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OMIG Audits, Regulations, and Implications

Linda Clark

Health Care Controversies Team Co-Leader

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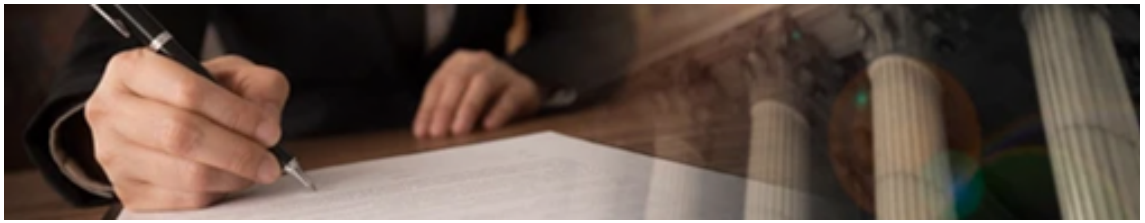
Office of the Medicaid Inspector General

- Established through executive order, OMIG was legislated to tackle widespread fraud highlighted by critical media coverage, aiming to secure Medicaid funds by enhancing accountability and efficiency.
- OMIG's mandate includes preventing, detecting, and investigating fraudulent and abusive activities within Medicaid alongside conducting audits to ensure compliance across health care providers.
- In its most successful year, 2022, OMIG recovered an unprecedented $300 million through audits, reflecting a significant impact on both the state budget and provider operations.



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The OMIG 2023 Annual Report

- **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.
- **OMIG highlighted in its annual report for the 2023 calendar year:** 891 finalized audits with over $4 billion in total recoveries and cost avoidance.
- **$238,112,905 in total audit recoveries in New York.**
- https://omig.ny.gov/information-resources/annual-reports

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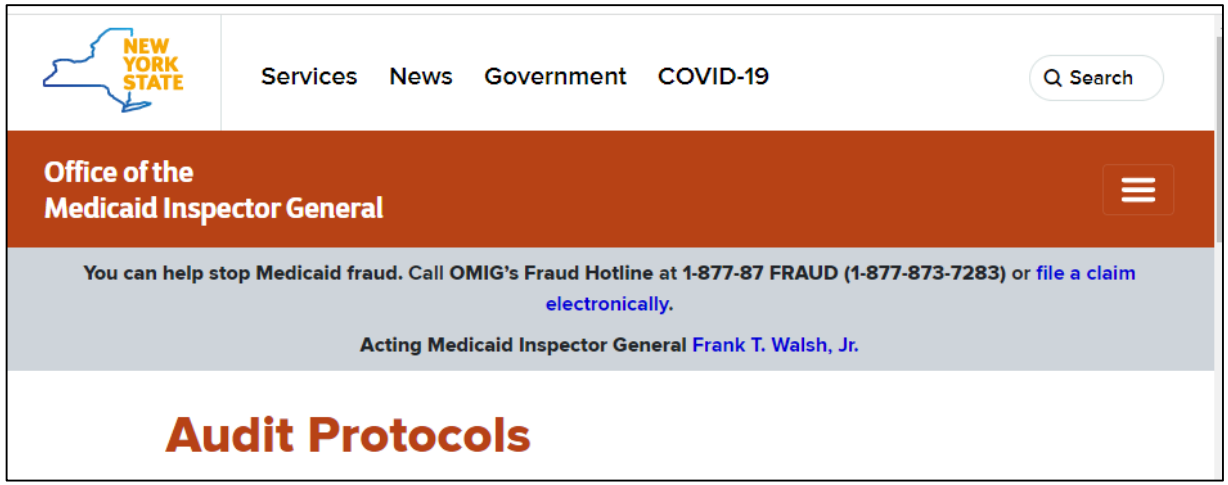
OMIG Audit Protocols

- Intended to assist providers in developing programs to evaluate compliance with Medicaid program requirements.
- Articulates Medicaid policies.
- Certain other state agencies also have audit protocols—e.g., OMH, OASAS.



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Issue: Overpayments/Extrapolation

- OMIG can rely on certifications of its statistician. **18 NYCRR 519.18(g)**
- Extrapolations are presumed valid in the absence of expert testimony and evidence to the contrary.
- Burden on the provider.
- Extrapolation has generally been upheld.

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Top 10 Things *Not* to Do If You're Audited

1.) Failing to involve counsel early

2.) Not scouring records thoroughly.

3.) Assuming technical errors don't matter.

4.) Relying on auditors to be reasonable.

5.) Not making every possible argument or challenging findings at every level.

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Top 10 Things *Not* to Do If You're Audited

6.) Assuming service delivery alone is a defense.

7.) Not requesting a withhold reduction immediately.

8.) Not asking for a hearing.

9.) Altering documentation after the fact.

10.) Not reviewing requested documents before submission.

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Issue: Provider Frustration

- Health care providers have experienced increasing dissatisfaction due to harsh penalties for minor errors and a perceived lack of transparency and fairness in OMIG's audit processes.

- The audit process often treats arguable clerical/administrative oversights with the same severity as intentional corner cutting.

- The cumulative effect of these audits not only burdens providers financially but also affects the overall quality of patient care by reallocating focus and resources away from treatment.

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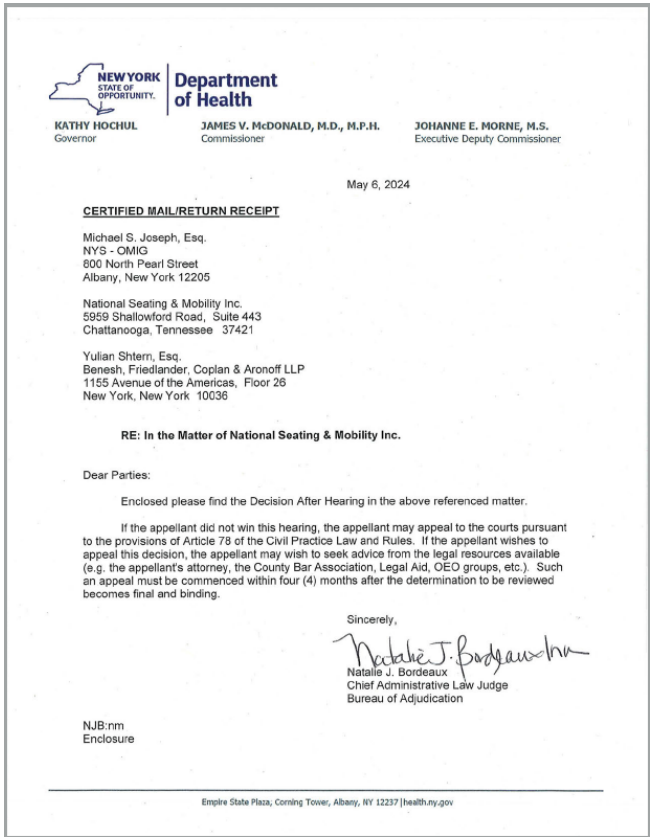
Recent Case Studies That Reveal the Problem With OMIG's Approach to Audits

- In the Matter of Schenectady ARC
- In the Matter of National Seating & Mobility Inc.
- In the Matter of Beth Israel Medical Center



NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

May 6, 2024

CERTIFIED MAIL/RETURN RECEIPT

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Yulian Shtern, Esq.
Benesh, Friedlander, Coplan & Aronoff LLP
1155 Avenue of the Americas, Floor 26
New York, New York 10036

RE: In the Matter of National Seating & Mobility Inc.

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter.

If the appellant did not win this hearing, the appellant may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the appellant wishes to appeal this decision, the appellant may wish to seek advice from the legal resources available (e.g. the appellant's attorney, the County Bar Association, Legal Aid, OEO groups, etc.). Such an appeal must be commenced within four (4) months after the determination to be reviewed becomes final and binding.

Sincerely,

Natalie J. Bordeaux
Chief Administrative Law Judge
Bureau of Adjudication

NJB:nm
Enclosure

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

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In the Matter of Schenectady ARC: Extrapolation

- A highly regarded upstate ARC is a private not-for-profit organization that is a registered Medicaid provider dedicated to supporting individuals with intellectual and other developmental disabilities and their families throughout New York State. 100 percent Medicaid funded based upon reported expenditures.
- OMIG demanded restitution of $1,239,242 based on findings of:
  - No explanation of benefits – was the main finding premised upon a debatable position that the ARC should have billed Medicare first even though the facility was not a Medicare provider and had no expectation that they were required to enroll.
  - Failure to meet minimum duration requirements
  - Missing elements of various documentations
- The provider appealed to a DOH ALJ.

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In the Matter of Schenectady ARC: ALJ Ruling

- Schenectady ARC argued that the extrapolation method had been flawed.
  - They went as far as to provide an expert report detailing the issues with the statistical study and extrapolation.
- OMIG offered no expert witness or report to rebut the report or support the etrapolation. In the face of evidence that the statistical method was incorrect and no evidence to the contrary, the ALJ ruled that even still, OMIG's methodology is presumed to be valid.
- The extrapolation was **upheld**, as it is in most cases.

This case highlights the complete deference that OMIG often gets even when the extrapolation methods are challenged.

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In the Matter of National Seating & Mobility Inc.

- National Seating & Mobility, Inc. (NSM) is a DME and surgical supplies supplier which is enrolled in the NYS Medicaid program.
- OMIG sought restitution of $270,804 based primarily upon findings that the provider did not receive a signed follow up order from the prescribed within 30 calendar days.
- The crux of the issue in this case was OMIG's position that although the services and items for which OMIG sought restitution **was** provided to **qualified recipients** the failure of prescribers to return the signed original prescription to the justified a complete loss of all reimbursement, ***even as the recipients retained the items and services in question!***

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In the Matter of National Seating & Mobility Inc (Cont.)

- Issue of Signed Fiscal Orders- Picking the Nits off the Regulatory Nats
  - NSM did in fact have copies of fiscal orders that were signed by the doctors. However, these were scanned and faxed copies that the doctor had sent over.
  - Fiscal orders can be **electronic**, but they have to originate from the provider's computer.
  - NSM fairly argued that when the doctor scans these orders and faxes them via an electronic transmission, this should constitute an electronic fiscal order.
  - OMIG disagreed. However, they did not apply this across the board. With fiscal orders that had headings that showed they were transmitted through an EHR system, OMIG had no issue. However, if there was any indication that they were faxed with no HER indications, OMIG did not accept these fiscal orders and labeled them as an overpayment.
  - Even more frustrating, the practice of faxed orders is now accepted in the new Medicaid manuals. However, for the time of the claims, these manuals did not apply.

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In the Matter of National Seating & Mobility Inc.: ALJ Decision

- Department of Health Administrative Law Judge John Terepka, as per norm, gave high deference to the policies and procedures of OMIG, as arbitrary as they are. He ruled that these recoveries were valid.
- However, even ALJ Terepka recognized the issues that OMIG has had the infamous reputation of having. He wrote:
  - "The OMIG's insistence on full restitution for all 113 claims in this case invites the criticism that it has been unnecessarily heavy handed in the exercise of the discretion require restitution. [...] The OMIG has chosen to demand restitution of over two-third of the appellant's Medicaid reimbursement during the audit period for DME it apparently did provide, almost entirely for practices the Department itself apparently might now accept." (https://www.health.ny.gov/health_care/medicaid/decisions/docs/nsam_inc.pdf, page 17)

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In the Matter of Beth Israel Medical Center

- Beth Israel Medical Center (BIMC) operated a hospital and health care center that operated an opioid treatment program (OTP).
- OMIG notified BIMC that it would be seeking $7,845,764 based on findings of missing documentation error. OMIG never claimed the findings of inadequate documentation affected the patient care of even one patient.
- In fact, four out of the five audit categories involved only one finding per category.
- BIMC in its submission to the ALJ stated that it would not be able to keep its clinic open if the recovery goes through.
  - The ALJ responded: "The Appellant claims that the OMIG's recovery of the overpayment using extrapolation methodology will result in the closure of one clinic serving anywhere from 400 to 1500 patients. That business decision is irrelevant to this review of a documentation audit and a resulting Medicaid overpayment." (https://www.health.ny.gov/health_care/medicaid/decisions/docs/beth_israel_medical_center_04-24-2020.pdf, Page 31)
  - The ALJ upheld the OMIG finding and BIMC had to close the clinic.

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What Does Reform Look Like?

- It's clear that legislative reform is necessary. What does this look like?
- New York State has passed various bills to address the growing complaints regarding OMIG.
- There were bills in the 2011, 2022, 2023, and 2024 legislative sessions.

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2011 Reform Bill

Key Provisions:

- Delayed Overpayment Recovery: The bill proposed delaying the recovery of overpayments identified in a Medicaid audit until at least 60 days after the final audit report or penalty notice was issued, giving providers adequate time to prepare for appeals.
- Limit on Reaudits: Prohibited OMIG from reauditing the same claims, bills, or contracts that had been audited within the previous three years, except under specific circumstances like new information or errors in the original audit.
- Consistency in Legal Standards: Audits were required to adhere to the existing legal and policy standards at the time of the provider's actions, preventing retroactive enforcement of new rules.
- Protection for Nonfraudulent Errors: The bill also called for protections against the recovery of funds for administrative or clerical errors provided these were not made with intent to defraud.
- Outcome?

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Vetoed by Governor Andrew Cuomo

- Governor Andrew Cuomo vetoed the bill in September 2011, expressing concerns that the bill was “too far reaching” and might allow fraudulent and abusive practices to go undetected, citing broad language and potential budgetary impacts.

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2022 Reform Bill

- The language in this bill relating to OMIG audits was almost identical to the 2011 bill. The only relevant divergence from the original bill was that on any claim that is audited for a service provided over two years prior to the commencement of the audit, the provider can resubmit that claim or accept the disallowance for the claim
- Outcome?

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Vetoed by Governor Kathy Hochul

- Governor Hochul vetoed the bill in December 2022. While acknowledging the issues raised, she cited restrictions the bill would place on OMIG's ability to recover overpayments as problematic, given the requirements of federal law and the potential financial implications for the state.
- Following the veto, Governor Hochul directed OMIG to engage with the provider community to review processes and identify improvements, although this was met with skepticism by providers who feared potential retribution and continued imbalance in audit practices.

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Issues With Provider Engagement With OMIG

- The providers feel that the underlying issues will continue to persist until OMIG is scaled back through legislation.
- In response to the engagement proposal, providers have cautioned that they would most likely not engage in input with OMIG because of the imbalance of power as they would fear retribution for openly and truthfully voicing their concerns.

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The Current Climate

- Increase in investigations by OMIG Investigations Unit, MFCU, and private payors
- Increase in exclusions (even for small overpayment amount)
- Compliance requirements being enforced
- Updated compliance and self-disclosure regulations
- Compliance program reviews by OMIG
- Self-disclosure requirements: Increasing number of referrals to OMIG's Division of Medicaid Investigation based on a provider self-disclosure
- Audits of OPWDD programs: Residential habilitation
- MDS (multiple data set) audits of nursing homes
- New OMIG audits: Health care worker bonus
- Censures/exclusions: Both reported to the National Practitioner Data Bank. While a censure does not limit a provider's participation in the Medicaid program, it may impact participation in other insurance programs.

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Renewed Bill in 2023 and 2024

- After repeated vetoes of previous reform efforts, there were bills introduced in the 2023 and 2024 legislative session which aimed to address persistent issues in OMIG's audit practices.
- The Bills both passed the Senate both years but were stalled in the assembly

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Provider Support

- A coalition of 41 health care organizations supported the bills, emphasizing the need to address the punitive nature of current audit practices that disproportionately penalize providers for minor clerical errors.
- The advocacy underscores that many providers, particularly in behavioral health, have faced closures due to financially crippling audit penalties, arguing for a more balanced approach to compliance and error correction.
- The unified voice of these organizations reflects a significant segment of the health care industry calling for legislative change to foster a more equitable and effective Medicaid audit process.

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Outcome?

- These bills passed the New York State Senate in 2023 and 2024.
- However, they stalled both years.
- The ongoing issue has now extended into yet another year.
- New York State needs to make some type of reform a priority.

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Renewed Bill in 2025

After repeated vetoes of previous reform efforts, there was a bill introduced in the 2025 legislative session which aims to address persistent issues in OMIG's audit practices.

The provisions in this bill included:

- **Applicable Standards:** Audits must use laws, regulations, and policies in effect at the time of service. Providers must have access to these standards before audits begin.
- **Clerical/Minor Errors:** Defines and protects against harsh penalties for small mistakes (e.g., typos, coding errors, duplicate claims). Limited recoupment for isolated occurrences.
- **Audit Standards & Transparency:** OMIG must publish audit protocols online in advance and provide detailed explanations of sampling and extrapolation methods in draft reports.
- **Fair Consideration of Provider Circumstances:** Overpayment findings must account for:
  - Whether errors are clerical/minor• Sustained or high-level error patterns
  - Provider's financial solvency
  - Potential impact on access to services
- **Provider Protections:**
  - Supporting documentation and attestations must be considered
  - Providers retain the right to settle based on Lower Confidence Limit calculations
  - Repayment/recovery cannot begin until 60 days after final audit report or hearing decision
- **Annual Reporting:** Expands OMIG's yearly report to include details on extrapolated audits, performance, savings, fraud mitigation, and impact on care quality and availability.

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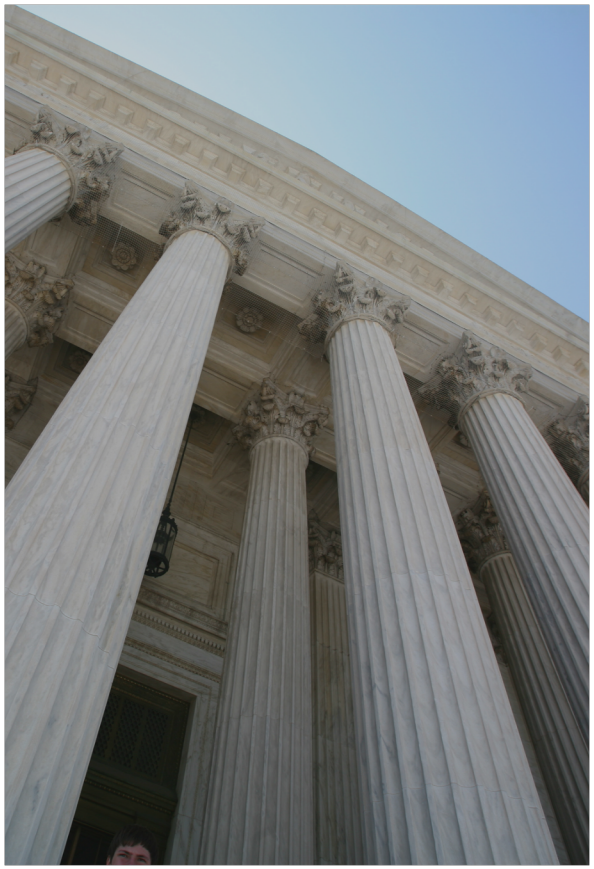
Urgent Need for Legislative Action and Executive Support

- Although the 2025 bill stalled in 2025, the ongoing legislative efforts still represent a crucial opportunity to address longstanding issues of fairness and operational impact on health care providers. In the legislative session next year, the New York State legislature and the governor should make it a legislative priority to enact OMIG reform.
- Given the history of vetoes, the possibility of an executive veto still remains; however, the legislature must be prepared to override such a veto to ensure that necessary reforms are enacted.
- It is imperative for Governor Hochul to recognize the consistent advocacy and documented issues by signing the new bill into law, thereby committing to a more just Medicaid system in New York State.



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OMIG Audits: Good News?!?

- We have received indications from OMIG of willingness to use Lower Confidence Levels

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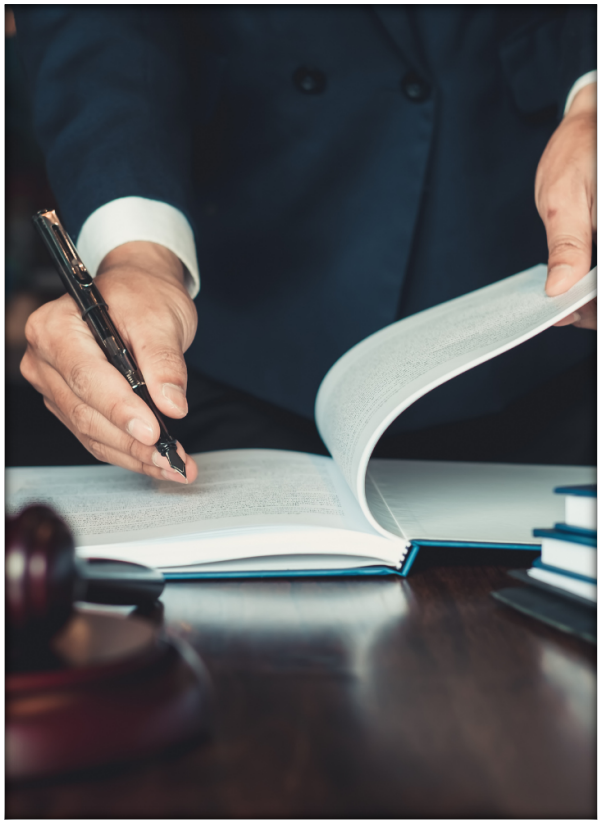
Progress of the Task Force

- The task force has prepared a report:
  "NYSBA Health Law Section Initial Report on the Medicaid Program and the Role of the Office of the Medicaid Inspector General"
- Click here to read the full report.



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The Report: Issues and Concerns With OMIG's Audit Practices

- Despite the ministerial focus of these audits, the consequences to providers are devastating. Providers subject to audit face recoupment for 100 percent of the reimbursement they received for services that were provided to Medicaid beneficiaries and for which the provider incurred staffing and other costs.
- The severe consequences of audit findings are completely disproportionate to the ministerial nature of the audit findings themselves. Minor technical deficiencies in documentation should never be the basis for disallowance of the entire payment received, where it is evident that a medically necessary service was in fact provided as required.
- No useful purpose is served by such disallowances. Indeed, the resulting payment disallowances actually hurt the Medicaid program. Providers opt out of Medicaid, leaving an inadequate number of providers willing to serve this population. In addition, recoupments reduce the financial resources available to providers who serve Medicaid recipients.

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The Report: Issues and Concerns With Administrative Hearing Process

- **Ongoing Financial Hardships**
  - Providers face financial strain even while pursuing an **administrative hearing** to contest OMIG's audit results.
- **Withholding During Hearing**
  - OMIG typically withholds **50 percent of payments** during the hearing process.
  - Recoupment often starts before the hearing concludes despite the final outcome being unresolved.
- **Interest Disparity**
  - If OMIG over-recovers, **no interest is paid back** to the provider.
  - Providers, however, must pay **prime plus 2 percent interest** from the audit report date until full payment is made.
  - OMIG has the authority to waive interest but **rarely exercises** this option.

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The Report: Risks Associated With the Financial Hardship Application Process

OMIG Payment Withhold Process

- **Payment Withhold Timeline**
  - OMIG can initiate payment withholds **20 days** post-final audit report.
- **Withholding Percentage**
  - No set limit on the percentage that OMIG can withhold.
  - Typically, **50 percent** of Medicaid payments are withheld unless a financial hardship is established.
- **Financial Hardship Determination**
  - Process to claim hardship is **intrusive and deters pro**viders.
  - Often leads providers to operate under **financial strain**.

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The Report: Risks Associated With the Financial Hardship Application Process (Cont.)

Concerns With OMIG Hardship Application Process

- **Unclear Standards**
  - Criteria for evaluating hardship are **not transparent**.
  - Applications reviewed **internally** not by an external CPA.
  - Lack of clear metrics or uniform application raises concerns about **decision integrity**.
- Impacts on Providers
  - Reports of increased withholding percentages following hardship applications.
  - No **internal review or appeal** mechanism for OMIG decisions.

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Other Audit Entities

- Medicaid is a joint federal-state program. Most administration duties are borne by the states (see 42 USC § 1396a), but other agencies and entities also exercise audit authority.
  - US Department of Health and Human Services Office of Inspector General (HHS-OIG)
  - Centers for Medicare & Medicaid Services (CMS)
    - CMS contractors – MACs, RACs, UPICs
  - Managed care payors – UnitedHealthcare, Centene, CVS Health
  - Pharmacy benefit managers

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Aside: Other Investigatory Authorities

- State
  - State Attorneys General, Medicaid Fraud Control Unit (MFCU)
- Federal
  - DOJ:
    - Health Care Fraud Units (Strike Forces/National Rapid Response)
    - FBI
    - US Attorneys' Offices

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HHS-OIG

- The Health and Human Services Office of Inspector General was established in 1976 (5 USC § 401 et seq.).
- Is responsible for oversight of federal health care programs, including Medicare and Medicaid, and ensures the programs operate efficiently by policing fraud, waste, and abuse (83 FR 55553).
- Specifically, HHS-OIG, in its audit functions:
  - Conducts and supervises audits
  - Detects fraud and abuse and identifies wrongdoers for appropriate remedies
  - Imposes administrative sanctions against providers, including exclusion from federal health care programs (42 USC § 1320a-7)

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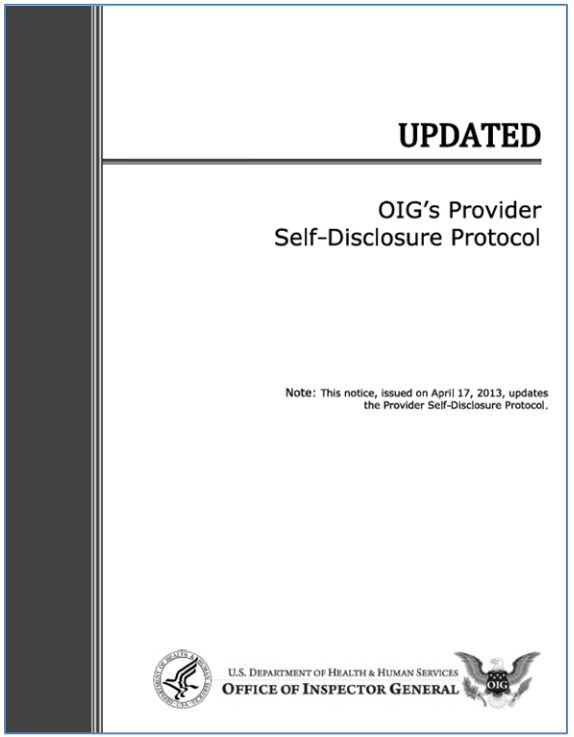
HHS-OIG (Cont.)

- Receives self-disclosures from health care providers and suppliers.
  - 42 CFR § 401.305: Return overpayment within 60 days of identification.
  - False Claims Act and reverse false claims (31 USC § 3729[a][1][G])
  - Reduced damages for reporting own violation within 30 days of obtaining information of violation (§ 3729[a][2])
- Must follow HHS-OIG protocols
- "Disclosing parties already subject to Government inquiry . . . are not automatically precluded from using SDP."



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HHS-OIG Future Focus Areas

Current Work Plan

Personal Care Services

18 NYCRR § 505.14; 42 CFR §§ 440.167, 440.450

- Medicaid-funded personal care service reviews showed:
  - Significant problems with state compliance with federal PCS requirements
  - Ineffective state program safeguards to ensure medical necessity, patient safety, quality, and proper payments
- HHS-OIG announces 2025 audit focus on whether PCS claims are compliant (W-00-19-31546)

Electronic Visit Verification

21st Century Cures Act; 42 USC § 1396b[l][1]

- EVV verifies elements of services, including date, time, and location
- Applies to PCS and home health care services
- Designed to address "longstanding fraud, waste, and abuse" with Medicaid PCS
- HHS-OIG announces 2024–2026 audit focus on state EVV data and use of EVV data for program integrity (OEI-09-24-00290)

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Centers for Medicare & Medicaid Services

- States retain primary responsibility for ensuring Medicaid program integrity. CMS is responsible for broad oversight of the Medicaid program.
- Deficit Reduction Act of 2005 (Social Security Act § 1936) obligated CMS to enter into contracts with eligible entities to:
  - Review Medicaid providers' and suppliers' conduct for fraud, waste, or abuse (or the likelihood of fraud, waste, or abuse)
  - Expenditure of Medicaid fund in a manner that is not intended under Title XIX (Medicaid)
  - Audit claims for payment under states' Medicaid plans
  - Identify overpayments to anyone receiving federal funds

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Comprehensive Medicaid Integrity Plan

- Five-year plans: Statutorily mandated (§ 1396u[d]) plan of CMS strategy for working with states to safeguard integrity of Medicaid.
  - CMS broadly defines integrity as preventing, detecting, and combating fraud, waste, and abuse.
  - CMS uses a vulnerability analysis process to identify and mitigate vulnerabilities. Focus areas for 2024–2028 include managed care, medical transportation, and HCBS.

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CMS Audit Contractors

Medicaid Audit Contractors

- Recovery Audit Contractors (RACs) are charged with identifying and recouping overpayments made on Medicaid claims on a post-payment basis.
  - State-led contracting process
  - Must follow state laws and regulations
  - Paid by state from amount recovered on contingency fee basis
  - Not all states participate, but NYS does
  - Providers have appeal rights (42 CFR § 455.512)
- Unified Program Integrity Contractors (UPICs) are charged with safeguarding Medicare and Medicaid from fraud, waste, and abuse.
  - Created under 42 USC § 1396u-6
  - Auditors utilize provider interviews, recipient interviews, provider employee interviews, and record requests and reviews
  - Defers to state extrapolation rules
  - Prioritizes work based upon program impact and urgency (PIM § 4.2.2.3)

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UPIC Audits

- Medicaid Program Integrity Manual Ch. 3
- In or about 2006, CMS redesigned the Medicaid Integrity Program to promote collaboration with state Medicaid agencies (SMAs), and the process reflects that.
- UPICs are charged with developing state-preferred and CMS-approved process for investigations and audits.
- Generally, Medicaid dollars at risk must be at least $50,000.

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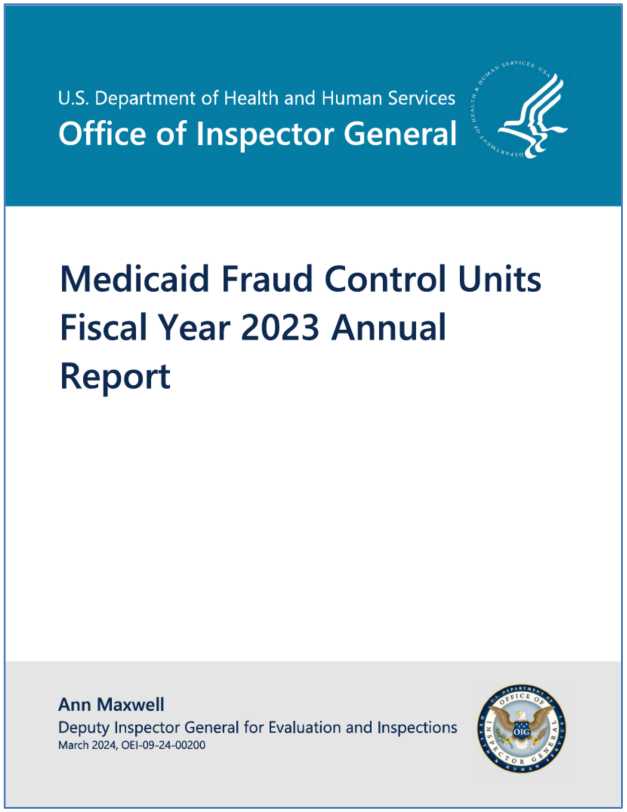
Federal Oversight Over States

- HHS-OIG and CMS both exercise oversight over state Medicaid programs, including:
  - HHS-OIG on-site reviews of MFCUs
  - CMS may pause FFP payments to states for noncompliance (42 USC § 1396c; 42 CFR § 431.1002[a]) or recover overpayments from the state (42 CFR Part 433.300 et seq.)



Available at oig.hhs.gov (Report OEI-09-24-00200)

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Managed Care Organizations (MCOs)

- Medicaid MCOs have an obligation to have procedures for detecting and preventing fraud, waste, and abuse (program integrity) (42 CFR § 438.608), including:
  - Reporting all identified overpayments to the state within 30 days
  - Referring potential fraud, waste, or abuse to OMIG/MFCU
  - Withholding payments at DOH or OMIG direction upon credible allegation of fraud
- State can recover overpayment to provider directly from MCO (SSL § 364-j[35]).

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MCO Audits and Recoveries

- Provider agreements permit access to provider records for auditing.
- Insurance Law § 3224-b:
  - Governs overpayment recovery process by MCOs
  - Applies to health care providers (Art. 28, Art. 36), MHL facilities, and licensed professionals under Education Law Art. 8 (nurses, MDs, LCSWs, pharmacy, therapy, etc.)

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MCO Audits and Recoveries (Cont.)

- MCOs must establish written policies and procedures for health care providers to follow to challenge overpayment recovery (§ 3224-b[b][2]). Demand clarity.
- Requires 30-day notice before recovery (but may not be a condition precedent to suit) (*Davenport*, 2016 NY Misc LEXIS 6677 [Sup Ct, Nassau County]).
- Two-year statute of limitations on overpayment recovery by MCOs.
  - Exceptions include where there is a "reasonable belief of fraud or other intentional misconduct, or abusive billing;" required by a self-insured plan, or required by a state or federal government program (§ 3224-b[b][4]).
  - Another exception may exist under the relation back doctrine (*Kofinas*, 25 Misc 3d 1243[A] [Sup Ct, New York County]).

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Questions?

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