



Office of the
Medicaid Inspector
General

ANNUAL REPORT 2022



Kathy Hochul
Governor

Frank T. Walsh, Jr.
Acting Medicaid Inspector General

Table of Contents

Message from the Acting Medicaid Inspector General	Page 3
General Overview	Page 4
Executive Organization Chart	Page 7
Regional Office Locations	Page 8
2022 Agency Highlights	Page 9
Education / Compliance / Self-Disclosure	Page 12
Business Intelligence and Third-Party Liability	Page 16
Medicaid Audits	Page 20
Division of Medicaid Investigations	Page 31
Office of Counsel	Page 48
External Audits	Page 52
Powers and Duties	Page 53
Frequently Used Acronyms	Page 55
Data Tables	Page 57
Back Cover / Contact Information	Page 64

Message from the Acting Medicaid Inspector General



On behalf of the Office of the Medicaid Inspector General (OMIG), I am pleased to share the 2022 Annual Report detailing the agency's activities, initiatives, and results.

Building upon lessons learned during the COVID-19 pandemic, OMIG continued to collaborate with partner agencies and stakeholders to help ensure sustained access to high-quality health care while promoting Medicaid program integrity. Through the introduction of new initiatives, streamlining agency processes and performing ongoing outreach to the Medicaid provider community, OMIG delivered on its mission to fight Medicaid fraud, waste, and abuse while contributing to a better, stronger, and more vibrant health care delivery system.

Throughout 2022, OMIG worked closely with Medicaid providers and stakeholders to address concerns, enhance their knowledge of program requirements and agency practices, and forge an enhanced collaborative approach to improve program integrity.

These combined efforts enabled OMIG to conclude over 3,500 audits and investigations and deliver impressive program integrity results in 2022, including generating more than \$3.4 billion in cost avoidance and recoveries to offset Medicaid program costs.

I am proud to lead the dedicated team at OMIG in their sustained efforts to collaborate and promote integrity in the Medicaid program. Going forward, OMIG's commitment to promoting Medicaid beneficiaries' access to the State's high-quality health care delivery system and the agency's tireless efforts to appropriately combat fraud, waste, and abuse will not waiver. In this fashion, OMIG will continue to set the national standard for Medicaid program integrity, controlling costs, and, in partnership with law enforcement, holding wrongdoers accountable.

Sincerely,

A handwritten signature in blue ink, appearing to read "Frank T. Walsh, Jr.", written in a cursive style.

Frank T. Walsh, Jr.
Acting Medicaid Inspector General

General Overview

History and Authority

On July 26, 2006, Chapter 442 of the Laws of 2006 was enacted, establishing OMIG as an independent office. The legislation amended the New York State (NYS) Executive, Public Health, Social Services, Insurance, and Penal laws to create OMIG and institute the reforms needed to effectively fight fraud and abuse in the State's Medicaid program. The statutory changes separated the administrative and program integrity functions, while still preserving the single state agency structure required by federal law. The Medicaid Inspector General reports directly to the Governor.

OMIG is charged with coordinating the fight against fraud and abuse in the Medicaid program. To fulfill its mission, OMIG performs audits, investigations, and reviews of Medicaid services and providers and works with other federal and state agencies that have regulatory oversight or law enforcement powers.

Mission Statement

The mission of OMIG is to enhance the integrity of the NYS Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds, while promoting high quality patient care.

Annual Reporting

As required by NYS Public Health Law (PBH) §35(1), OMIG must annually submit a report summarizing the activities of the agency for the prior calendar year. This Annual Report includes information about audits, investigations, and administrative actions, initiated and completed by OMIG, as well as other operational statistics that demonstrate OMIG's program integrity efforts.

Amounts reported within this document represent the value of issued final audit reports, self-disclosures, administrative actions, and cost avoidance activities. OMIG recovers overpayments when it is determined that a provider has not complied with program requirements or submitted or caused to be submitted claims for medical care, services, or supplies for which payment should not have been made. OMIG recovers these amounts by receipt of cash, provider withholds, and/or voided claims. The recovery amounts presented in this report may be associated with overpayments identified in earlier reporting periods and may be larger than the amounts identified during the

reporting period. Identified overpayments and recovery amounts reflect total dollars owed to the Medicaid program, as well as adjustments related to hearing decisions, and stipulations of settlement. Hearing requests may not be fully resolved within the same calendar year that the hearing request is received.

Function

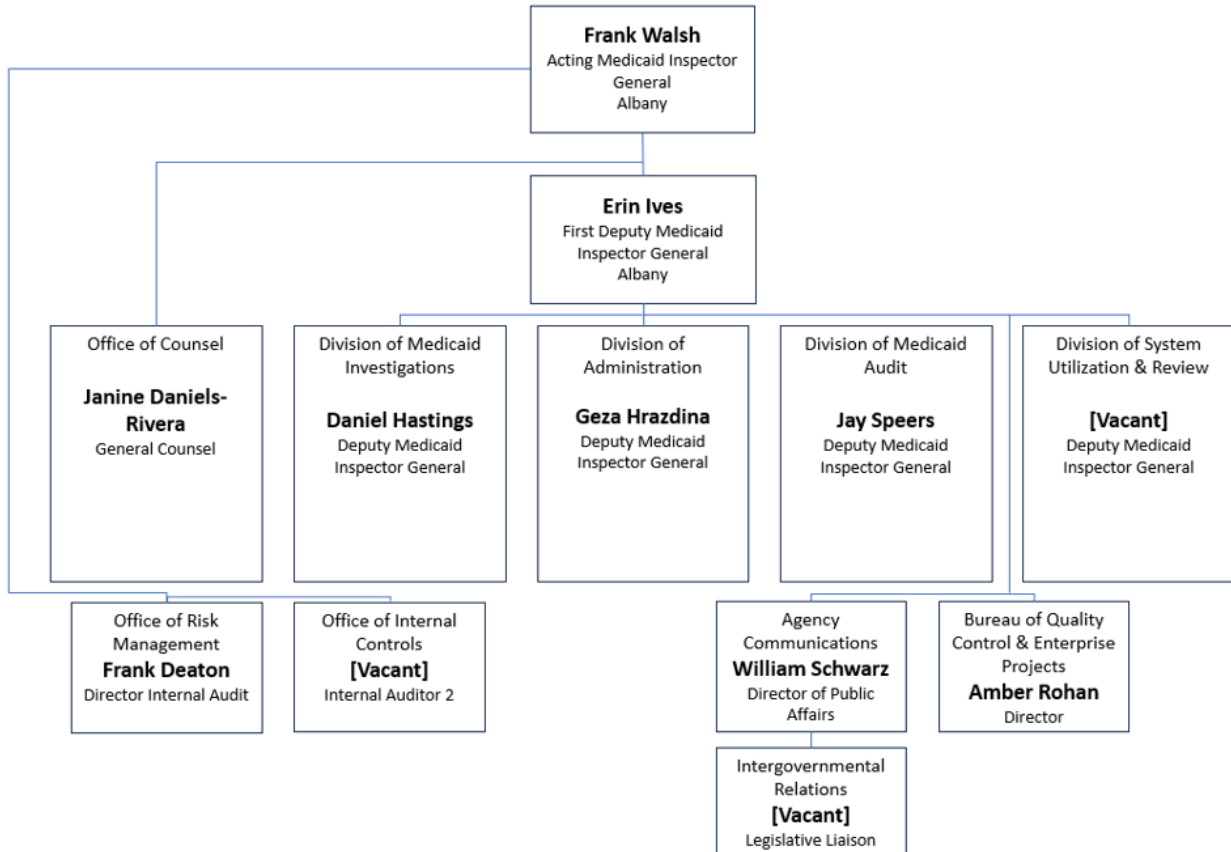
OMIG is an independent agency responsible for the enhancement and promotion of Medicaid program integrity statewide, the protection of efficient and high-quality health care service delivery, and the preservation of resources and support for the continued provision of critical health care services to nearly eight million Medicaid recipients. In realizing these objectives, OMIG actively seeks to:

- ❖ Understand, promote, and advise on Medicaid policies and procedures that advance program integrity objectives.
- ❖ Closely coordinate with NYS Department of Health (DOH) and other state agencies involved in the Medicaid program to identify their priorities and objectives and develop enforcement strategies that align with these priorities and objectives.
- ❖ Educate and collaborate with Medicaid providers and payers, including Managed Care Organizations (MCO), to improve their understanding and compliance with current Medicaid requirements.
- ❖ Monitor, identify and evaluate aberrant fiscal or programmatic trends and prioritize those that merit investigation or audit.
- ❖ Partner with and support other Federal, State, and local law enforcement and governmental agencies to identify inappropriate practices and enforce Medicaid rules and requirements.

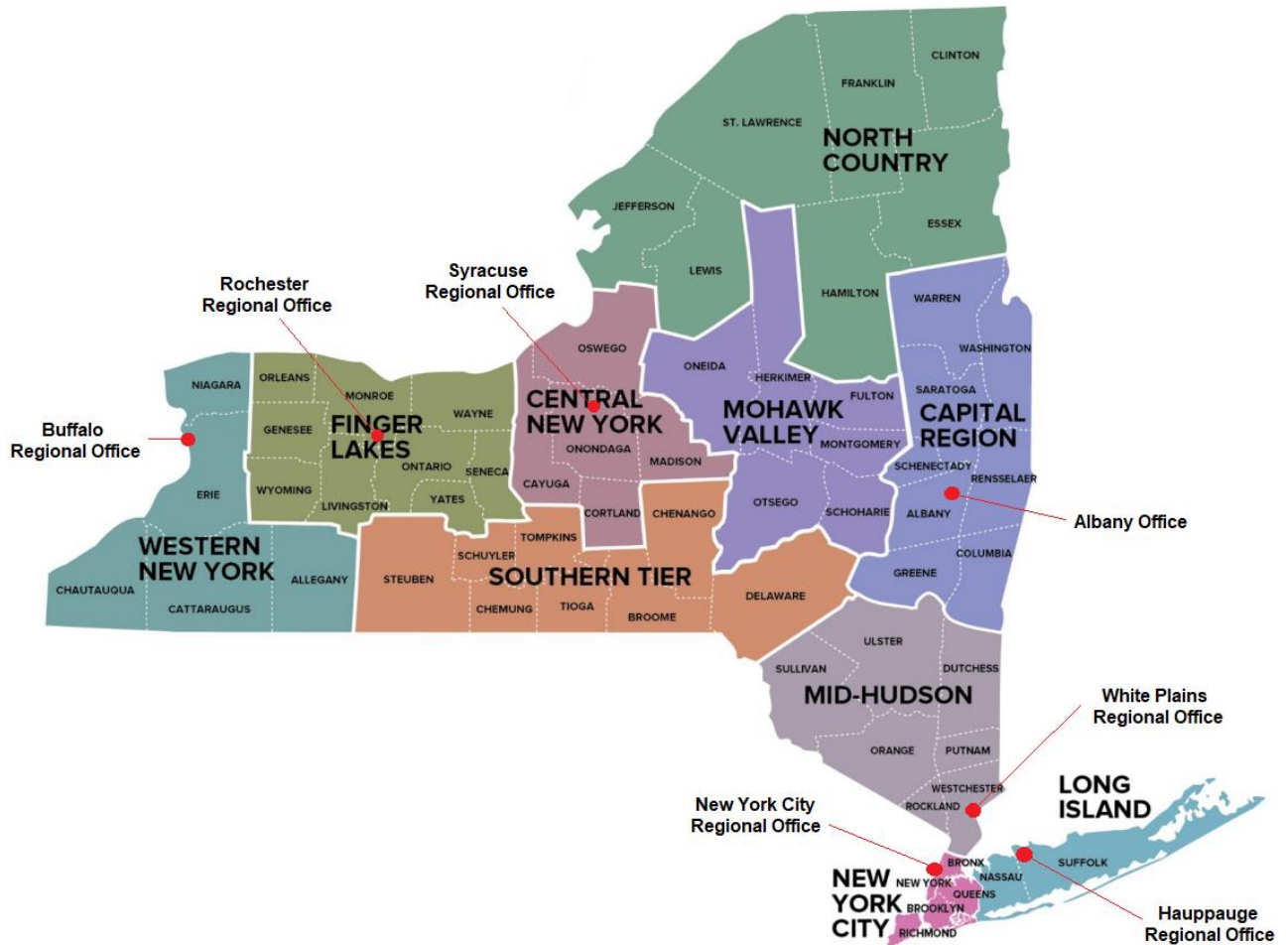


- ❖ Cooperate, comment, and conduct appropriate follow-up actions, including the recovery of identified Medicaid overpayments, resulting from external audits of the NYS Medicaid program.
- ❖ Conduct audits in identified areas to assess provider compliance with Medicaid program and reimbursement practices to ensure that Medicaid recipients have access to quality medical services and that services are delivered efficiently. Where appropriate, OMIG publishes audit protocols in advance that are created in conjunction with the relevant state agencies and the provider community.
- ❖ Respond to allegations of fraud, waste, and abuse within the Medicaid program, initiate investigations of providers or recipients and take appropriate enforcement actions, including censure, exclusion, recipient restriction, or pre-payment review (PPR). OMIG also coordinates activities with the Special Investigative Units (SIU) of Medicaid managed care (MC) providers which strengthens program integrity and increases the number of referrals to OMIG.
- ❖ Referral of credible allegations or identified instances of fraud to the NYS Attorney General's Medicaid Fraud and Control Unit (MFCU) for review, recovery, and potential prosecution. OMIG works closely with MFCU to identify and analyze trends while safeguarding the activities undertaken to ensure they do not conflict with MFCU activities.
- ❖ Promote and provide opportunities for due process in the course of OMIG audits, investigations, and reviews, and associated final agency actions. Defend final agency actions at administrative hearing or Article 78 judicial proceeding.

Executive Organization Chart



Regional Office Locations



OMIG staff primarily work on Medicaid program integrity functions. These positions include auditors, investigators, nurses, data analysts, pharmacists, other clinical/medical professionals, compliance specialists, program administrators/managers, and persons providing legal, technological, and clerical support, in seven offices across the state.

2022 Agency Highlights



Policy/Process Highlights

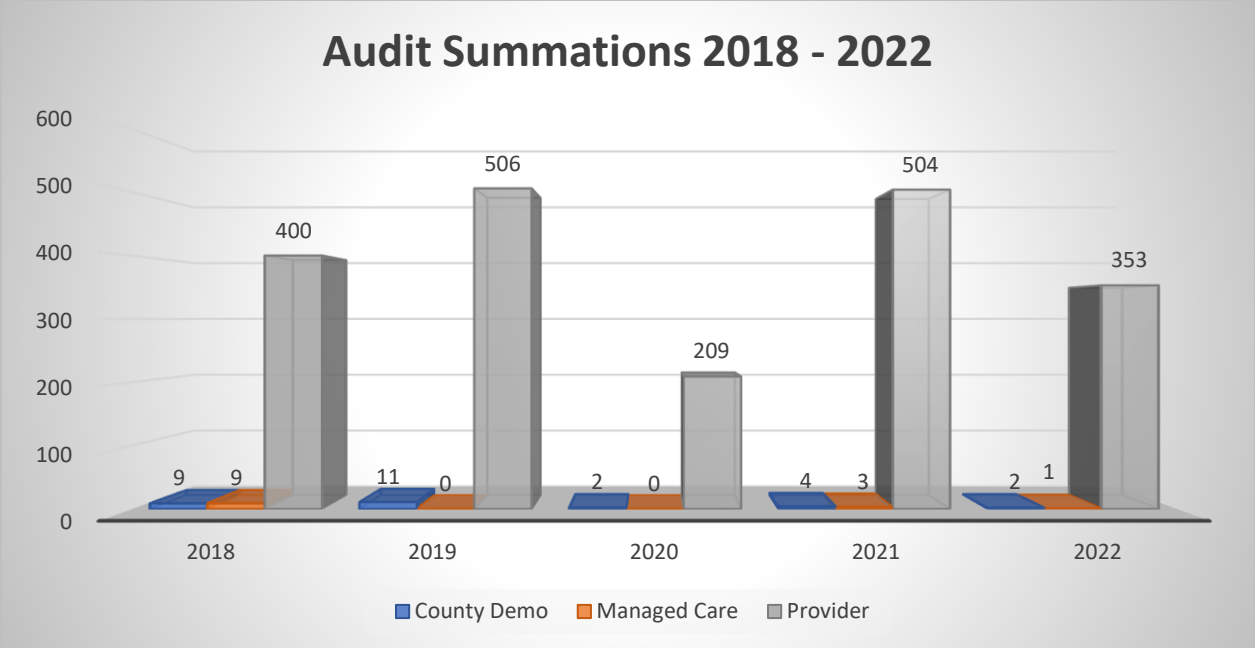
In 2022, the Office of Counsel (OC) worked closely with the Casualty and Estates (C&E) unit in the Division of Systems Utilization and Review (DSUR) to streamline, update, and revise an internal process to improve the intake and assignment of Medicaid lien cases. This joint endeavor resulted in the creation and implementation of a Medicaid Lien Intake form utilized by the OC to provide preliminary information for C&E to identify the existence of a Medicaid lien. This information allows C&E to more efficiently check its database and notify OMIG's third-party contractor earlier in the process to obtain necessary case information, better facilitate timely assignment of the case to an OC attorney and improve coordination with County partners and local districts in representing the State's Medicaid interest.

Healthcare Worker Bonus System

As part of the Fiscal Year 2022-23 Budget, Governor Kathy Hochul announced the launch of the Health Care and Mental Hygiene Worker Bonus (HWB) Program, which allocated \$1.3 billion for the payment of recruitment and retention bonuses to certain health care and mental hygiene workers. OMIG staff, in consultation with DOH, have developed processes to support agency audits, investigations, and reviews of HWB claims and payments, as well as the self-disclosure of employer identified HWB overpayments, to ensure that these bonuses are appropriately distributed.

Audit Summations – Demonstrations of Provider Compliance

The intent of OMIG audits is to assess compliance with Medicaid program requirements and identify instances of non-compliance. During the audit process there are instances when OMIG determines that for the audit period and objectives reviewed, the provider has generally adhered to applicable Medicaid billing rules and regulations. In these cases, OMIG issues an Audit Summation Letter advising the provider that pursuant to 18 NYCRR §517.3(h), the audit is concluded and no further action is required by the provider. In 2022, OMIG issued 356 Audit Summations – which are posted on the OMIG website as “Positive Reports” – and are indicative of provider compliance with Medicaid requirements in nearly 25 percent of finalized audits.



Financial Hardships

OMIG is sensitive to the fiscal health of the provider community and works closely with our partnering Medicaid state agencies to maintain uninterrupted access to necessary health care services and supports. During the course of an audit engagement or other OMIG proceedings, providers have the opportunity to inform the audit team of the potential financial impact the audit may have on their business. OMIG has an enhanced financial hardship process, which affords providers the opportunity to apply for relief in the event an OMIG audit may pose a financial hardship to the organization. Providers that have received a Final Audit Report and wish to apply for financial hardship consideration may contact OMIG’s Bureau of Collections Management who will send the provider a Financial Hardship Application. The intent of this process is to offer objective and reasonable repayment relief for providers facing financial hardship. Upon request, a hardship application is sent to the provider to be filled out in its entirety. Once the completed application is received and reviewed by OMIG, an appropriate repayment plan is determined and communicated to the provider. Providers who have received hardship relief are required to re-apply on an annual basis so OMIG can assess any changes in their fiscal position. In 2022, OMIG received three new requests for financial hardship, along with 19 requests to renew their hardship. Three of the renewals were denied because the providers did not submit the required application or documentation, and the other 19 requests were granted hardship relief.

Education / Compliance / Self-Disclosure

**9 Presentations
2,000+ Participants**



**42 Audit Protocols Posted
Including 1 Updated in 2022**

**Finalized 301 Self-Disclosures
Identifying \$10 Million in
Overpayments**



Education

Provider Outreach

OMIG delivers an array of provider outreach and education services to providers, associations, and other Medicaid stakeholders across the state through informational webinars, guidance materials, presentations, and meetings. In 2022, OMIG conducted nine presentations - both virtually and onsite - to more than 2,000 participants across a diverse group of organizations. Topics included:

- ❖ OMIG's audit process
- ❖ Overview of OMIG agency priorities and new initiatives
- ❖ Compliance and Self-Disclosure requirements
- ❖ Managed Care Special Investigative Unit (SIU) standards
- ❖ Exclusion process
- ❖ Internal risk management
- ❖ Current issues in healthcare litigation
- ❖ Recipient restriction program

Compliance Regulations

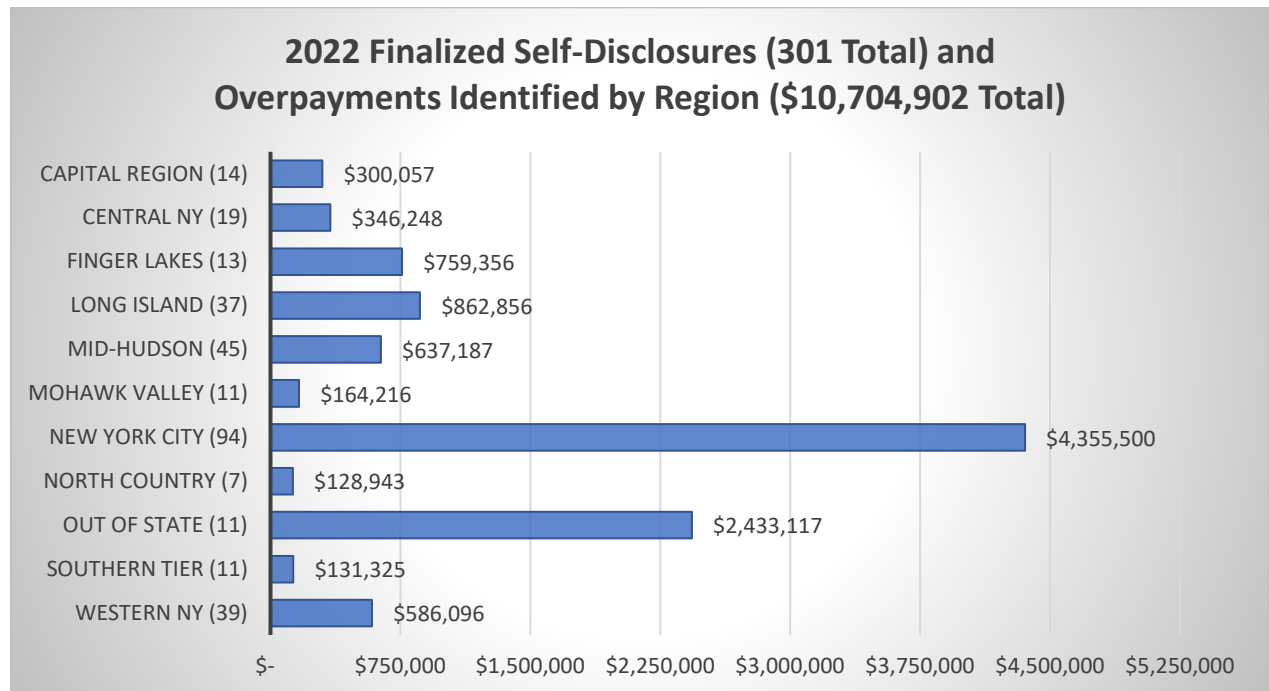
Effective December 28, 2022, Title 18 of the New York Codes, Rules and Regulations (NYCRR) Part 521 was amended to implement statutory changes adopted in the State Fiscal Year (SFY) 2020-2021 Enacted Budget. These changes impact the requirements for establishing and operating compliance programs pursuant to Social Services Law (SOS) §363-d, establish requirements for Medicaid Managed Care (MC) Fraud, Waste and Abuse Prevention Programs pursuant to SOS §364-j(39), and update requirements that persons shall report, return, and explain overpayments pursuant to SOS §363-d(6) and (7).

The finalized regulatory package benefited from extensive provider outreach, review and engagement aimed at identifying and addressing provider concerns with the new regulatory requirements. During this process OMIG received comments from 28 Medicaid stakeholders – including hospitals, health plans, community-based long term care providers, physical health care and behavioral health care associations, individual providers and program advocates – that combined to express their concerns in 61 separate subject areas, including but not limited to, concerns about timeframes to implement the new requirements, how OMIG will conduct its compliance program reviews, and the application of the compliance program requirements to provider contractors and subcontractors. OMIG reviewed and responded to each concern that

was raised during the regulatory review process. The full regulatory package can be found at <https://omig.ny.gov/information-resources/laws-and-regulations>.

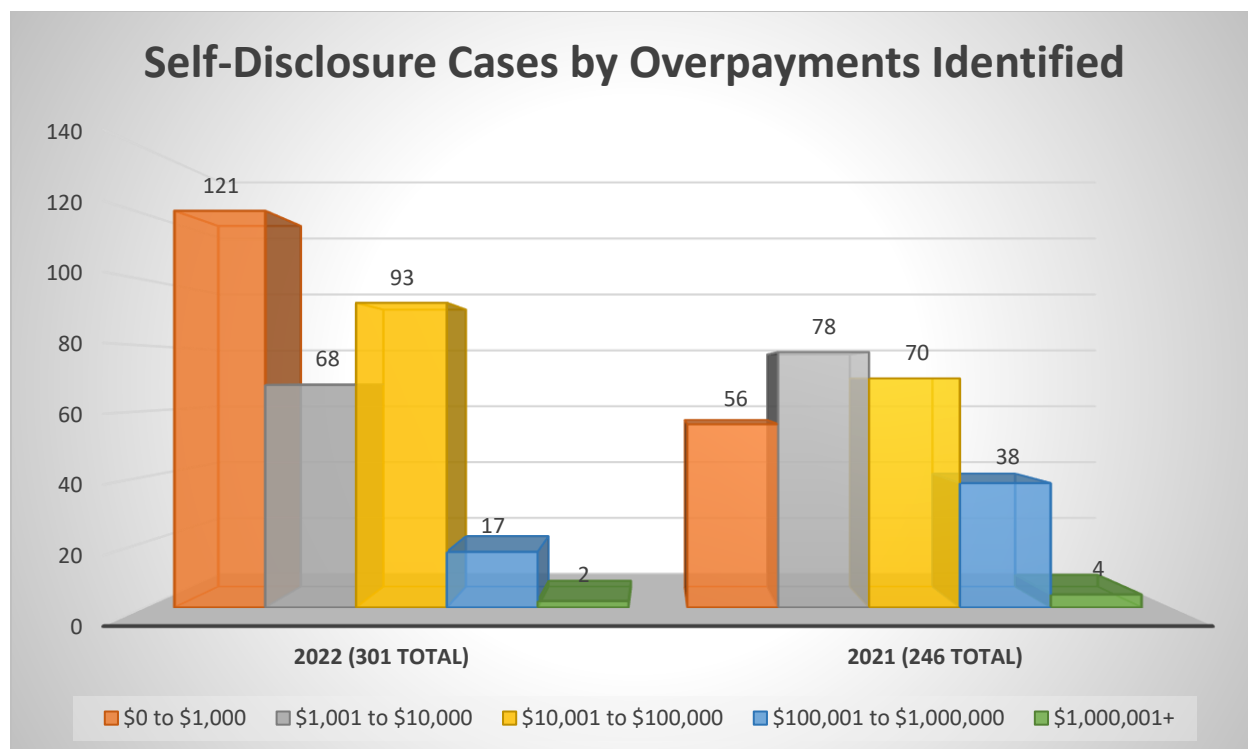
OMIG has also posted guidance on the NYS OMIG website, at: <https://omig.ny.gov/>, to assist providers who must adopt and implement programs designed to detect, prevent, report, and correct incidents of fraud, waste, and abuse in the Medicaid program.

Self-Disclosure



Another measure of provider knowledge and compliance with Medicaid program requirements is reflected in their identification and self-disclosure of overpayments that they have received. Equally, it is a requirement under both federal and State law to report, return, and explain Medicaid overpayments they are responsible for and/or have received. OMIG’s Self Disclosure Program supports providers in meeting these requirements.

In December 2022, OMIG published amended regulations, Part 521 of Title 18 of the NYCRR implementing the statutory changes to SOS § 363-d enacted in 2020. These regulations included the most comprehensive clarification of purpose and process for the Self-Disclosure Program since its inception and include details about provider eligibility, processing time frames, and enforcement. In 2022, OMIG processed 301 self-disclosures which is a 22% increase in cases from 2021, for a total of \$10,704,902. Of those cases, 40% were for overpayments under \$1,000.







Identification of Lost or Destroyed Records

Pursuant to Title 18 NYCRR § 504.3, providers are required to prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records, upon request. If records are damaged or destroyed the provider won't be able to produce them in response to a future audit, investigation, or review.

If a provider becomes aware that their records have been damaged, lost, or destroyed, they are required to report that information to the Self-Disclosure Program as soon as practicable, but no later than thirty (30) calendar days after discovery. To satisfy their obligation for reporting, providers may use the Statement of Lost or Destroyed Records form and OMIG's secure uplink which are available in the Self-Disclosure section of OMIG's website. Once self-disclosures review of the submitted information is complete the provider will receive a notification letter detailing acceptance of the report. In 2022 OMIG processed seven of these reports.

Business Intelligence and Third-Party Liability

<p>\$2.5 Billion Pre-Payment Insurance Verification Cost Avoidance</p> 	<p>\$210 Million Third-Party Liability Recoveries</p> 
<p>\$120 Million Casualty and Estate Recoveries</p> 	<p>\$171 Million Recovery Audit Contractor Recoveries</p> 

Business Intelligence Overview

NYS Medicaid is a data-intensive and complex program of multiple information systems including eMedNY - the Medicaid Management Information System, and the Medicaid Data Warehouse (MDW) - the central data repository of all Medicaid paid and denied claims. Utilizing technology is essential to effective program integrity oversight of the services provided to nearly eight million recipients by more than 200,000 enrolled providers. OMIG is heavily reliant upon and utilizes these systems to perform oversight of the Medicaid program, confirm the appropriateness of provider payments, and provide timely, accurate, and defensible data and analysis to support Medicaid program integrity initiatives throughout the agency. OMIG staff members employ specialized knowledge of Medicaid data and systems to apply technological solutions and develop complex data analytics to inform and support management decisions, audits, investigations, and hearings.

Pre-Payment Insurance Verification Cost Avoidance

Medicaid provides health care coverage under federal law, and is intended only to be billed after all other forms of insurance coverage have been exhausted. Under the Third-Party Liability Contract, OMIG utilizes its contractor, Gainwell, to identify third-party insurers, verify insurance coverage and policy periods, and update the Medicaid claim processing system by either adding or end-dating insurance coverage information. These preventative actions cause claims submitted to Medicaid to be denied in instances when other payers are liable. As a result of these activities, the Medicaid program avoided more than \$2.5 billion in 2022 by accessing other forms of health care coverage.

Third-Party Liability Match and Recovery Services

As the payor of last resort, Medicaid will pay for covered services only after all other third-party sources of coverage have paid claims under their policies. However, not all liable third-party insurers are billed prior to claims being submitted to Medicaid. OMIG contracts with Gainwell to identify and confirm other payment sources. Whereby valid third-party coverage existed prior to being updated to the Medicaid system, Gainwell initiates reviews directing providers and Managed Care Plans to bill these payment sources for services inappropriately paid by Medicaid. These reviews generated more than \$209 million in recoveries in 2022.

Casualty & Estates

If a Medicaid recipient receives a settlement due to personal injury, amounts paid by Medicaid for the treatment of those injuries may be recovered from settlement funds. Upon a recipient's death, the estate and any assets owned by the recipient are subject to recovery for any Medicaid expenses associated with services provided prior to the recipient's death. Casualty and Estate (C&E) recoveries are pursued on behalf of OMIG in instances where Medicaid recipients are awarded a personal injury settlement and/or from estate assets. Recovery requests are considered, and determinations are based on case specific circumstances. OMIG manages these recoveries through a contract with Gainwell. Recoveries under the C&E program in 2022 remained relatively consistent with prior years at more than \$119 million.

OMIG effectuates the C&E program along with DOH and Local Department of Social Services (LDSS). Eligibility and/or litigation concerns are directed to DOH for recipients eligible under the NYS of Health Marketplace (NYSoH), or to the LDSS associated with the recipient's Medicaid eligibility. Court appearances in litigation proceedings for both casualty and estate cases are made by the relevant LDSS and county attorney. DOH oversees all LDSS and provides direction for appearances made by county attorneys on the State's behalf.

Medicaid Recovery Audit Contractor

Pursuant to a federal requirement under the Affordable Care Act, the Recovery Audit Contractor (RAC)'s mission is to coordinate efforts with the State to reduce improper payments through the efficient detection and collection of overpayments, to report suspected fraudulent and/or criminal activities, and implement actions that will prevent future improper payments. The OMIG RAC – Gainwell – utilizes data mining to identify improper payments and works with providers to recover identified overpayments. In 2023 there was an increase in recoveries resulting from a project where OMIG recovers Medicaid capitation payments for recipients determined by DOH to be simultaneously enrolled in comprehensive health care coverage through any government health insurance program. In addition, OMIG continues to facilitate the exchange of Medicare data with Centers for Medicare & Medicaid Services (CMS) Unified Program Integrity Contractor to enhance the RAC's ability to identify potential overpayments that would likely not be detected by reviewing Medicaid claims data alone. Projects performed under the RAC resulted in recoveries of more than \$171 million.

Home Health Care Medicare Maximization

OMIG, through its contractor, the University of Massachusetts Chan Medical School (UMass), works to maximize Medicare coverage for dual eligible recipients who receive home health care services paid by Medicaid. Through 2021, a settlement agreement with CMS allowed OMIG and UMass to recover an agreed-upon percentage of the value of Medicare's payment of appealed home health claims in lieu of the traditional process of appealing claims to the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council and if necessary, the Federal District Court. Upon expiration of the settlement agreement in December 2021, UMass resumed seeking Medicare coverage of Medicaid claims using the traditional appeal process. Recoveries of more than \$5.4 million throughout 2022 included claims paid from the settlement agreement as well as those paid from the traditional Medicare appeals process.

OMIG and UMass staff noted a considerable number of claims denied by Medicare for non-compliance with Medicare billing rules, such as failing to submit required documentation. Insufficient documentation hinders OMHA's ability to review the case, precluding a successful appeal for favorable Medicare coverage determinations. To address this concern, staff explored strategies aimed at educating providers and improving compliance with the Medicare demand billing and claim submission process. Staff performed analytics of claims denied for billing errors and issued a Medicaid Update reminding providers of their responsibility to comply with all Medicare billing and claim submission requirements.

The Home Health Care Medicare Maximization project continually adapts to ever-changing policy and payment environments within both the Medicaid and Medicare programs. As a result of significant Medicaid reform efforts in recent years, the enrollment of dual-eligible recipients into Managed Long-Term Care (MLTC) plans has steadily increased in NYS. This shift of recipients receiving home health services into MLTC plans and the Fully Integrated Duals Advantage Demonstration Program highlights the importance of enhancing and expanding Medicaid program integrity efforts into new areas.

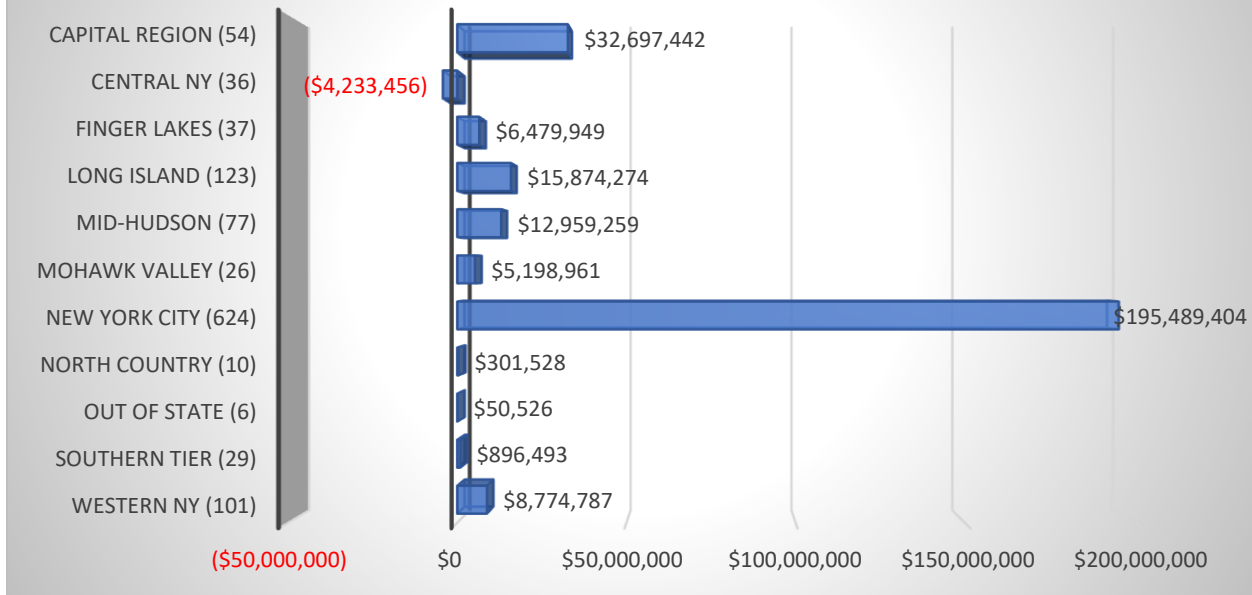
Additionally, most Medicaid home health claims have been reimbursed by the Episodic Payment System (EPS) since 2012. To inform future program integrity and implementation strategies, OMIG in collaboration with UMass, developed innovative data mining techniques to review claims data to identify billing patterns that may have emerged since implementation of changes in both the Medicare and Medicaid programs. OMIG staff considered the impact of changes to the Medicare home health billing model and the Medicare Appeals process, both of which have the potential to create vulnerabilities in the Medicaid program. Potential pilot projects under review include examining managed care and EPS claims to ensure that the Medicare home health benefit has been fully maximized prior to Medicaid paying.

Medicaid Audits



OMIG conducts audits of Medicaid expenditures across all provider and payer types, including MCOs, hospitals, clinics, nursing homes, home health, assisted living, and medical practitioners. The purpose of these audits is to assess provider compliance with Medicaid program integrity statutes, as well as regulations and guidance issued by DOH or other relevant State agencies, to identify and resolve deficiencies and to recover associated overpayments. Where appropriate, OMIG publishes protocols created in conjunction with the relevant State agencies and the provider community to ensure a common understanding and application of Medicaid requirements as part of the agency's audit procedures. Audits are performed to ensure that Medicaid recipients have appropriate access to quality medical services, that services are documented and billed appropriately, and that those receiving program funds adhere to the program requirements which ensures that Medicaid recipients receive services at least equal to those who have private health insurance. Audits are conducted in a manner which fosters communication with providers throughout the engagement to successfully resolve disputes over potential findings. Providers are encouraged to submit documentation to support the appropriateness of claim payment. OMIG reviews all submitted documentation and determines the appropriateness of the claim based on the information provided. Active provider participation and sharing of documentation, helps facilitate the audit process and may help to resolve audit findings and issues early in the process. OMIG's audit process is collaborative, and providers are encouraged to remain engaged throughout the process. Where documentation is found to be out of compliance with Medicaid requirements, OMIG identifies and recovers associated Medicaid overpayments. In 2022, OMIG finalized 1,123 audits identifying overpayments of over \$274 million. Audit recoveries accounted for roughly one-third of total OMIG recoveries.

2022 Finalized Audits (1,123 Total) and Overpayments Identified by Region (\$274,489,168 Total)



New Project – PARIS Match

The Public Assistance Reporting Information System (PARIS) Interstate Match audit identifies NYS Medicaid recipients who are actively receiving public assistance in another state, which makes them ineligible to qualify for duplicative NYS Medicaid benefits. In NYS, Medicaid recipients identified on the PARIS Match are reviewed by the entity responsible for managing the recipient’s Medicaid eligibility, either the LDSS or NYSoH. Upon completing its review and closing Medicaid cases where appropriate, the LDSS or NYSoH should submit a retroactive disenrollment notification to the appropriate Plan to recover capitation payments paid to the Plan for months the recipient was no longer eligible for NYS Medicaid benefits. OMIG makes recoveries based upon the disenrollments effectuated by LDSSs and NYSoH.

In 2022, OMIG commenced its first standalone, follow-up review to identify any inappropriately paid capitation payments that were not identified for retroactive disenrollment by the LDSS or NYSoH. In order to conduct this review, OMIG staff reviewed the PARIS file after LDSS and NYSoH staff completed their review, isolating individuals whose eligibility was closed by the district due to the match. OMIG partnered with CMS to use Transformed Medicaid Statistical Information System (TMSIS) beneficiary eligibility data from other states to confirm the information present on the PARIS Match file. In 2022, OMIG finalized six standalone audits identifying overpayments of more than \$67,000 and recovered more than \$31,000 by year end.

New Project – Enrollment Reconciliation – MC/Fee-For-Service

Medicaid eligibility was previously managed by two eligibility systems, the Welfare Management System (WMS) Upstate and WMS Downstate (NYC). The existence of two eligibility systems resulted in complications, and in 2014, a third eligibility system was introduced with the goal of combining all or most of the NYS Medicaid population into one eligibility system. Over the years, Medicaid recipients have had their eligibility transferred to this new system, NYSoH.

When NYSoH was first implemented, conflicts sometimes arose where the same recipient had enrollment on NYSoH and one of the WMS systems. Although MCO's were notified of their responsibility for Medicaid recipients, they did not receive a capitation payment, but did pay for services provided to the recipient. However, due to confusion resulting from the multiple eligibility systems, providers billed both the MCO and Medicaid Fee-For-Service (FFS) for the same service creating duplicate Medicaid payments. OMIG staff worked in collaboration with DOH staff to identify these potential duplicate payments. After the analysis was complete, DOH reimbursed the plans for services provided, and OMIG issued audits to recover the duplicate FFS payments. In 2022, OMIG finalized 29 audits identifying overpayments of more than \$403,000 and recovered more than \$251,000 by year end.

Managed Care Audits

Ongoing Project – Multiple CIN

OMIG audits capitation and enrollment issues in several managed care areas, including Medicaid recipients who have been enrolled in one or more managed care plan under multiple Client Identification Numbers (CINs). Each recipient is assigned a CIN upon enrollment in the Medicaid program. In some cases, an individual may be assigned more than one CIN, which presents a significant risk for overpayments. The LDSS, NYSoH, and the New York City Human Resources Administration (NYC HRA) work to identify currently active multiple CINs. OMIG follows up with a second-level review. Using a complex query to detect perfect and imperfect matches that may have been missed, OMIG identifies periods of overlapping Medicaid managed care enrollment. For the identified matches where both CINs remain open, OMIG works with the LDSS, NYSoH, and NYC-HRA to close one CIN. In 2022, OMIG finalized 25 audits identifying overpayments of more than \$24.2 million and recovered more than \$24.8 million over the course of the year.

Ongoing Project – Deceased Recipients

OMIG conducts reviews to identify instances where capitation payments have been made to MC Plans for recipients after their month of death. Staff identify capitated payments paid after the recipient's death and issue those findings to the Plans for payment. OMIG uses the following data to identify those after death payments:

- ❖ DOH's Bureau of Vital Statistics,
- ❖ NYC Vital records,
- ❖ eMedNY, and
- ❖ Inpatient claims in the MDW that indicates the patient's date of death.

In 2022, OMIG finalized 61 audits identifying overpayments of more than \$37 million and recovered of more than \$37.2 million over the course of the year.

New Project – Enhanced Nursing Home Rate Code

Historically, when a MC recipient was permanently placed in a nursing home, the recipient became ineligible for MC. These rules were updated so that MC recipients permanently placed in a nursing home could remain in MC. An enhanced capitated rate was developed for those recipients due to the additional costs associated with nursing home placement. The Managed Care/Family Health Plus/HIV Special Needs/Health and Recovery Plan Model Contract (Model Contract) outlines the procedures for a recipient's placement in a nursing home and the Plan's obligation to pay the nursing home. OMIG staff reviewed encounter data and recipient eligibility information to identify instances where the system did not show evidence of a recipient having been placed in a nursing home, the nursing home having been paid, or the recipient meeting the eligibility requirements for nursing home placement.

Since this is a relatively new audit area, some Plans had questions about the audit. OMIG staff conducted calls with several Plans providing them the opportunity to discuss the audit and the determinations made, providing the Plans with the opportunity to submit additional documentation if needed. In 2022, OMIG finalized 20 audits identifying overpayments of more than \$47.3 million and recovered of more than \$41.7 million over the course of the year.

Supplemental Maternity and Newborn Payment Reviews

Plans receive a supplemental maternity and newborn payment, or "kick" payments, to account for the additional costs associated with the birth of a newborn. OMIG conducts

reviews of these payments to identify instances where the Plan received a kick payment without meeting the conditions for the payment as outlined in the MC model contract. Specifically, in order to receive the maternity kick payment, the Plan must pay the hospital for the cost of the birth. OMIG staff review encounter data associated with members for whom the Plan received kick payments to identify instances where the data indicates there may not have been a full-term hospital birth. When audits identify these questionable payments, OMIG provides the Plans an opportunity to submit evidence of having met the terms outlined in the MC contract. OMIG reviews all documentation submitted, and when Plans demonstrate that they have met the requirements, the payment is deemed paid appropriate and removed from the audit findings. In 2022, OMIG finalized 30 audits identifying overpayments and recovered more than \$11.7 million.

Managed Long-Term Care

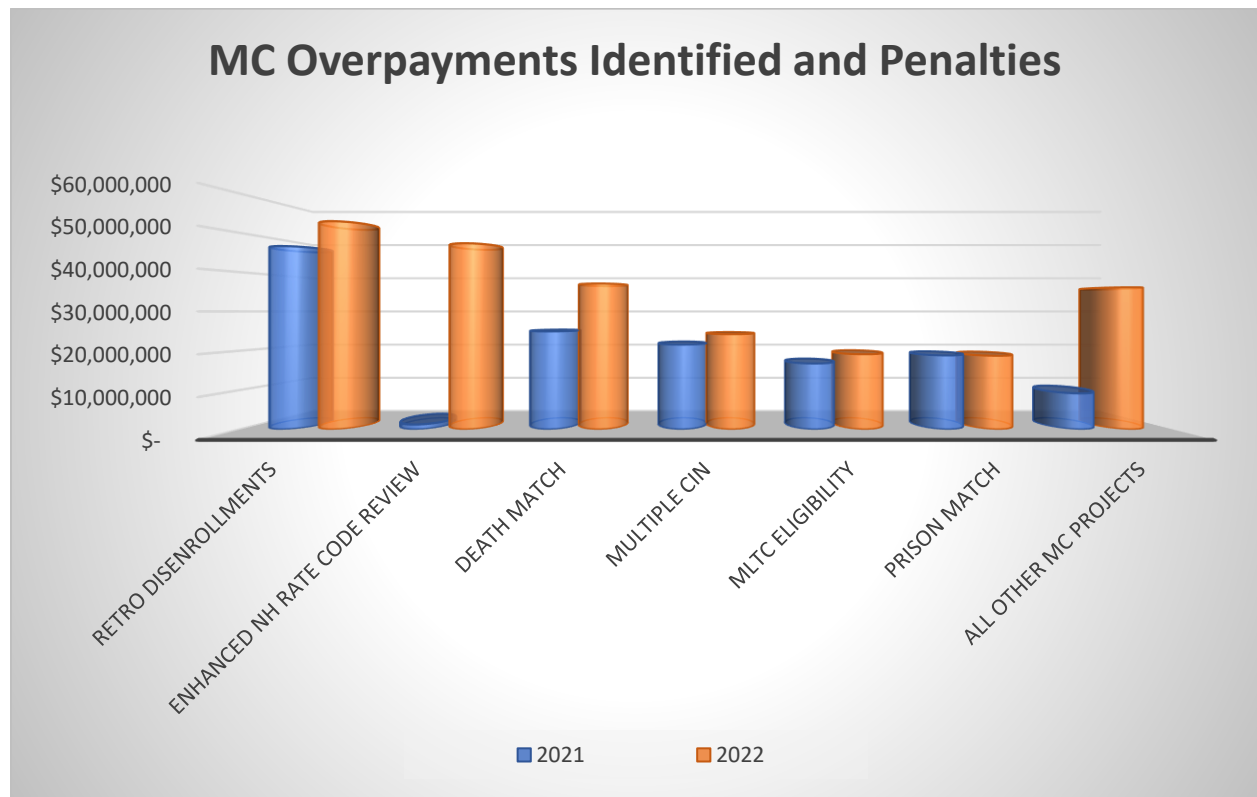
The MLTC Partial Capitation program allows for Medicaid recipients requiring a significant level of care to receive services in their home and community rather than in a nursing home setting. The MLTC Plan is responsible for the care management of their recipients, to ensure the care has been determined to be medically necessary and it has been received by recipients on their roster. OMIG performs audits to ensure recipients are eligible for the program, maintain their eligibility, received prescribed services, and care management is being provided by the MLTC plans in accordance with assessments and care plans specific to the recipients. In 2022, OMIG finalized 12 audits identifying overpayments of more than \$19.1 million and recovered more than \$18.7 million over the course of the year.

New Project – Pharmacy Services

Controlled substances are being abused and OMIG is identifying areas of concern. Medicaid regulations require pharmacy providers to fill prescription orders of controlled substances within 30 days of being initiated by the prescriber. OMIG performs audits of controlled substance claims to determine compliance with existing Medicaid regulations that require pharmacy providers to fill prescription orders of controlled substances within 30 days of being initiated by the prescriber. This audit program ensures programmatic payment will be made for controlled substances when appropriately authorized. OMIG conducted pharmacy claim validation audits of MCOs as well as FFS providers to verify providers have been adhering to this requirement. In 2022, OMIG finalized four audits of MCOs identifying overpayments of more than \$2.3 million.

New Project – Medicaid Managed Care Operating Report

Medicaid Managed Care Operating Report (MMCOR) reviews are conducted to validate the costs reported by the MCOs in their cost report submission. These reviews ensure that pertinent costs and data reported on MMCORs submitted to DOH is accurate, complete, and allowable. OMIG performs these reviews of both MC and MLTC plans' cost reports. SOS §364-j(38) was enacted in 2020 allowing OMIG to impose a penalty of twice the amount of any misstatement in the cost report. In 2022, OMIG finalized two reviews with penalties of more than \$5.95 million, which were recovered in full.



Provider Audits

Extrapolation

Extrapolation is a federally-conforming audit technique – used to minimize the administrative burden and disruption of operations associated with a claim-by-claim review -- which tests a sample of claims against audit criteria and statistically projects the results across a defined universe. The universe of claims is a set of claims or encounters for a specified period of time and a specific service claimed/reported. The sample is reflective of the universe and the error rate is statistically applied to the universe. Extrapolation is not used for all findings, for instance it is not used when the

sample size is small or where the finding is unique within the sample universe (i.e., employee training). OMIG's use of extrapolation and methods are overseen and certified by an independent statistical consultant and is subject to challenge and scrutiny as part of an administrative hearing and/or judicial review. When challenged, OMIG's use of extrapolation has been upheld.

As part of its mission to enhance the integrity of the Medicaid program, OMIG performed audit activities that examined over \$2.3 billion in Medicaid reimbursement for FFS claims. This included completing projects in program areas such as personal care, assisted living programs, consumer directed personal assistance programs and certified home health agencies, with a combined universe of Medicaid claims of more than \$713 million. Of this universe OMIG identified overpayments of \$28 million, an error rate of approximately four percent.

Office of Addiction Services and Supports Conflicting Services

OMIG continues its oversight of the Office of Addiction Services and Supports (OASAS) outpatient chemical dependence and OASAS Opioid Treatment Programs (OTP) to ensure billing accuracy. OASAS outpatient chemical dependence and OASAS OTP services must be performed in accordance with rules and regulations that set a daily standard for the procedures that can be provided to patients. OMIG conducted audits and identified portions of claims that exceeded the daily procedure limit which is contrary to program requirements. In 2022, OMIG finalized 36 audits of outpatient chemical dependence providers identifying overpayments of more than \$152,000, as well as finalizing four audits of OTP providers identifying overpayments of approximately \$12,000. Audits in these areas recovered more than \$175,000 combined over the course of the year.

Consumer Directed Personal Assistance Program

Consumer Directed Personal Assistance Program (CDPAP) is a Medicaid program that provides in-home services to recipients who have a medical need for assistance with daily activities or skilled nursing services. OMIG conducted audits of CDPAP providers and had audit findings for missing health assessments, Tuberculosis tests, and service documentation. These are directly related to patient safety as the providers could transmit a communicable disease to a recipient in their care if they are infected. In 2022, OMIG finalized two audits in this area, reviewing a claims universe of over \$37 million, identifying overpayments of more than \$46,000 representing a 99 percent claiming accuracy. Audits in this area recovered more than \$41,000 by year end.

Personal Care Services

Personal care services (PCS) provide individuals with partial or total assistance with personal hygiene, dressing and feeding, nutritional and environmental support functions, and health-related tasks. Such services must be essential to the maintenance of the recipient's health and safety within their own home, as determined by the LDSS in accordance with the regulations of DOH; ordered by the attending physician; based on an assessment of the recipient's needs; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse. Personal care services must be provided by an agency that is licensed or certified by the DOH to operate as a home care agency; and that has a contract with the LDSS in the county where the agency is licensed or certified to provide services. OMIG conducted audits of PCS providers identifying several findings, the three most frequently found extrapolated and not-extrapolated findings are listed below:

Extrapolated:

- ❖ PCA worker was not present at nursing supervision visit. This finding ensures the care is supervised by a nurse.
- ❖ Billed for more units than authorized. This finding illustrates that unit volume is monitored.
- ❖ Failure to complete the required orientation visit.

Not Extrapolated:

- ❖ Failure to complete the Annual in-home visit.
- ❖ Missing certificate of immunization.
- ❖ Missing documentation of a tuberculosis test or follow up.

In 2022, OMIG finalized nine audits and issued six audit summations of PCS providers reviewing a total claims universe of more than \$259 million. Nine audits were finalized identifying findings of more than \$1 million and recoveries of more than \$1.3 million. For the six audit summations, it was determined that for the audit period and objectives reviewed, the provider generally adhered to the Medicaid billing rules and regulations.

Transportation

In 2022 OMIG performed audits of transportation providers to address deficiencies identified as part of an audit conducted by the U.S. Department of Health and Human Services, Office of the Inspector General (HHS-OIG). HHS-OIG audit findings included, but were not limited to, inadequate service documentation, non-compliance with driver

qualification requirements, and services not provided. Throughout 2022, OMIG has continued its audits of transportation providers and has initiated eight transportation audits with a universe of claims totaling \$34 million. In 2022, OMIG finalized one audit identifying overpayments of more than \$1.1 million and recovered more than \$63,000 over the course of the year.

Federally Qualified Healthcare Centers FFS/MC Crossover

Federally Qualified Healthcare Centers are eligible for Medicaid payments to cover their costs of providing a comprehensive package of health care services consistent with federal requirements. OMIG identified instances where providers received both a Medicaid FFS shortfall payment indicating payment for the threshold visit that was paid by an MCO, as well as a FFS all-inclusive payment for the same individual recipient on the same date of service. In 2022, OMIG finalized six audits identifying overpayments of more than \$730,000 and recovered more than \$700,000 by year end.

Rate-Based Providers

Audits of rate-based providers, such as nursing homes, are conducted to enhance program integrity by ensuring only accurate and allowable costs are reported and reimbursed. Costs that are misstated by a provider may artificially inflate the rate paid to that provider. Most Residential Health Care Facilities' costs are fixed, OMIG conducts property component audits of individual providers to verify reported capital costs are accurate, allowable, and substantiated. Property audits analyze and confirm or adjust the capital costs reimbursed in the property component of the rate.

Disallowances can be determined for various reasons, even for a single type of cost being reimbursed. For example, OMIG assessed moveable equipment depreciation expenses on audit and found that a provider was over-reimbursed because the percentage used to allocate costs within the organization was incorrect. Another example is when project costs exceed the DOH approved cost threshold, these costs are not reimbursable and subject to recovery. This includes moveable equipment depreciation expenses resulting from purchasing assets whose costs are above the DOH approved amounts. In 2022, OMIG issued 37 final audit reports and notice of rate changes identifying overpayments of more than \$17.4 million and recovered more than \$20 million over the course of the year.

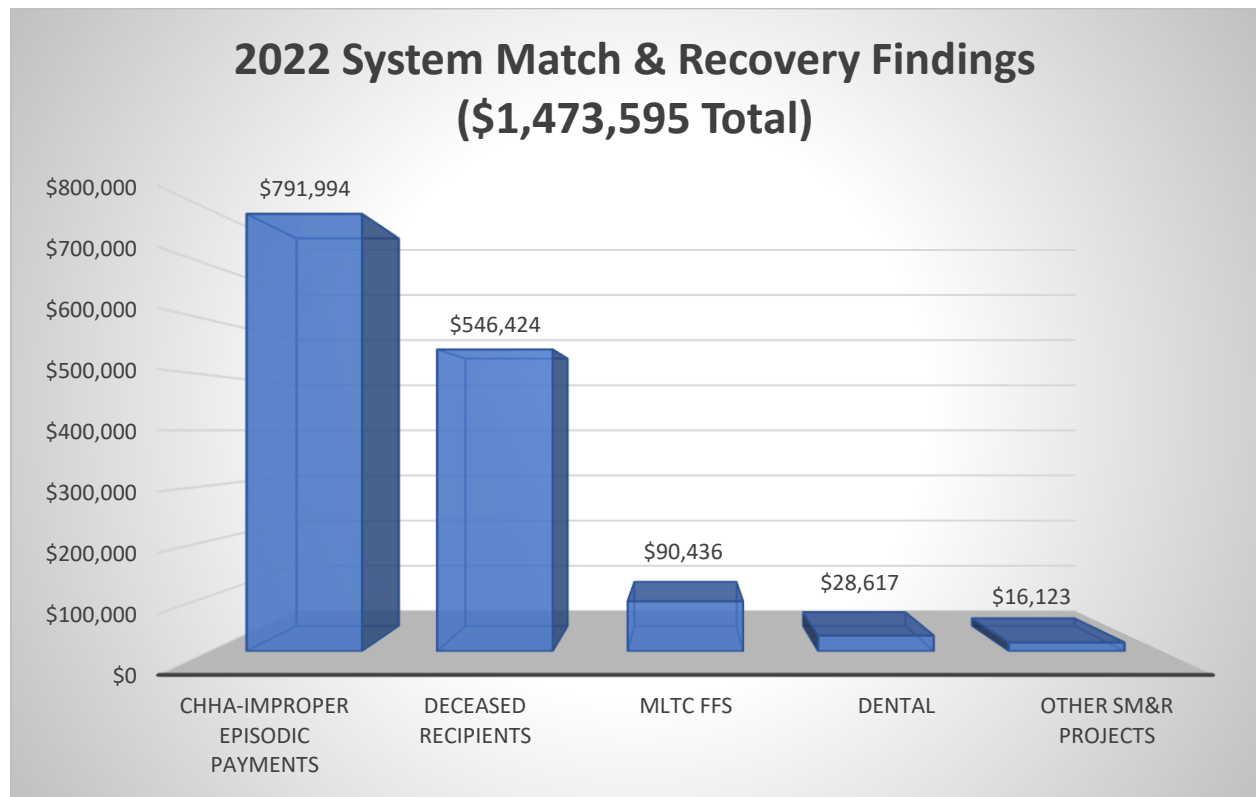
County Demonstration

The Medicaid County Demonstration Program was implemented in 2006 and is a partnership between OMIG, NYS counties, and NYC to identify provider overpayments. Participating counties can recoup 40 percent of the non-federal share of

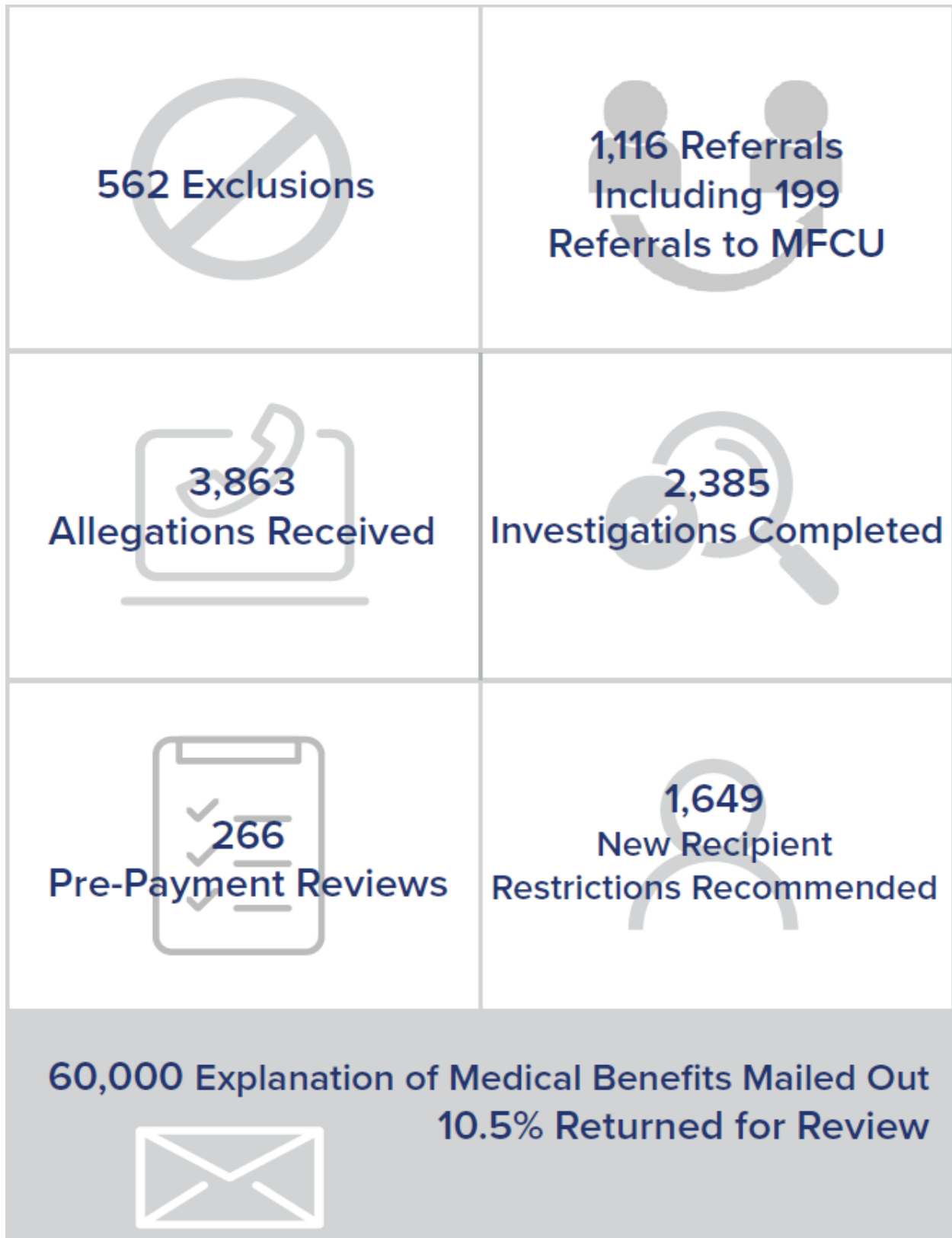
the recovery amount, net the state-funded share of their administrative audit costs. Under the County Demonstration Program, the counties, with OMIG oversight and training, perform audits of pharmacy, transportation, durable medical equipment, and assisted living program providers. In 2022, 14 audits were finalized, identifying overpayments of more than \$8.2 million and recovered more than \$8.5 million over the course of the year.

System Match and Recovery Projects

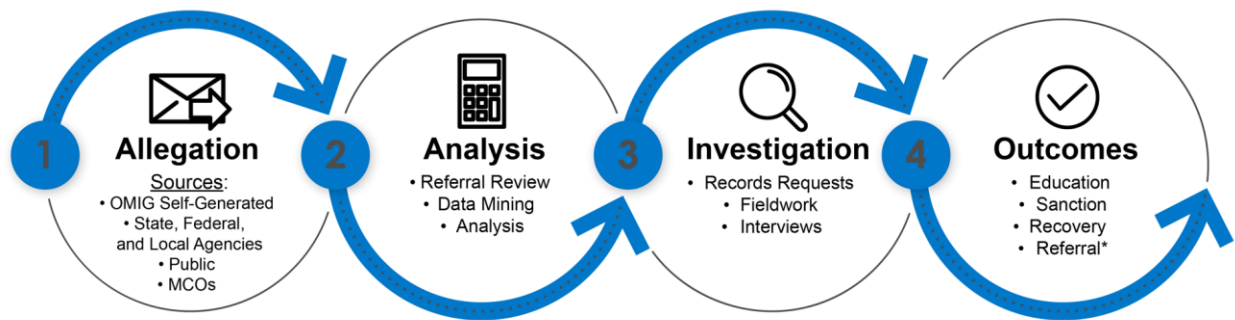
OMIG performs analysis on paid claim data sets to identify non-compliance with Medicaid claiming rules, uncommon or potentially inappropriate provider claiming, or aberrant billing patterns which warrant further review. This analytical approach allows OMIG to conduct comprehensive System Match and Recovery Audits (SM&R) of many providers in a particular program area as part of one review. During the audit process, OMIG educates providers to improve their compliance with Medicaid billing rules to reduce future claim errors. In 2022, OMIG finalized 206 audits identifying overpayments of more than \$1.4 million. These audits were performed in multiple project areas including, but not limited to, duplicate durable medical equipment (DME)/pharmacy claims, deceased FFS recipients, duplicate FFS claims for services covered by MLTC, CHHA – improper episodic payments, and transportation. SM&R also recovered more than \$1.6 million over the course of the year.



Division of Medicaid Investigations



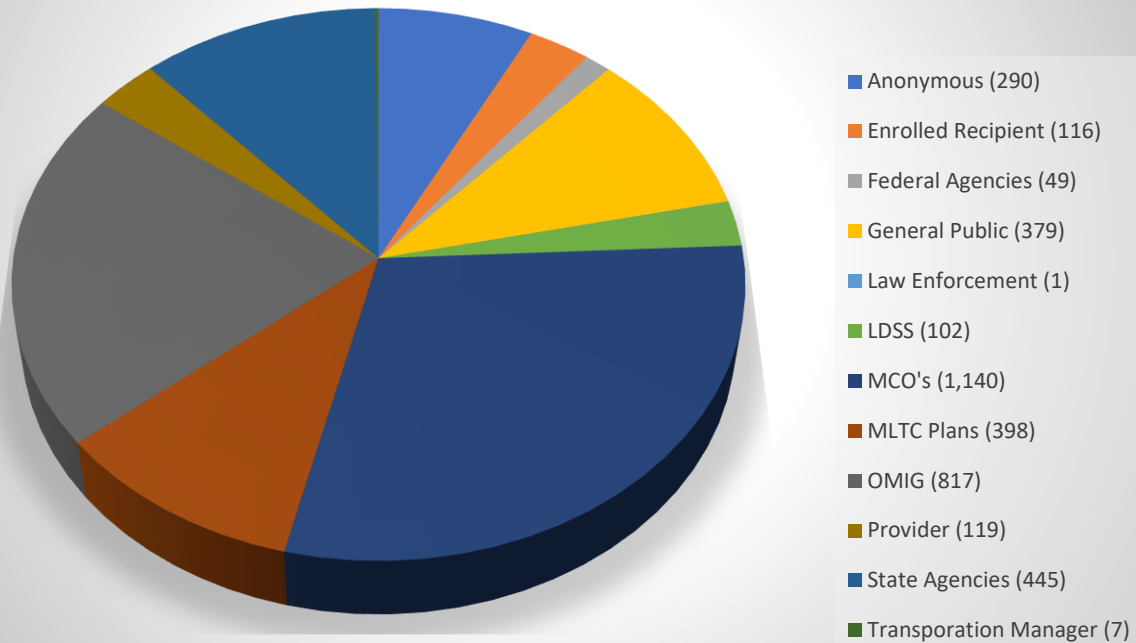
OMIG reviews all allegations of potential fraud, waste, and abuse within the Medicaid program. These allegations can be self-generated through data analysis performed by OMIG, or received from a variety of sources including federal, state, and local law enforcement or governmental agencies, health care plans and providers, Medicaid recipients, and the general public. In 2022, OMIG received 3,863 allegations of fraud, waste or abuse. Over 20 percent of these allegations were identified by subject matter experts within OMIG.



* Including to MFCU (for criminal or civil recoveries) or other courts of appropriate jurisdiction for criminal and civil actions

Allegations can involve enrolled and non-enrolled providers (e.g., home health aides, consumer directed personal assistants), health care related organizations, and recipients that are interacting with the Medicaid program. Allegations are fully analyzed by OMIG staff to identify if there is sufficient evidence requiring a more thorough investigation, which may warrant OMIG action or referral to another enforcement entity, as necessary. Analysis is done by utilizing a variety of methods, including but not limited to data mining, undercover operations, analysis of returned Explanation of Medical Benefits (EOMB) letters, and interviews of complainants and subjects. Investigations can lead to referrals, recoveries, administrative actions, and/or sanctions. OMIG is required to refer all credible allegations of fraud to the MFCU.

2022 Allegations Received by Source (3,863 Total)



OMIG thoroughly evaluates each allegation to determine if there is sufficient evidence to support an investigation. OMIG utilizes data analytics as well as comprehensive peer reviews conducted by dentists, medical doctors, hygienists, registered nurses, and pharmacists as part of this evaluation. The peer reviewers work collaboratively with investigative staff by conducting professional reviews of medical records, clinical analysis of Medicaid claims data, and applying clinical knowledge. These specialized investigative techniques are used by investigators to evaluate services provided to Medicaid recipients, to identify patterns of fraud or abuse, correct behavior, prevent inappropriate payments, and recover improperly expended Medicaid funds through administrative action or referral.

Managed Care Referrals

With the expansion of service delivery through managed care, OMIG closely collaborates with MCOs and their Special Investigation Units (SIU) in its oversight of the Medicaid program. MCOs are contractually required to conduct oversight of their provider networks to ensure compliance with Medicaid program and reimbursement requirements. MCOs conduct this oversight using their SIU or compliance officers that are tasked with identifying, evaluating, and referring instances of fraud, waste, and abuse to OMIG. These referrals are reviewed for accuracy and completeness, and the

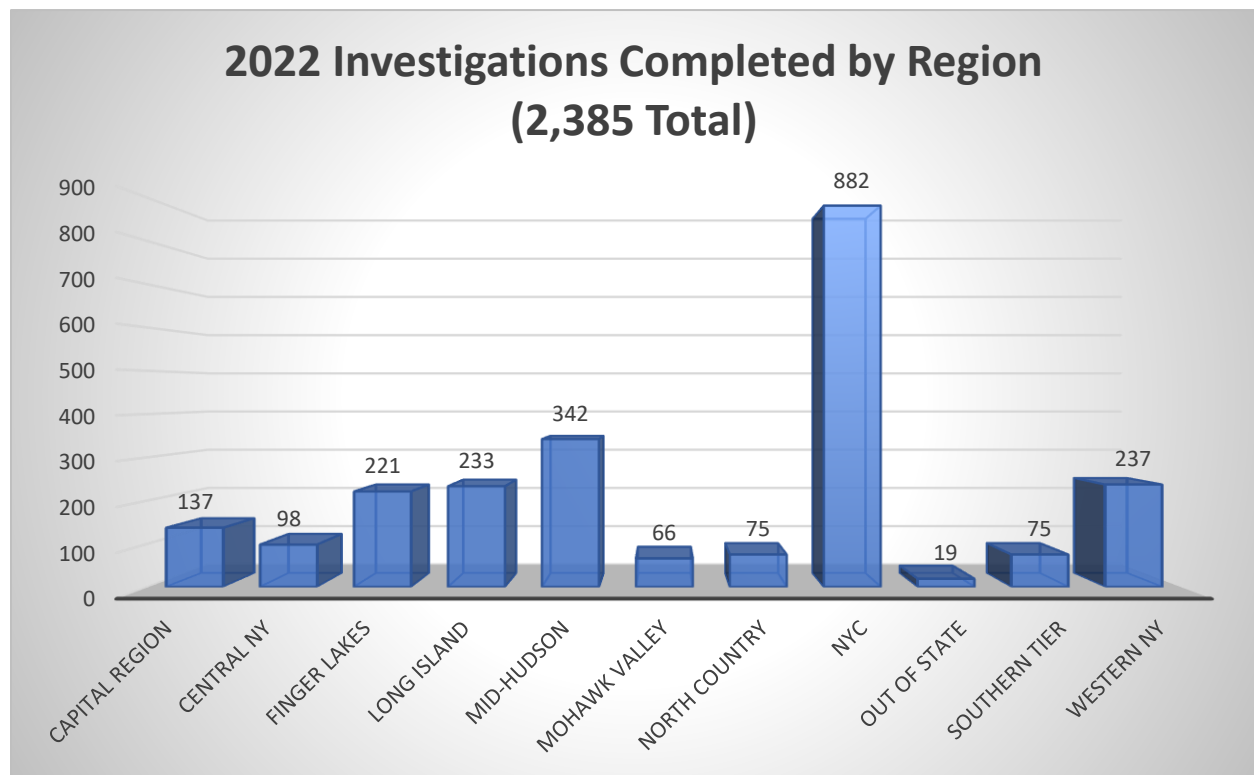
assessment results are evaluated as part of the Managed Care Program Integrity Reviews (MCPIR) of the MCOs. In addition, OMIG facilitates monthly meetings between MCO SIUs and their designated OMIG liaisons to discuss investigations in process and identified areas for review.

In reviewing MCO referrals, OMIG identifies those necessitating further investigation, cases that have statewide relevance, or overlap existing activities and merit review, as well as cases that are best addressed at the MCO level. At the conclusion of these reviews, OMIG notifies the MCO of its determination in connection with the referral and provides clearance for the MCO to recover identified overpayments where appropriate.

In 2022, OMIG processed 1,003 referrals involving 1,537 unique subjects (individuals, providers, etc.), supporting OMIG’s ability to pursue fraud, waste, and abuse based upon these referrals.

Investigations

In 2022, OMIG finalized 2,385 investigations statewide. As detailed in the chart below, these cases were regionally disbursed with the majority of the cases involving subjects in the New York City Region.



Depending upon the subject or facts of the case, these cases involved a variety of investigative approaches to bring the case to a conclusion. These included:

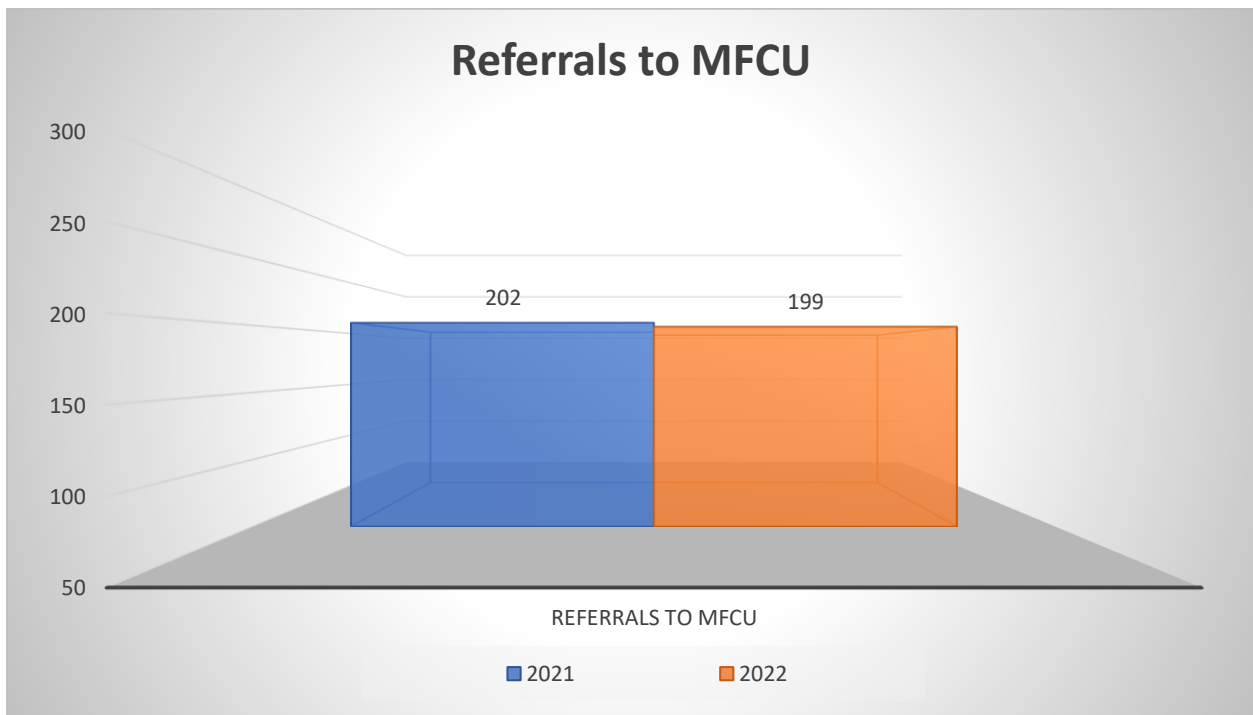
- ❖ **Closed Medicaid Benefit:** OMIG uses multiple data systems and investigative tools to identify if a recipient is qualified to receive Medicaid benefits in New York State. When the investigation identifies an individual that is not qualified to receive Medicaid benefits this information is referred to the DOH with a recommendation to close the recipient's benefit.
- ❖ **Pre-Payment Review:** Where OMIG identifies an aberrant claiming pattern, OMIG may initiate a pre-payment review process to educate the provider to the error and correct claiming on a prospective basis. The pre-payment review process pends claims for a review to identify their compliance with Medicaid guidelines prior to payment. This is a particularly effective process for smaller providers or new entrants to the Medicaid program (e.g., transportation).
- ❖ **Credential Verification Review (CVR):** OMIG investigation staff routinely conduct on-site reviews to gather and verify information needed to determine compliance with Medicaid requirements. This process allows staff to educate providers as to Medicaid guidelines and gather information on staff credentials and training, service delivery, the storage of pharmaceuticals and medical supplies, the physical layout of the business, record keeping protocols and Medicaid claiming practices. Since 2020, a portion of these reviews have been conducted remotely through telephone, video or using photographs. In 2022, The majority of CVR reviews conducted were of transportation and pharmacy providers.
- ❖ **Explanation of Medical Benefits (EOMB) Review:** EOMBs are required by federal law. EOMBs are used to communicate with Medicaid recipients regarding the care that they are receiving and have become a useful investigative tool to both educate recipients and to verify if those services were actually delivered appropriately. OMIG uses internal data analytics to determine where EOMBs may have the greatest benefit.

In 2022, OMIG generated 60,000 EOMBs across multiple provider categories, including transportation, telehealth, pharmacies, home health care, and dental. Of the 6,331 EOMBs returned by recipients to OMIG, 1,157 recipients reported not receiving services, or had concerns with the services billed. These allegations led to OMIG initiating or supporting 271 investigations.

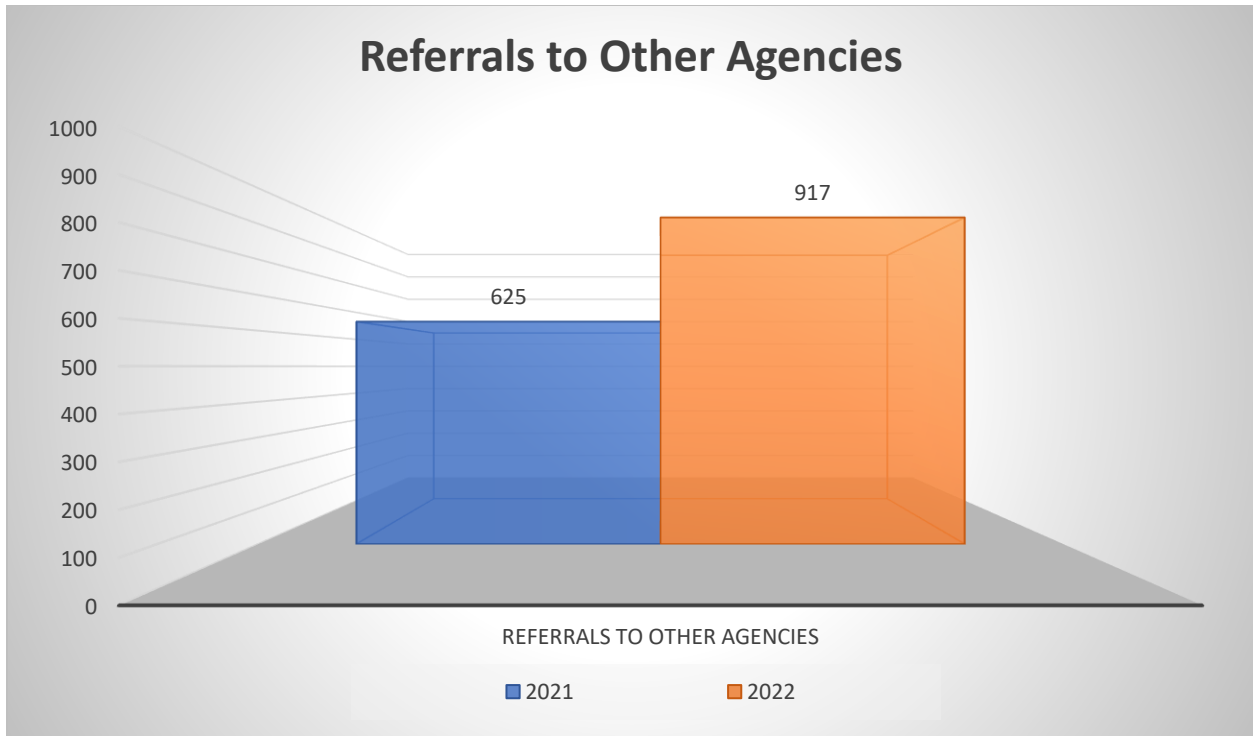
- ❖ Education Letters: OMIG issues education letter to providers when supported by investigative findings. This outreach provides the details on Medicaid program requirements, emphasizes their obligations as a Medicaid provider and offers an appropriate contact for them to call to request assistance or answer any questions.

Referrals

OMIG is required to refer credible allegations or identified instances of fraud to MFCU. Therefore, OMIG works closely with MFCU during its investigations to provide information on possible referrals, a comprehensive referral and support to pursue and prosecute the alleged fraud. In 2022, OMIG referred 199 cases of suspected fraud to MFCU for further investigation or prosecution. The level of referrals was in line with the prior year.



In addition, OMIG maintains close connections to other federal and state agencies and law enforcement organization with a role in Medicaid program integrity or other regulatory responsibilities. This allows OMIG to participate in joint investigations and pool resources to maximize enforcement capabilities. In addition, it allows OMIG to refer observations made during its investigation to the most appropriate agency to correct the problem. In 2022, OMIG made 917 referrals to other federal or state agencies or law enforcement organizations (other than MFCU). Most of these referrals were to DOH.



Transportation

Transportation remains an area of focus – from both a State and national perspective -- as it has been one of the fastest growing Medicaid service categories, both from a provider enrollment and cost perspective. In NYS, most new providers are small, regionally specific operations with limited knowledge or connection to the Medicaid program, its providers or the needs of its recipients.

OMIG continues to be successful in improving provider awareness and compliance with Medicaid requirements and preventing inappropriate Medicaid payments. In this service area, the OMIG strategy primarily relies upon:

- ❖ CVRs to educate providers on Medicaid guidelines and to review the provider’s credentials and qualifications to deliver the services. In 2022, 92 CVRs were conducted with identified transportation providers.
- ❖ Enhanced data analytics to identify trends and inform targeted investigations and provider outreach. In 2022, the use of enhanced data analytics resulted in a significant savings to the Medicaid program related to the reimbursement of tolls. NYS Medicaid guidelines reimburse transportation providers for the actual costs of tolls and parking occurred per vehicle (not for each recipient in the vehicle). Over time, OMIG data analysis identified a surge of transportation providers

billing the maximum allowable amount for tolls or \$50. OMIG staff can now run regular queries to identify inappropriate payments for investigative staff to determine if the payments were appropriate. When inappropriate payments are identified, the provider is placed on PPR to allow future claims to be reviewed prior to payment. In 2022, these reviews contributed to an average monthly reduction of \$15,000 in inappropriate toll claims to Medicaid.

OMIG has also implemented a Disproportionate License Plate/Driver's License Billing activity report, which identifies transportation providers who have billed claims for an impossible number of miles. This report identified an egregious example of one driver claiming to have driven more than 277,000 miles in one month, or 412.4 miles per hour if they drove 24 hours per day. This newly developed report is now an important analytic tool for identifying outliers for further investigations.

- ❖ The EOMB process is used to identify transportation claims where either no or inappropriate service delivery was rendered or claims without a corresponding medical visit.
- ❖ As noted above, PPR is a valuable tool to both educate providers on Medicaid billing requirements while pending inappropriate claims for further review. In 2022, OMIG initiated 266 PPRs of unique transportation providers' claims, leading to Medicaid costs savings of over \$4 million.

OMIG also uses the information identified through its investigations to inform DOH and influence policy and provider outreach. As a result of these collaborative discussions, DOH published a Medicaid Update in February 2022 to remind providers of the Medicaid Transportation Policy Guidelines related to driver license number and toll entries on claims.

Physician Investigations

OMIG investigates physicians identified as having aberrant billing patterns, as well as patterns of ordering services and pharmaceuticals that aren't medically supported. OMIG utilizes data analytics, peer review, investigative field work, and clinical reviews in these investigations.

❖ *Case Files: Dermatologist*

OMIG assisted the HHS-OIG in its Health Care Fraud Strike Force investigation of Yekaterina Kleydman, a dermatologist in Forest Hills. Between January 2015 and March 2018, Kleydman fraudulently submitted \$1.8 million in claims to Medicare, NYS Medicaid, and other health care benefit programs for a procedure considered cosmetic and not covered by NYS Medicaid. An OMIG investigator interviewed Russian-speaking recipients, and an OMIG nurse provided a clinical data analysis and clinical information related to billing and certain procedures. On March 11, 2022, Kleydman pled guilty in federal court to one count of Healthcare Fraud, and on July 5, 2022, was sentenced to five years of probation and \$239,771 restitution, with \$2,563 to be directed to NYSDOH. Kleydman has been excluded from participating in the NYS Medicaid program since 2018.

❖ *Case Files: Ear, Nose, and Throat Physician*

On July 8, 2022, Harold Bendelstein, an ear, nose, and throat physician in Queens, was convicted in federal court of Healthcare Fraud in the first degree for defrauding Medicare and NYS Medicaid between January 2014 and February 2018. OMIG assisted with interviewing Russian speaking recipients, ultimately leading to Bendelstein being convicted of billing Medicare and Medicaid for hundreds of incision procedures of the external ear, while only performing ear exams or ear wax removals, costing the programs approximately \$585,000 for procedures that were never performed. Mr. Bendelstein has been excluded from participating in the NYS Medicaid program since 2018.

Non-enrolled Providers

OMIG investigates individuals and entities who are not enrolled in the Medicaid program by contract with the Department of Health but who may be directly or indirectly providing care, services, or supplies to Medicaid recipients. Although not enrolled in Medicaid, if an investigation determines an unacceptable practice has been committed, OMIG may still sanction and recover overpayments from non-enrolled individuals.

❖ *Case Files: Housing Scheme*

On March 24, 2022, Leslie Montgomery was sentenced to 3-9 years in prison and ordered to pay back more than \$4 million dollars in restitution to NYS. On February 25, 2022, Montgomery pleaded guilty to Grand Larceny and Money Laundering for defrauding NYS Medicaid of millions of dollars using social media

to advertise a fake housing scheme in order to lure low-income New Yorkers into providing personal information, including their NYS Medicaid ID numbers. The information was then used to submit false claims for back braces that were neither needed nor ordered by the recipients. Montgomery did business as Healthy Living Center and owned LCM Livery P/U, Inc., who have been excluded from NYS Medicaid.

Pharmacy Program Integrity Unit

The Pharmacy Program Integrity Unit was established within OMIG's Division of Investigations in February 2022 with the goal to inform, support, and guide agency-wide pharmacy program integrity activities through regular collaboration and engagement with OMIG division partners and outside agency stakeholders.

OMIG collaborated with DOH to finalize a system change to improve prescription compound payment logic. OMIG staff identified that current logic was not taking the ingredient submitted cost into account and that brand-generic pricing was not working as expected, resulting in overpayments. This project introduces a new payment logic that considers the brand-generic status and pharmacy submitted cost at the ingredient level when determining the payment. The system change was implemented in March 2023.

OMIG coordinated with DOH in preparation for the pharmacy benefit transition back to FFS through regular participation in bi-weekly NYRx transition workstream meetings and bi-weekly NYRx transition technical workgroup calls with managed care plans. Pharmacy program activities and processes were assessed internally for issues or risks and revised to accommodate the transition through bi-weekly internal task owner meetings with representation from units from all OMIG divisions.

EOMBs – Improved Accessibility

EOMBs (commonly known as Explanation of Benefits or EOBs) are used to communicate with recipients about the care they are receiving from New York State Medicaid providers, and to ensure that they are receiving the services Medicaid is paying for based on claims submitted by their providers. OMIG has worked with its partner agencies to ensure that EOMBs sent to NYS recipients are accessible to those who speak languages other than English, or who need to receive it in an accessible format. NYS Law requires all NYS vital documents to be translated into to the top 12 non-English languages spoken in the state. OMIG EOMBs are now accessible in the top 26 languages spoken in NYS, as determined by the most recent census data. As the most common limited English proficient populations throughout the state change, OMIG worked to expand the languages available, increasing language access to more recipients of EOMBs. These languages include:

- ❖ Spanish
- ❖ Simplified Chinese
- ❖ Traditional Chinese
- ❖ Russian
- ❖ Bengali
- ❖ Haitian Creole
- ❖ Korean
- ❖ Italian
- ❖ Yiddish
- ❖ Italian
- ❖ Arabic
- ❖ Polish
- ❖ French
- ❖ Urdu
- ❖ Yoruba
- ❖ Tagalog
- ❖ Greek
- ❖ Hindi
- ❖ Japanese
- ❖ Nepali
- ❖ Ukrainian
- ❖ Vietnamese
- ❖ Albanian
- ❖ Somali
- ❖ Swahili
- ❖ Twi

All of the languages are also available in additional accessible formats including large print, as a data CD, an audio file, and in Braille.

OMIG continues to improve the EOMB template by containing a space for OMIG to communicate to a recipient regarding what is included in the EOMBs in plain language. For example, some procedures such as a “prophylaxis” and “periapicals” can be explained as meaning a “dental cleaning” and “x-rays”. The box has provided clarity to the recipients on the EOMB forms and has resulted in more accurate information being returned.

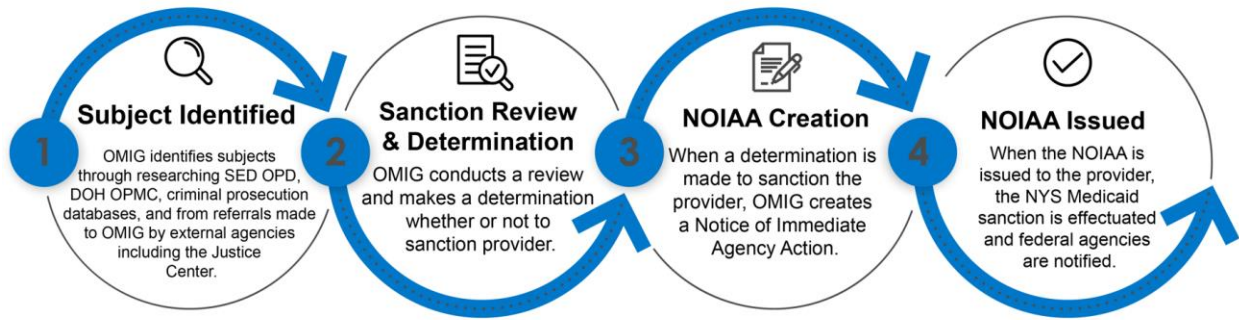
Provider Enrollment and Reinstatement

OMIG assists DOH by reviewing Medicaid enrollment applications for certain high-risk providers such as transportation providers (excluding ambulance), independent pharmacies, DME suppliers, dental groups, laboratories, physical therapists, and physical therapy groups. Additionally, all provider types applying to be reinstated into the Medicaid program, removed from the Excluded Provider List, or to change ownership are also reviewed by OMIG. Determinations on all applications are made in accordance with state and federal regulations.

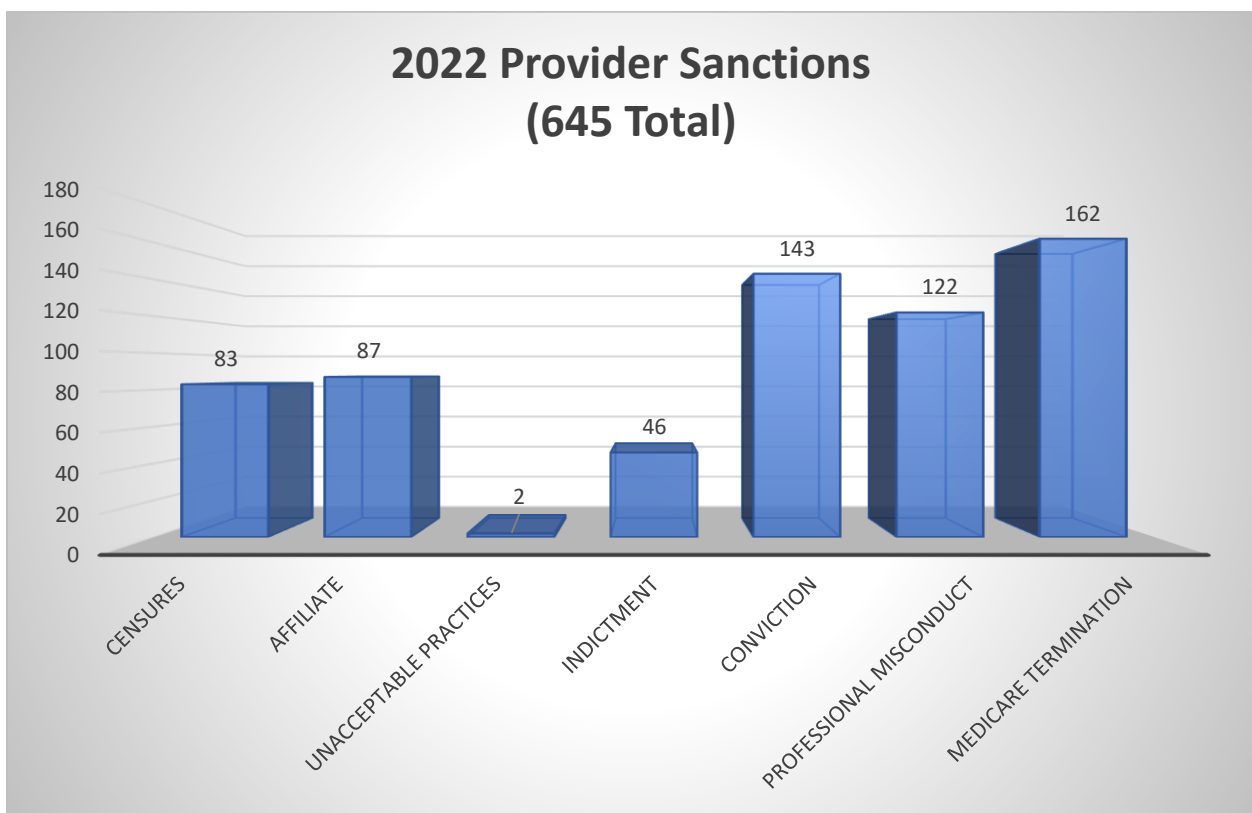
- ❖ In 2022, OMIG and DOH enhanced collaboration on the review of new enrollment applications for enrollment in NYS Medicaid. As a result, OMIG issued 23 application denials in 2022. These denials were a result of a fraud, waste, and abuse review by OMIG and a review by the respective policy unit within DOH.
- ❖ After successfully reviewing applications remotely in 2020 and 2021, OMIG determined it was more efficient to conduct the majority of all on-site inspections virtually, which has shortened the timeline for reviewing applications. In person inspections are conducted on an as needed basis.
- ❖ In 2022, OMIG processed 77 requests for removal from the NYS Medicaid Exclusion List. Of those, 19 were denied and 58 were approved. This process allows rehabilitated providers to help serve the Medicaid population by increasing the number of available providers and allowing those previously excluded to return to work.

Provider Sanctions

OMIG is responsible for investigating providers to determine if identified actions or behaviors on the part of the provider warrant a sanction by the NYS Medicaid program and then effectuating those sanctions. These actions protect NYS Medicaid recipients, ensuring recipients receive quality care from providers, and protects the integrity of the NYS Medicaid program.



In 2022, OMIG issued 645 sanctions, an increase of nearly 20 percent compared to 2021.



New Project – Justice Center Referrals

The Justice Center for the Protection of People with Special Needs (Justice Center) investigates allegations of abuse or neglect of individuals with intellectual and developmental disabilities. In 2022, an OMIG and Justice Center workgroup was assembled to improve the process by which the Justice Center reports abuse and neglect to OMIG in connection with requirements under SOS §493.2. These referrals are required when allegations for abuse and neglect are substantiated by the Justice

Center, and the conduct qualifies as an unacceptable practice under 18 NYCRR §515.2. The workgroup developed and implemented an improved way of submitting referrals and enhancing access to data for use by both agencies. The first referrals using this new process were received by OMIG in November 2022. The Justice Center sent OMIG the names of 153 individuals with substantiated allegations of abuse or neglect for OMIG to review for possible exclusion from the NYS Medicaid program, protecting the vulnerable patient population, and ensuring that those with special needs are receiving high quality health care services.

Recipient

The Recipient Investigations Unit (RIU) is the single contact point for all statewide Medicaid eligibility and prescription drug diversion investigations. The RIU conducts investigations generated from complaints and referrals received from the general public, other state, federal and local governmental and law enforcement agencies. The RIU also conducts investigations generated through internal data mining and data analysis. Additionally, the RIU coordinates with LDSS, NYSoH, as well as local, county, state, and federal law enforcement and regulatory agencies to advance the integrity of the Medicaid program.

Since the creation of NYSoH, OMIG became the primary unit to investigate recipient fraud allegations throughout the State. The RIU developed processes to triage complaints and investigate recipient eligibility fraud to protect the NYS Medicaid program and ensure that only those who qualify for Medicaid are receiving those benefits.

In 2022, the RIU exceeded program goals for its recipient cost avoidance project by internally identifying, investigating, and finalizing investigations of recipients who were residing out-of-state and fraudulently receiving NYS Medicaid benefits. The RIU finalized 318 investigations as part of this initiative, resulting in a total cost avoidance to the program of \$2,625,101. RIU Investigators performed data analysis using internal and external data systems and internet tools to identify NYS Medicaid recipients suspected of residing out of state. Investigators compiled evidence, completed necessary field investigations, and made fraud referrals to NYSoH personnel, LDSS, SIU, and Social Security Administration Office of the Inspector General, generating the appropriate Medicaid eligibility closure for these substantiated cases.

Recipient Investigation Collaboration

- ❖ OMIG collaborations with local districts have yielded positive results for the State and respective county. For example, OMIG, Nassau County District Attorney's (DA) Office, and Nassau County LDSS worked together in developing an effective process to investigate and prosecute Medicaid fraud. On March 7, 2022, OMIG's RIU led discussions with Nassau County DA's Office and Nassau County LDSS/SIU personnel regarding two active cases referred by OMIG and agreed on an action plan with assigned agency tasks in support of anticipated prosecution. OMIG staff provided a detailed overview and interpretation of the recipient's State Medicaid eligibility application documents and provided updated guidance for the current Medicaid eligibility emergency period. OMIG has an additional thirteen referred cases pending action with the Nassau County DA's Office.
- ❖ On April 7, 2022, OMIG investigative staff held a meeting with the Schoharie LDSS/SIU Fraud Supervisor at the LDSS office. OMIG provided guidance and clarification for the district to notify the Social Security Administration Field Office to correct cases when NYS MA-SSI recipients are found to be residing in another state.
- ❖ OMIG staff gave two presentations, at the 37th New York Welfare Fraud Investigators Association Annual Training Conference in Oswego attended by LDSS staff and investigators, multiple law enforcement officers, assistant DA, and other state agency staff from the Office of Temporary and Disability Assistance, and the Office of Children and Family Services. The presentations covered OMIG RIU's processes and successes and shared how OMIG assisted local district investigators, law enforcement, and DAs in their investigations related to Medicaid recipient fraud. The presentations were well received and opened future communications and collaborations with attendees.
- ❖ *Case File: Recipient*

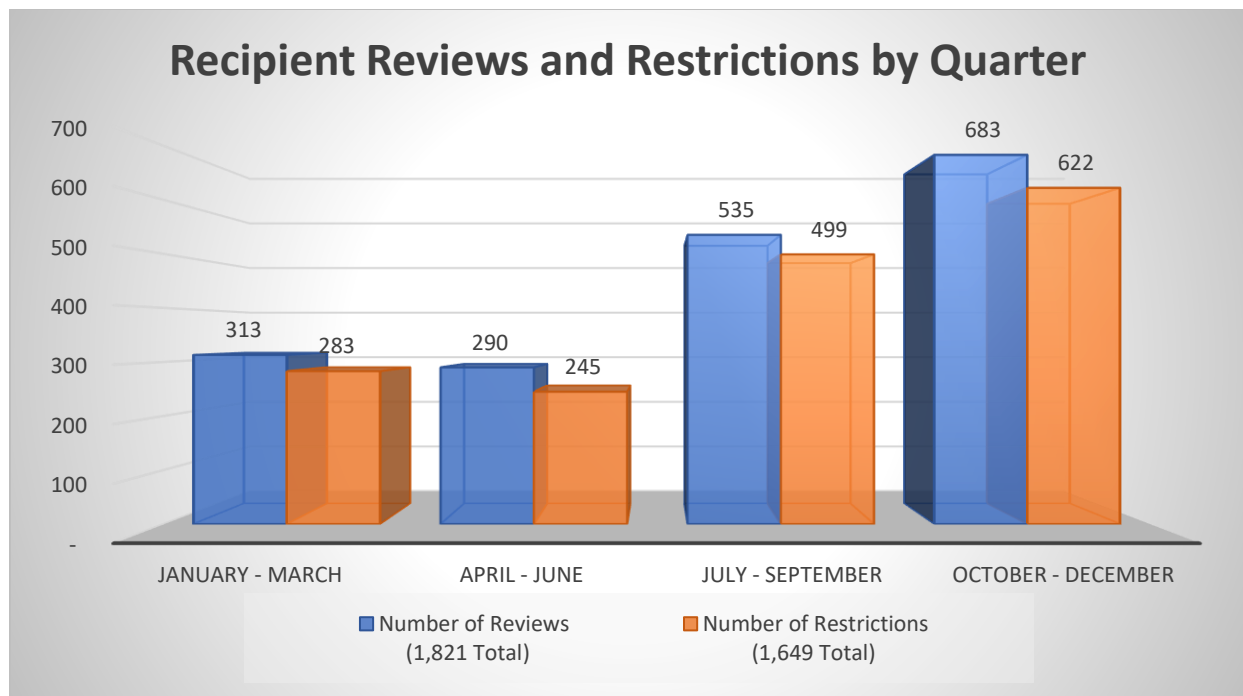
In March 2021, OMIG initiated an investigation of a recipient receiving NYS Medicaid transportation between Fort Edward and a treatment center in Albany, and was allegedly not attending the treatment center, using the transportation for personal use and other suspected illegal activities. An OMIG investigator compiled and reviewed transportation provider service records, established Medicaid transportation expenditures for the identified fraudulent transports, and

coordinated joint investigative activities with the Washington County Sheriff's Office.

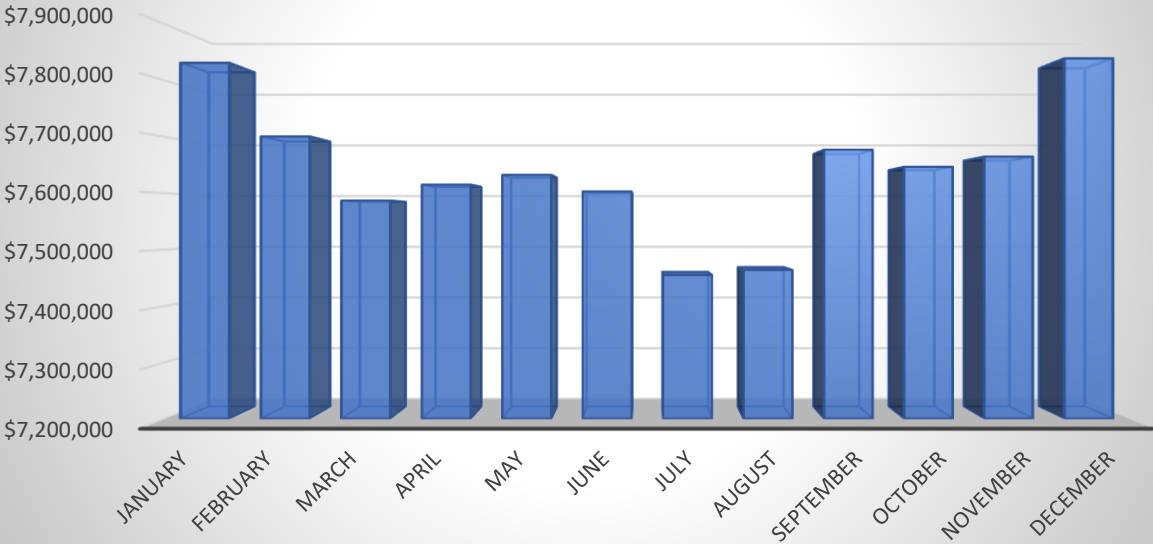
On September 1, 2021, OMIG presented the transportation fraud case with evidence-based documents to the Washington County DA's office for prosecution. On April 14, 2022, the recipient was arrested and charged with Grand Larceny for stealing over \$3,000 in Medicaid-funded transportation.

Recipient Restriction Plan






The Recipient Restriction Plan (RRP) is a program that limits access to services if, upon review, it is found that the recipient has received duplicative, excessive, contraindicated, or conflicting health care services, drugs, supplies, or has committed fraudulent acts with their benefit card such as forged prescriptions, card loaning, or doctor shopping. In such cases, the recipient is required to access specific types of medical care and services through a designated primary provider or providers. The State Medical Review Team, within the RRP, performs comprehensive recipient utilization reviews and identifies where there is a need for a recipient to be added to the restriction program.



Recipient Restriction Cost Avoidance by Month (\$91,716,606 Total)



Office of Counsel

 <p>30 Hearings Requested</p>	 <p>13 Hearings Conducted</p>
 <p>26 Settlements</p>	 <p>285 Medicaid Lien Litigations Received</p>
 <p>56 Hearings Resolved Preserving \$67 Million in Medicaid Funds</p>	

Mission

The mission of the Office of Counsel (OC) is to support and enhance the statutory responsibilities of OMIG by providing quality legal representation and counsel. OC is comprised of attorneys and administrative staff spread among three regional offices, primarily located in Albany and NYC. The OC attorneys serve two primary functions: representing the agency at administrative hearings and in litigation proceedings and providing legal support to all of OMIG's divisions and executive staff. This legal support includes, but is not limited to reviewing audit reports, notices of agency action, and audit protocols; drafting regulations and legislation; drafting and/or negotiating contracts and contract amendments; conducting legal research; and issuing legal opinions.

Due Process Protections

Due Process is based on concepts of fundamental fairness. It is grounded in providing individuals with "notice" and an "opportunity to be heard." Providers engaged with OMIG in the audit and investigative processes are afforded due process throughout the engagement. It is an integral part of those processes and is also part of OMIG's regulatory structure. Providers are afforded the right to respond to the OMIG's preliminary finding issued as either a Draft Audit Report or Notice of Proposed Agency Action within 30-days of receipt. When a provider elects to respond, OMIG is then required to consider any response prior to finalizing the action and issuing a Final Audit Report or Notice of Agency Action.

Administrative Hearings

Providers who have received a Final Audit Report, or a Notice of Agency Action (collectively referred to as the "final determination") are afforded additional due process protections and are entitled to challenge that final determination in an administrative hearing. Such hearings are conducted by DOH Administrative Law Judges (ALJ) in the Bureau of Adjudications and defended by OMIG attorneys. In 2022, 30 new hearing requests were received. However, all requests for a hearing are not fully resolved within the same calendar year that the hearing request is received.

Hearings must be requested within 60 days of the date in the final determination. The final determination may include identified Medicaid overpayments, and/or sanctions for unacceptable practices. Prior to the commencement of the hearing, OMIG is required to hold a pre-hearing conference with the provider to exchange documentation and other information for hearing. At hearing, providers or their representatives have the opportunity to cross-examine OMIG witnesses, introduce exhibits into evidence, and

present their own witnesses to prove OMIG’s final determination was incorrect. The OMIG attorney manages the progress of the case by communicating with the provider or their representative to either facilitate the hearing process, or to reach a fair and mutually agreeable resolution for both parties.

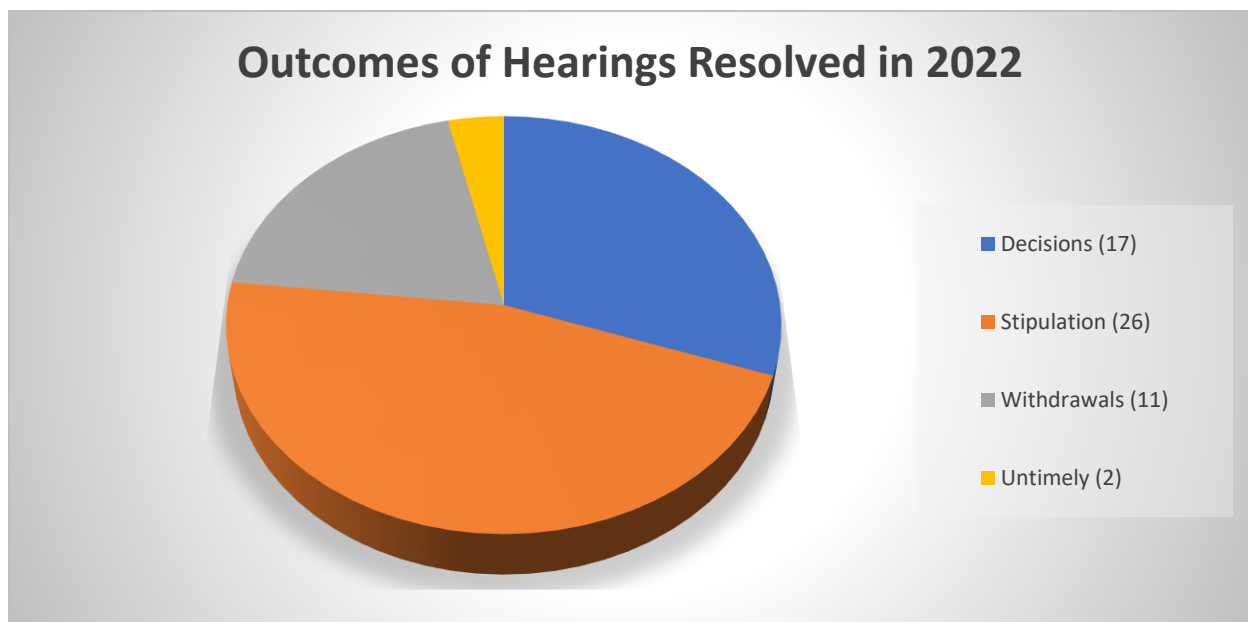
Most hearing requests are resolved through settlement to the satisfaction of OMIG and the provider in lieu of proceeding to hearing. Others are resolved by the provider voluntarily withdrawing their request for a hearing. Cases that go to a full hearing without being resolved through settlement or voluntary withdrawal result in a decision rendered by the ALJ.

In 2022, 56 administrative hearings cases were resolved as follows:

- ❖ 19 hearing decisions issued by an ALJ, including two in which the ALJ determined in the decision that the Provider’s hearing request was untimely;
- ❖ 11 hearing requests withdrawn by the provider; and
- ❖ 26 stipulations of settlement.

In most of the cases that went forward to a full hearing, the ALJ’s decision affirmed OMIG’s audit findings. These decisions can be found at:

www.health.ny.gov/health_care/medicaid/decisions/.

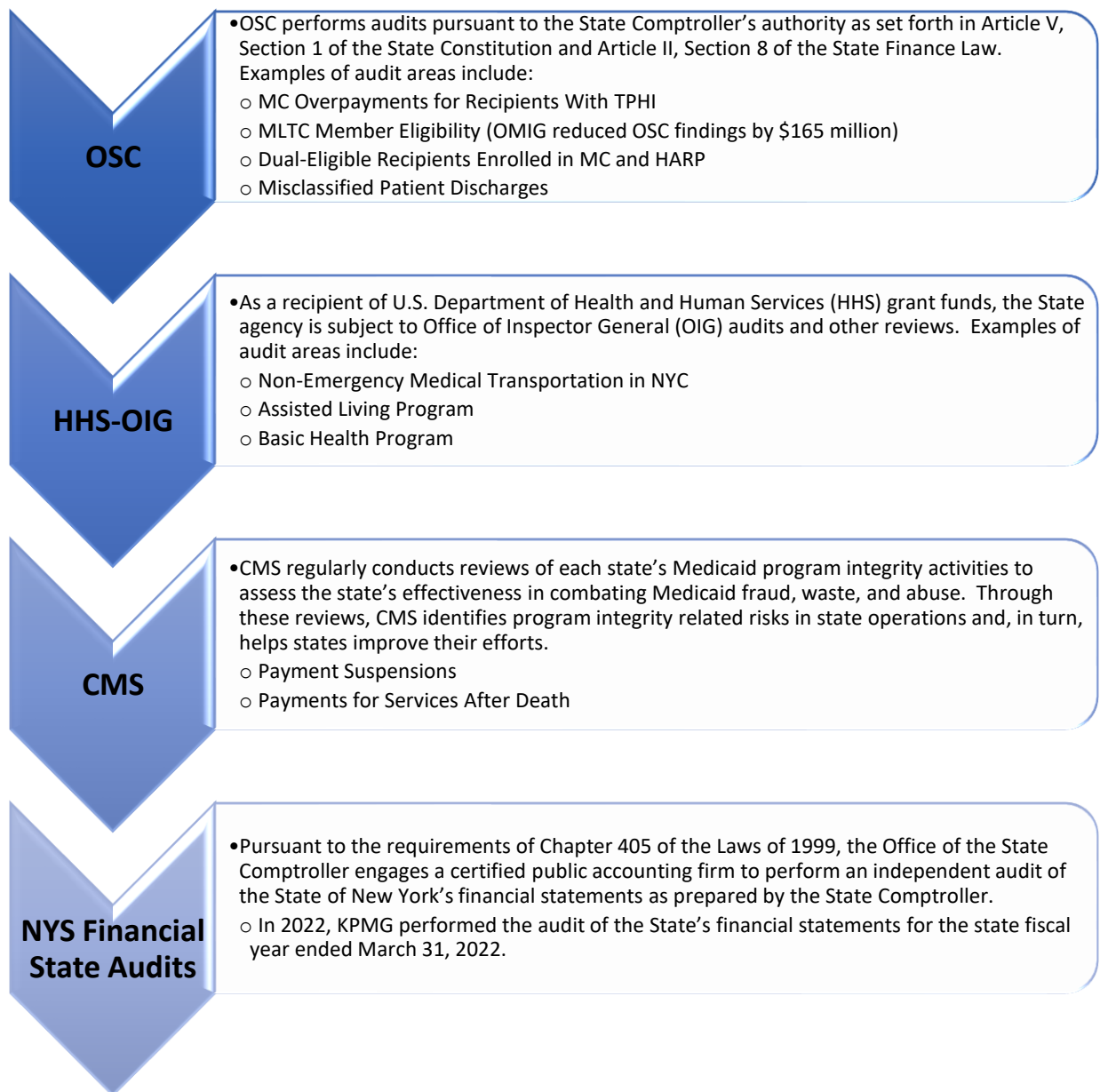


Stipulations of Settlement

OMIG attorneys negotiate and facilitate settlements between the agency and providers. Stipulations of Settlement may result from a provider agreeing to resolve an audit following an exit conference, prior to or following the issuance of a draft audit report, or after the issuance of a final audit report to resolve a request for hearing. Additionally, providers who self-disclose Medicaid overpayments may also request a stipulation of settlement. Stipulations of Settlement are formal written documents executed by the provider and OMIG, which define the terms of settlement, including but not limited to, the review period in question, the overpayment amount owed, and the repayment terms. In 2022 OC finalized 51 stipulations, of which 26 were in lieu of proceeding to an administrative hearing, and 25 were for pre-final determinations and self-disclosure cases.

External Audits

OMIG's External Audit Unit (EAU), working with DOH, coordinates and manages audits of the Medicaid program conducted by outside audit agencies, such as the Office of the State Comptroller (OSC), HHS-OIG, and CMS. The following chart is a summary of OSC reports, HHS-OIG reports, CMS reviews, and independent audits received during 2022. In 2022, EAU received a total of 46 audit reports/reviews containing millions of claims and managed care encounters. Addressing these audits involve OMIG staff from all divisions across the agency. Staff are engaged in all stages of the audit process, including fieldwork, meetings, data analysis, follow-up questions, and preparing responses to all reports received.



Appendix

Powers and Duties (Public Health Law (PBH) Article 1, Title 3)

- ❖ Conduct and supervise activities to prevent, detect, and investigate Medical Assistance (MA) program fraud and abuse in coordination with DOH, the Office of Mental Health, the Office of Addiction Services and Supports, the Office of Temporary and Disability Assistance, the Office of Children and Family Services, and the Office for People with Developmental Disabilities.
- ❖ Coordinate, to the greatest extent possible, activities to prevent, detect and investigate MA program fraud and abuse amongst State agencies, local governments, and entities; and to work in a coordinated and cooperative manner with, to the greatest extent possible, the deputy attorney general for Medicaid fraud control; other law enforcement entities, MCOs, and the State Comptroller.
- ❖ Meet quarterly with representatives of LDSS to discuss the status of ongoing cooperative efforts between the OMIG and districts, including demonstration programs, the potential for additional and/or for improved or innovative techniques to be employed, and any issues of concern to such districts with respect to the prevention and detection of fraud and abuse in the MA program.
- ❖ Solicit, receive, and investigate complaints related to fraud and abuse within the MA program.
- ❖ Keep the Governor, Attorney General, State Comptroller, the Legislature, and the heads of agencies with responsibility for the administration of the MA program apprised of efforts to prevent, detect, investigate, and prosecute fraud and abuse within the MA program.
- ❖ Review and audit contracts, cost reports, claims, bills, and all other expenditures of MA program funds to determine compliance with applicable Federal and State laws and regulations, and take such actions as are authorized by Federal or State laws and regulations.
- ❖ Pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts within the MA program.
- ❖ Subpoena and enforce the attendance of witnesses, administer oaths or affirmations, examine witnesses under oath, and take testimony.
- ❖ Require the production of documents relevant or material to an investigation, examination or review, or necessary for the inspector to perform its duties and responsibilities that are prepared, maintained or held by or available to any state agency or local entity the patients or clients of which are served by the MA program, or which is otherwise responsible for the control of fraud and abuse within the MA program.
- ❖ Conduct, in the context of the investigation of fraud and abuse, on-site facility and office inspections.

- ❖ Recommend and implement policies relating to the prevention and detection of fraud and abuse; provided however, that the consent of the Attorney General shall be obtained prior to the implementation of any policy that shall affect the operations of the Office of the Attorney General.
- ❖ Work with the fiscal agent employed to operate the Medicaid management information system to optimize the system.
- ❖ Monitor the implementation of any recommendations made by the office to agencies or other entities with responsibility for administration of the MA program.
- ❖ Prepare cases, provide testimony, and support administrative hearings and other legal proceedings.
- ❖ Work in a coordinated manner with relevant agencies in the implementation of information technology relating to the prevention and identification of fraud and abuse in the MA program.
- ❖ Conduct educational programs for MA program providers, vendors, contractors, and recipients designed to limit fraud and abuse within the MA program.
- ❖ In conjunction with DOH, develop protocols to facilitate the efficient self-disclosure and collection of overpayments and monitor such collections, including those that are self-disclosed by providers. A provider's good faith self-disclosure of overpayments may be considered as a mitigating factor in the determination of an administrative enforcement action.
- ❖ Receive and investigate complaints of alleged failures of State and local officials to prevent and prosecute fraud and abuse in the MA program.
- ❖ Implement and amend, as needed, rules and regulations relating to the prevention, detection, investigation, and referral of fraud and abuse within the MA program and the recovery of improperly expended MA program funds.
- ❖ Take appropriate actions to ensure that the MA program is the payor of last resort.
- ❖ Develop training materials with respect to the office's audit standards and criteria for identifying fraud or waste, for use by LDSS who are engaged with the office in demonstration programs or other collaborative efforts; and
- ❖ Perform any other functions that are necessary or appropriate to fulfill the duties and responsibilities of the office in accordance with Federal and State law.

Frequently Used Acronyms

Acronym	Term
ALJ	Administrative Law Judge
C&E	Casualty and Estates
CDPAP	Consumer Directed Personal Assistance Program
CIN	Client Identification Numbers
CMS	Centers for Medicare & Medicaid Services
CVR	Credential Verification Reviews
DA	District Attorney
DME	Durable Medical Equipment
DOH	Department of Health
DSUR	Division of Systems Utilization and Review
EAU	External Audit Unit
EOMB	Explanation of Medical Benefits
EPS	Episodic Payment System
FFS	Fee-for-Service
HHS-OIG	U.S. Department of Health and Human Services, Office of the Inspector General
HWB	Health Care and Mental Hygiene Worker Bonus
LDSS	Local Departments of Social Services
MA	Medical Assistance
MAS	Medical Answering Service
MC	Managed Care
MCO	Managed Care Organization
MDW	Medicaid Data Warehouse
MFCU	New York State Attorney General's Medicaid Fraud and Control Unit
MLTC	Managed Long-Term Care
MMCOR	Medicaid Managed Care Operating Report
NOIAA	Notice of Immediate Agency Action
NYC	New York City
NYC HRA	New York City Human Resources Administration
NYCRR	New York Codes, Rules and Regulations
NYS	New York State
NYSOH	New York State of Health
OASAS	Office of Addiction Services and Supports
OC	Office of Counsel
OMHA	Office of Medicare Hearings and Appeals
OMIG	Office of the Medicaid Inspector General
OPWDD	Office for People with Developmental Disabilities

Acronym	Term
OSC	Office of the State Comptroller
OSDS	Original Source Data Submitter
OTP	Opioid Treatment Programs
PARIS	Public Assistance Reporting Information System
PBH	Public Health Law
PCS	Personal Care Services
PPR	Pre-Payment Review
RAC	Recovery Audit Contractor
RIU	Recipient Investigations Unit
RRP	Recipient Restriction Program
SFY	State Fiscal Year
SIU	Special Investigative Units
SOS	Social Services Law
UMass	University of Massachusetts Chan Medical School
WMS	Welfare Management System

Data Tables

2022 Initiated Audits by Region				
Region	County Demo	Managed Care	Provider	Total
Capital Region	0	44	41	85
Central NY	0	31	28	59
Finger Lakes	0	15	39	54
Long Island	0	46	71	117
Mid-Hudson	0	33	121	154
Mohawk Valley	0	14	33	47
New York City	3	265	452	720
North Country	0	0	6	6
Out of State	0	0	5	5
Southern Tier	0	19	25	44
Western NY	2	62	93	157
Grand Total	5	529	914	1,448

2022 Finalized Audits by Region				
Region	County Demo	Managed Care	Provider	Total
Capital Region	0	37	17	54
Central NY	0	20	16	36
Finger Lakes	0	15	22	37
Long Island	0	48	75	123
Mid-Hudson	0	31	46	77
Mohawk Valley	0	15	11	26
New York City	6	261	357	624
North Country	0	0	10	10
Out of State	0	0	6	6
Southern Tier	0	18	11	29
Western NY	8	59	34	101
Grand Total	14	504	605	1,123

2022 Audit Overpayments Identified by Region				
Region	County Demo	Managed Care	Provider	Total
Capital Region	\$0	\$30,950,268	\$1,747,175	\$32,697,442
Central NY	\$0	\$2,192,144	(\$6,425,600)	(\$4,233,456)
Finger Lakes	\$0	\$5,772,179	\$707,770	\$6,479,949
Long Island	\$0	\$6,144,645	\$9,729,629	\$15,874,274
Mid-Hudson	\$0	\$7,213,226	\$5,746,033	\$12,959,259
Mohawk Valley	\$0	\$3,838,566	\$1,360,395	\$5,198,961
New York City	\$7,734,539	\$165,163,803	\$22,591,063	\$195,489,404
North Country	\$0	\$0	\$301,528	\$301,528
Out of State	\$0	\$0	\$50,526	\$50,526
Southern Tier	\$0	\$2,608,914	(\$1,712,421)	\$896,493
Western NY	\$522,835	\$5,679,582	\$2,572,370	\$8,774,787
Grand Total	\$8,257,374	\$229,563,327	\$36,668,467	\$274,489,168

2022 Penalties Issued by Region				
Region	County Demo	Managed Care	Provider	Total
Capital Region	\$0	\$0	\$0	\$0
Central NY	\$0	\$0	\$0	\$0
Finger Lakes	\$0	\$0	\$0	\$0
Long Island	\$0	\$0	\$0	\$0
Mid-Hudson	\$0	\$0	\$0	\$0
Mohawk Valley	\$0	\$309,656	\$0	\$309,656
New York City	\$0	\$5,643,046	\$0	\$5,643,046
North Country	\$0	\$0	\$0	\$0
Out of State	\$0	\$0	\$0	\$0
Southern Tier	\$0	\$0	\$0	\$0
Western NY	\$0	\$0	\$0	\$0
Grand Total	\$0	\$5,952,702	\$0	\$5,952,702

2022 Audit Recoveries by Region				
Region	County Demo	Managed Care	Provider	Total
Capital Region	\$123,465	\$29,852,242	\$2,880,259	\$32,855,965
Central NY	\$0	\$2,306,662	\$649,603	\$2,956,264
Finger Lakes	\$0	\$4,125,299	\$2,175,928	\$6,301,227
Long Island	\$0	\$7,833,720	\$9,225,650	\$17,059,370
Mid-Hudson	\$105,560	\$7,329,287	\$8,331,204	\$15,766,051
Mohawk Valley	\$0	\$4,148,222	\$680,958	\$4,829,180
New York City	\$8,055,955	\$164,307,121	\$34,865,951	\$207,229,027
North Country	\$0	\$0	\$377,492	\$377,492
Out of State	\$0	\$0	\$53,033	\$53,033
Southern Tier	\$0	\$1,961,247	\$693,224	\$2,654,471
Western NY	\$289,570	\$6,769,859	\$3,009,299	\$10,068,728
Grand Total	\$8,574,551	\$228,633,658	\$62,942,600	\$300,150,809

2022 Audit Summations	
Audit Department	Amount
County Demonstration Program	2
Managed Care	1
Provider	353
Total Summations	356

2022 Self-Disclosures by Region				
Region	Initiated	Finalized	Findings	Recoveries
Capital Region	22	14	\$300,057	\$247,587
Central NY	11	19	\$346,248	\$479,963
Finger Lakes	19	13	\$759,356	\$742,496
Long Island	29	37	\$862,856	\$1,315,568
Mid-Hudson	39	45	\$637,187	\$1,109,920
Mohawk Valley	8	11	\$164,216	\$159,527
New York City	101	94	\$4,355,500	\$4,445,130
North Country	10	7	\$128,943	\$28,108
Out of State	11	11	\$2,433,117	\$2,229,357
Southern Tier	12	11	\$131,325	\$188,365
Western NY	33	39	\$586,096	\$595,941
Grand Total	295	301	\$10,704,902	\$11,541,961

2022 Summary of Investigations by Source of Allegation and Region								
Initial Source	Downstate		Upstate		Out of State		Totals	
	Opened	Completed	Opened	Completed	Opened	Completed	Opened	Completed
Anonymous	114	130	116	105	1	1	231	236
Enrolled Recipient	50	55	32	36	3	4	85	95
Federal Agencies	5	23	4	8	0	0	9	31
General Public	139	127	144	140	2	2	285	269
Law Enforcement	3	15	0	3	0	0	3	18
LDSS	34	24	74	52	0	0	108	76
MCO's	122	94	43	44	5	4	170	142
MLTC Plans	17	47	8	16	0	0	25	63
OMIG	319	460	523	654	9	5	851	1,119
Provider	31	44	34	47	0	0	65	91
State Agencies	106	98	153	143	6	3	265	244
Transportation Manager	2	1	0	0	0	0	2	1
Total	942	1,118	1,131	1,248	26	19	2,099	2,385

2022 Referrals to MFCU	
Provider Type	Amount
Capitation Provider	1
Clinical Social Worker (CSW)	1
Consumer Directed Aide	7
Dental Groups	2
Dentist	2
Diagnostic and Treatment Center	5
Home Health Agency	5
Home Health Aide	3
Laboratory	4
Long Term Care Facility	1
LPN- Home Health	1
Multi-Type	7
Multi-Type Group	1
Non-Enrolled Provider	15
Nurse	3
Optician	1
Optometrist	1
Other	1
Personal Care Aide	1
Pharmacy	12
Physician	53
Physicians Group	13
Social Adult Day Care	18
Recipient	6
Transportation	35
Total	199

2022 Referrals to Other Agencies	
Agency	Amount
Law Enforcement Agency	6
LDSS	62
MAS-Medical Answering Service	2
NYC Department of Health	10
NYC HRA Adult Protective Services	1
NYC HRA Bureau of Client Fraud Investigations	52
NYC Office of the Special Narcotics Prosecutor	1
NYS Department of Environmental Conservation	1
NYS Department of Health	515
Department of Justice	57
NYS DOH Office of Professional Medical Conduct	26
NYS Education Department – Not Professional Discipline	3
NYS Education Department – Office of Professional Discipline	26
NYS Office for People with Developmental Disabilities (OPWDD)	1
NYS Justice Center	1
NYS Office of Health Insurance Programs (OHIP)	15
NYS Office of Mental Health (OMH)	1
Out of State	1
U.S. Attorney	5
U.S. Department of State Office of Inspector General	1
U.S. Health and Human Services (HHS-OIG)	130
Total	917

2022 Exclusions	
Reasons for Exclusions	Number of Actions
18 NYCRR 504.1(d)(1) – Affiliations	87
18 NYCRR 515.2 – Unacceptable Practice	2
18 NYCRR 515.7(b) – Indictments	46
18 NYCRR 515.7(c) – Convictions	143
18 NYCRR 515.7(e) – Professional Misconduct	122
18 NYCRR 515.8 – Mandatory Exclusion	162
Total	562

2022 Contractor Recoveries	
Activity Area	Amount
Third-Party Liability	\$209,994,286
Recovery Audit Contractor	\$171,555,503
Casualty & Estate	\$119,849,598
Home Health Care Medicare Maximization Project	\$5,437,739
Self-Disclosed Third-Party Health Insurance	\$290,076
Total	\$507,127,201

2022 Recoveries	
Activity Area	Amount
Managed Care	\$228,633,658
Third-Party Liability	\$209,994,286
Recovery Audit Contractor	\$171,555,503
Casualty & Estate	\$119,849,598
Provider	\$62,942,600
Self-Disclosure	\$11,541,961
County Demonstration Program	\$8,574,551
Home Health Care Medicare Maximization Project	\$5,437,739
Self-Disclosed Third-Party Health Insurance	\$290,076
Investigation Financial Activities	\$274,846
Total	\$819,094,818

2022 Cost Avoidance Activities	
Activity Area	Amount
Pre-Payment Insurance Verification Commercial	\$2,200,425,647
Pre-Payment Insurance Verification Medicare	\$302,975,506
Recipient Restriction	\$91,716,606
Medicare Coordination of Benefits w/Provider Submitted Duplicate Claims	\$9,182,803
Medical Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	\$6,115,857
Enrollment and Reinstatement Denials	\$2,934,963
Exclusions/Terminations – External	\$2,823,773
Recipient Medicaid MC Benefits - Case Closures for False Information	\$2,625,101
Exclusions/Terminations – Internal	\$862,032
Dental Claim Denials (Active Pre-Payment Review Providers) – Edit 1141	\$282,300
Total	\$2,619,944,589



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