation and Enforcement to impose sanctions, in the form of stipulated penalties or exclusions, against providers who breach their integrity agreement obligations.

Bureau Support

OOC will continue to draft and review contracts and provide legal advice to the Division of Finance and Operations and will provide legal advice and support for the Division of Human Resources and to the Collections Management Unit. OOC will continue to provide legal advice and support to the Bureau of Audit, the Bureau of Investigation and Enforcement, and the Bureau of Information.

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Administrative Decision-Making

OOC will continue issuing appellate decisions addressing provider appeals of notices of immediate agency action that immediately exclude providers from participation in the medical assistance program.

Hearings and Litigation

OOC will continue to represent OMIG in administrative hearings in which providers appeal findings of overpayments, unacceptable practices, and other abuses of the medical assistance program resulting in the issuance of penalties, sanctions, repayment determinations, and exclusions from participation in the medical assistance program. OOC will continue to provide legal support to the Office of the Attorney General in its representation of OMIG in cases in court. OOC will continue to negotiate settlements.

Appendix A

Glossary of Abbreviations

ADHC	Adult Day Health Care
ALP	Assisted Living Programs
BLTCR	Bureau of Long Term Care Reimbursement
BMA	Bureau of Medicaid Audit
CHHA	Certified home health agency
CIN	Client identification number
CMA	Center for Medicaid Advocacy
CMS	Center for Medicare and Medicaid Services
CQC	Commission on Quality of Care
D&TC	Diagnostic and Treatment Centers
DME	Durable medical equipment
DOH	Department of Health
DRG	Diagnosis-related group
DSH	Disproportionate hospital share payments
EAR	Enrollment Audit Review
FFY	Federal fiscal year
FQHC	Federally qualified health center
FWA	Fraud, waste and abuse
HCBS	Home and community-based services
HHA	Home health agencies
HHS	Department of Health and Human Services
IMD	Institutions for mental disease
LDSS	Local Social Services District
MCO	Managed care organization
MFCU	Medicaid Fraud Control Unit
MICSA	Medicaid Insurance Community Service Agency
MLTC	Managed long term care organizations
MMIS	Medicaid Management Information Systems
MUT	Medicaid Utilization Threshold Program Unit
NMMDAC	New York Medicare Medicaid Data Analysis Center
NYCRR	New York Code of Rules and Regulations
OASAS	Office of Alcoholism and Substance Abuse Services
OHIP	Office of Health Insurance Programs
OMH	Office of Mental Health
OMIG	Office of the Medicaid Inspector General
OMRDD	Office of Mental Retardation and Developmental Disabilities
OTDA	Office of Temporary Disability Assistance
PERM	Payment Error Rate Measurement
PHL	Public Health Law
PPS	Prospective Payment System
SSI	Supplemental Security Income
TBI	Traumatic Brain Injury
TOA	Threshold Override Application