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TO: LeadingAge New York
FROM: Hinman Straub P.C.
RE: New York State Office of the Medicaid Inspector General 2018-19 Work Plan
DATE: April 11, 2018

NATURE OF THIS INFORMATION: This is general information you might find helpful or informative.

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

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THE FOLLOWING INFORMATION IS FOR YOUR FILING OR ELECTRONIC RECORDS:

Category: #2 Providers and payments to them; and Suggested Key Word(s):
#9 Medicaid and Medicare

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The New York State Office of the Medicaid Inspector General (OMIG) recently released its Work Plan for fiscal year 2018-2019 (the “2018-19 OMIG Work Plan”). The Work Plan is available on the OMIG website and may be accessed at the following link:

- <https://omig.ny.gov/information/work-plan#Compliance-Activities>

Unlike prior years, where OMIG updated its Work Plan once a year and identified all agency priorities for the upcoming year in the Work Plan, starting this year, OMIG intends to make its Work Plan more fluid, and update priorities over the course of the year to “adapt to the changing Medicaid landscape.” Thus, the Work Plan for 2018-19 is no longer a finalized document but a website containing ongoing agency priorities that will be updated over the course of the year. These updates will be communicated via email to the OMIG listserv.

While the format of the Work Plan may have changed, OMIG’s priorities, or at least those identified so far, are consistent with virtually all of the priorities identified in the 2017-18 Work Plan.

However, one notable new addition is the creation of a new Medicaid Managed Care Project Team: the Value-Based Payments (VBP) Project Team. As you may recall, OMIG established five project teams¹ in 2016 to focus exclusively on managed care related oversight. Each team has a specific charge and reports on progress to OMIG’s Executive Staff. The VBP Project Team will work with DOH to gain an understanding of how value-based payments will be reflected in the Medicaid data; discuss ways of ensuring integrity within the data; and ensure access to information is readily available to OMIG to be able to audit and investigate in a VBP environment. According to the Work Plan, VBP team members are already meeting regularly with DOH to remain apprised of the best practices and lessons learned from the VBP Pilot program. With the overwhelming majority of the Medicaid program now in managed care, and managed care payments moving to value-based payment arrangements, this is likely to be an area of continued development as OMIG evolves its practices to account for VBPs.

Consistent with last year’s Work Plan, the 2018-19 Work Plan discusses high-risk audit areas in the context of OMIG’s “SFY 2018-2020 Strategic Plan”. The Strategic Plan embodies OMIG’s aim to be the national leader in promoting and protecting Medicaid program integrity and sets forth three goals for achieving its vision:

- Goal #1: Collaborate with Providers to Enhance Compliance: OMIG will continue existing efforts to educate providers about compliance and generate policy based on provider collaboration efforts;
- Goal #2: Coordinate with stakeholders to identify and address fraud, waste, and abuse in the Medicaid program: OMIG will coordinate with law enforcement and managed care SIUs to identify fraud, waste, and abuse. Key objectives of this goal include continuing existing work referring cases of suspected fraud to the Attorney General’s Medicaid

¹ The five teams were the: (1) Pharmacy Review Project Team; (2) Managed Care Plan Review Project Team; (3) Network Provider Review Project Team; (4) Data Review Project Team; and, the (5) Contracts Review Project Team. As noted in the introduction, OMIG has added a new VBP Project Team for a total of six Project Teams.

Fraud Control Unit (MFCU); and continuing the work of the Managed Care Project Teams, specifically, what looks to be a coordinated project involving the Managed Care Plan Review, Network Provider Review, and the Pharmacy Project Teams to develop efficient and effective audit processes to operate in a managed care environment;² and

- Goal #3: Develop innovative analytic capabilities to detect fraudulent or wasteful activities: OMIG will work to develop and employ innovative analytic capabilities to extract high-level data on fraudulent and wasteful activities. OMIG's objectives are to enhance multidisciplinary activities, including improved data access, storage and mining capabilities, and to use these activities to improve their audit and recovery efforts.

The 2018-19 OMIG Work Plan has organized the presentation of high-risk audit areas historically reviewed according to their corresponding "business line team" (BLT) into eight action items that align with the goals of the 2018-2020 Strategic Plan. The first action item (1) Compliance Activities, is included as part of Goal #1 of collaborating with providers to enhance compliance. Six action items form the core of Goal #2, to coordinate with stakeholders to identify and address fraud, waste, and abuse. They are: (1) combatting prescription drug and opioid abuse; (2) home health and community-based care services; (3) long-term care services; (4) Medicaid Managed Care; (5) transportation; and (6) ongoing program integrity activities. These action items are identical to the "six priority areas for targeting fraud and abuse" that OMIG included in the 2017-18 Work Plan last year. The eighth action item relates to data analytics activities, and is connected to OMIG's third Strategic Goal (Goal #3) of developing analytics to detect fraudulent or wasteful activities.

As you may recall, OMIG has BLTs that focus on a specific area of Medicaid health care service delivery (i.e., provider type) and oversee the various oversight initiatives for that provider type. In 2016, there were eleven BLTs.³ We do not believe there have been any changes to the BLTs, but that this is simply a formatting change to better align the 2018-19 OMIG Work Plan with the 2018-2020 OMIG Strategic Plan.

Key Takeaways

The 2018-19 OMIG Work Plan describes activities that OMIG plans to initiate or continue during 2018 and 2019, and has important implications for plans and providers participating in New York's Medicaid program. Medicaid participating providers and health plans are required, pursuant to Social Services Law § 363-d, to adopt and implement effective compliance programs that include systems for conducting internal audits of high risk areas. OMIG expects participating providers to incorporate in these internal audit plans high-risk areas identified through a number of sources, including OMIG's annual work plan.

² The five teams are the: (1) Pharmacy Review Project Team; (2) Managed Care Plan Review Project Team; (3) Network Provider Review Project Team; (4) Data Review Project Team; and, the (5) Contracts Review Project Team.

³ The eleven BLTs in 2016-17 were: DSRIP; Home and Community Care Services; Hospital and Outpatient Services; Managed Care; Managed Long-Term Care; Medical Services in an Educational Setting; Mental Health, Chemical Dependence, and Developmental Disability Services; Pharmacy and Durable Medical Equipment; Physicians, Dentists and Laboratories; Residential Health Care Facilities; and Transportation.

As such, plans and providers participating in New York's Medicaid Program should review the 2018-19 OMIG Work Plan to identify applicable high-risk areas and make any necessary revisions to their compliance programs to include related targeted internal audits.

This memorandum identifies OMIG's high-risk audit areas for SFY 2018-19. It highlights new OMIG initiatives as well as important ongoing areas of focus.

While the particular initiatives described in the 2018-19 OMIG Work Plan are of primary importance, three general themes highlight areas of concern to OMIG. These include:

- Continued expansion of the focus on managed care organizations in response to the growth of managed care in New York's Medicaid program, with particular focus on pharmacy as a major cost driver within the program and the shift to VBP arrangements;
- Emphasis on data integrity and managed care plan encounter data which drives managed care plan premiums; and
- Focus on cost drivers of Managed Long Term Care (MLTC). In particular, the Consumer Directed Personal Assistance Program (CDPAP) is included in the 2018-19 Work Plan after being omitted from the 2017-18 Work Plan, as is oversight of "Private Duty Nursing Agencies".

GOAL 1: COLLABORATE WITH PROVIDERS TO ENHANCE COMPLIANCE

The 2018-19 OMIG Work Plan identifies four objectives to enhance provider compliance. These are:

- (1) Continuing to provide providers with compliance program guidance and assistance, such as compliance webinars, guidance materials, self-assessment tools, and presentations;
- (2) Compliance Certifications: providers subject to the annual certification requirement who fail to complete an annual certification on OMIG's website may be identified for potential administrative action;
- (3) Continuing with compliance program reviews; and
- (4) Continuing with corporate integrity agreement monitoring and enforcement.

SSL § 363-d and NYCRR Part 521 require certain Medicaid providers to implement and operate an effective compliance program. The Work Plan notes that most OMIG compliance program reviews are triggered by a provider's failure to meet the annual compliance program certification obligation each December.

Compliance program reviews were expanded in 2016-17 to include MCOs, even though they were always subject to the compliance program mandate. As expected, OMIG will continue to review both managed care plan and provider compliance programs this fiscal year.

GOAL 2: COORDINATE WITH STAKEHOLDERS TO IDENTIFY AND ADDRESS FRAUD, WASTE, AND ABUSE IN THE MEDICAID PROGRAM

As noted in the introduction, the 2018-19 Work Plan follows last year's model of organizing high-risk audit areas according to action items or priority areas instead of OMIG's BLTs. The six action items encapsulate the focus of the different BLTs. Once again, these action items are: (1) fighting prescription drug and opioid abuse; (2) home health and community-based care; (3) long-term care; (4) transportation; (5) managed care; and (6) ongoing program integrity activities. Each action item is discussed in detail below.

The 2018-19 Annual Work Plan notes that in pursuing these action items, OMIG will continue to collaborate with (1) local and national law enforcement to pursue cases of Medicaid fraud, including continued participation in the FBI health care fraud strike forces that exist throughout the State; (2) the DOJ Medicare Fraud Strike Force, based in the Eastern District of New York, (3) District Attorneys; and (4) the Attorney General's Medicaid Fraud Control Unit (MFCU).

1. Combatting Prescription Drug and Opioid Abuse

New Initiatives (none)

Continuing Initiatives

- **I-STOP Compliance:** OMIG will work on prescription monitoring and work in tandem with the DOH Bureau of Narcotics Enforcement (BNE) to ensure provider compliance with the Internet System for Tracking Over-Prescribing (I-STOP), NYS's Prescription Monitoring Program (PMP) registry to monitor provider compliance with mandated e-prescribing and identify fraudulent prescriptions. This initiative was not included in last year's Work Plan but was included in the 2016-17 OMIG Work Plan.
- **Restricted Recipient Program:** OMIG will continue to work with DOH to provide oversight of MCOs' restricted recipient programs ("RRPs") and to coordinate with plan SIUs. OMIG will also continue working with DOH to review MCOs using an operational survey and onsite reviews, with a focus on determining whether special investigation units are adequately performing investigative functions to detect and prevent fraud, waste and abuse in compliance with the Managed Care Model Contract. Since RRP's inception, over 100,000 cases have been reviewed and those recipients found culpable recommended for restriction to ensure better care for the recipient, and eliminate excessive cost to the Medicaid program for unnecessary services.

2. Home Health and Community-Based Care Services

Home Health and Community-Based Care Services (HCBS) refers to services provided by the following Medicaid providers and programs: Certified Home Health Agencies (CHHAs), Long-term home health care programs (LTHHCPS), personal care aides (PCAs), traumatic brain injury program providers (TBI Programs), and private duty nursing services (PDN Services). Services provided by Licensed Home Care Service Agencies (LHCSAs) are referenced in connection with PDN Services and PCA services. Assisted Living Program (ALP) services are included in the

separate “Long Term Care” category, which also includes nursing homes and “Managed Long Term Care”.

The 2018-19 OMIG Work Plan once again notes that HCBS services remain an important focus as utilization continues to grow as the population ages and moves away from long-term care placements and hospitalizations under the transition to value-based payments (VBP).

New Initiatives

- **Consumer Directed Personal Assistance Program (CDPAP):** The 2018-19 Work Plan makes a point of noting that OMIG will audit and investigate CDPAP providers to ensure compliance with rules and regulations as the program continues to expand. In January, OMIG finalized audit protocols for CDPAP, which are available at the following website:
 - https://www.omig.ny.gov/images/stories/audit_protocols/CDPAP%20PROTOCOL%20Posted%20copy%20-%201-16-18.pdf

CDPAP was identified as a high-risk area in the 2016-17 OMIG Work Plan but was surprisingly omitted from the 2017-18 Work Plan despite the fact that the program remained under close scrutiny from DOH and the Attorney General’s Medicaid Fraud Control Unit (MFCU). In the 2016-17 OMIG Work Plan, OMIG mentioned that it would review Medicaid payments for CDPAP services to determine adherence with program eligibility requirements, compliance with regulatory requirements, and conduct audits to verify that services billed to Medicaid were actually delivered. **We encourage providers and plans involved in the program to remain vigilant on all aspects of CDPAP program integrity and closely review the CDPAP audit protocols and take steps that are necessary to enhance their own compliance.**

- **Personal Care Services:** The 2018-19 Work Plan notes that OMIG has convened a monthly meeting with a cross section of team representatives to discuss initiatives related to personal care services (PCS). The Work Plan notes that MCOs are responsible for assessing recipients and making service determinations with respect to PCS. Given that the MLTC program has grown much faster than anticipated, with the State reviewing whether this growth is simply due to demographic trends or potentially untoward enrollment practices by PCS providers, it is likely these meetings may result in updated Work Plan priorities and oversight initiatives relating to PCS and LHCSAs.

Continuing Initiatives

Personal Care Services: In addition to potentially new oversight initiatives, OMIG will continue to audit PCS FFS claims and claims provided by MCOs.

- **Minimum Wage Compliance:** OMIG will work with DOH and the New York Department of Labor (DOL) to audit MCOs and their contracted network providers’ records and reports to verify that funds paid for employee wage increases are distributed to health care workers in accordance with the minimum wage statute and DOH’s policies and procedures. Notice of this new initiative was first communicated to plans and providers in the DOH Dear

Administrator Letter (DAL) “Minimum Wage Fiscal Policy/Implementation Guidelines” that was sent October 28, 2016. This DAL specifically noted that OMIG would conduct audits of MCOs and providers to ensure that payments were made in accordance with statutory requirements and the methods discussed in the DAL. Accordingly, providers and MCOs should treat the requirements set forth in the DAL, as well as any subsequent DOH policy decisions as compliance expectations that will be subject to audit and review by OMIG. A copy of this DAL is available [here](#).

- **HCBS Providers Subject to Home Care Worker Wage Parity Mandates:** OMIG will continue to work with DOH and DOL to verify that home care providers are providing wage and fringe benefit compensation to employees in compliance with wage parity laws.
- **CHHA EPS Audits:** OMIG will continue to conduct CHHA FFS audits and will initiate CHHA Episodic Payment System (EPS) audits.
- **CHHA and LTHHCP Cost Reports:** OMIG will also continue to audit LTHHCP and CHHA cost reports to verify per-visit and hourly rates for ancillary services, as well as rate add-ons (e.g. for worker recruitment).
- **Dual Eligibles: CHHA and LTHHCP:** In connection with Goal 3 of the 2018-2020 Strategic Plan, “Develop Innovative Analytic Capabilities to Detect Fraudulent or Wasteful Activities”, OMIG will continue with Medicare home health maximization and continue to work with the University of Massachusetts to review home health claims for dual eligibles.
- **NHTD and TBI Waiver Programs:** OMIG will continue to examine FFS claims under both programs to determine compliance with program requirements.

3. Long Term Care Services

Long Term Care services includes residential health care facilities (i.e., skilled nursing/residential health care facilities), assisted living programs (ALPs), and Managed Long Term Care Plans. Relevant initiatives include:

New Initiatives (none)

Continuing Initiatives

- **ALP Medicaid Regulation Compliance:** OMIG and DOH’s Division of Adult Care Facilities and Assisted Living Surveillance will coordinate efforts to monitor ALP provider’s compliance with Medicaid regulations. In the event OMIG identifies a potential quality of care or patient endangerment issue, DOH will be contacted immediately and remedial activities will be coordinated among the agencies.
- **ALP Claim Documentation:** OMIG will review documentation of care given to residents of ALPs to determine whether payments for services are valid and patient needs are being met. OMIG will review patient records for up coding and overbilling for services provided to ALP residents, and to ensure patient records include all required authorizing documents. OMIG

will also provide oversight of ALP resident care audits conducted as part of the County Demonstration Program.

- **RHCF Capital Cost Reimbursement:** As part of its review of RHCF rates, OMIG will review the capital cost component of RHCF rates, including confirmations and certifications that are provided by RHCFs to DOH to certify to the proposed capital reimbursement under DOH's new capital reimbursement rate setting methodology. OMIG will also continue to review Minimum Data Set (MDS) submissions. MDS submissions are used by DOH rate setting to calculate each facility's Case Mix Index (CMI), which is used to determine the direct cost portion of each facility's Medicaid rate.
- **Social Day Care: Managed Long-Term Care:** In conjunction with the Medicaid Fraud Control Unit and the New York City Buildings Department, OMIG will continue its investigations of social adult day care centers. OMIG will also coordinate with DOH and the New York State Office for the Aging (NYSOFA) to implement the state certification process and align this process with the existing registration process that exists for New York City facilities. Additionally, OMIG will continue to verify that social adult day care centers have documentation required to maintain certification, and will continue to meet quarterly with Managed Long term Care plans and the New York City Department for the Aging to coordinate efforts to identify ongoing issues.
- **Enrollment: Managed Long-Term Care:** OMIG will review MLTC enrollment records to determine if MLTC plans have properly determined eligibility for enrollment and whether they have provided proper care management to selected MLTC members. OMIG will also continue to review plans of care and claims data to determine if MLTC plans are providing services deemed medically necessary by the MLTC plan for the recipient.

4. Medicaid Managed Care (Mainstream Medicaid Managed Care)

In response to the growing role of MCOs within the New York Medicaid Program, the 2018-19 OMIG Work Plan continues OMIG's emphasis on managed care plan oversight, with project management teams coordinating oversight of managed care within OMIG.

The 2018-19 OMIG Work Plan includes one new Project Management Team: The VBP Project Team. Otherwise, there are no new updates to this section at this time.

Project Management Team Activities

New Initiatives

- **Value-Based Payments Project Team:** OMIG's Value-Based Payments (VBP) Project Team will continue to work with DOH to: gain an understanding of how value-based payments will be reflected in the Medicaid data; discuss ways of ensuring integrity within the data; and ensure access to information is readily available to OMIG to be able to audit and investigate in a VBP environment. VBP team members have also been meeting regularly with DOH to keep OMIG apprised of the best practices and lessons learned from the VBP Pilot program.

Continuing Initiatives

- Pharmacy Review Project Team: The 2018-19 OMIG Work Plan provides that the Pharmacy Team will conduct managed care network pharmacy audits to ensure pharmacy compliance with State and Federal laws, MCO contract requirements, and pharmacy benefit components of MMC. In the 2017-18 Work Plan, this activity was described as including reviews to assess the accuracy of formulary and benefit administration and financial and pricing arrangements, but this detail was not included in the 2018-19 Work Plan. The 2017-18 Work Plan also noted that the Pharmacy Team would review pricing methodologies between MCOs and Pharmacy Benefit Managers (PBMs) that are paid to network pharmacy providers. This is not explicitly mentioned in the 2018-19 Work Plan though there is nothing to indicate the Team will not continue this activity. The 2018-19 Work Plan provides that Pharmacy Team will continue to review pharmacy encounters for accuracy in billing and payment of encounter claims.
- Contracts Review and Policy Management Project Team: The Contracts and Policy Management Project Team (formerly just known as the Contracts Review Team) works to develop amendments to the mainstream Medicaid and MLTC model contracts addressing program integrity issues. No specific priorities are provided in the 2018-19 Work Plan at this time. For 2017-18, the team focused on amendments to address the CMS Medicaid Managed Care Mega-Rule provisions relating to program integrity.
- Network Provider Review Project Team: This team performs audits of providers within MCO networks to verify regulatory and contractual compliance. The team will continue to review plan encounter submissions to identify improper encounter claims submitted by providers that contribute to inflated MCO premiums. Audits will be coordinated with MCOs and their Special Investigation Units (SIUs).
- Managed Care Plan Review Project Team: This team will continue to audit MMCORs and test data submitted by MCOs to ensure costs were reported correctly. Audits will focus on the review of reported pertinent medical and administrative costs for accuracy and allowability to ensure only proper costs were utilized in the development of respective rate components.
- Data Review Project Team: This team is discussed in the 2018-19 OMIG Work Plan in conjunction with “Goal 3”. The Data Review Project Team will continue to evaluate the accuracy of various sources of data that are important to Medicaid program integrity, including MCO submitted encounter data, vital statistics from BNE, DMV, and the State Department of Taxation and Finance (DTF), and data provided through various data repositories including the Medicaid Data Warehouse, Salient Data Mining Solution, and the All Payer Database. The purpose of these reviews is to ensure this data is usable to assist OMIG in its audits and recoveries. The Team represents OMIG on the Encounters Steering Committee, a committee that is accountable for governance of Encounter Intake System changes with the goal of promoting transparency, stakeholder communication and shared decision-making.

Other MCO Target Areas

New Initiatives (none)

Continuing Initiatives

- **Family Planning Chargeback:** OMIG will continue to audit claims for family planning and health reproductive services (chargebacks for family planning services) paid by MCOs for enrollees who go to non-network providers when family planning services are included in the MCO's benefit package. This topic was not included in the 2017-18 Work Plan but has been included in prior Work Plans, including most recently the 2016-17 Work Plan.
- **SIU Coordination:** OMIG will continue to work closely with MCO SIUs to better coordinate activities related to fraud investigations. MCO have a designated OMIG liaison to work with their SIU representative. OMIG liaisons meet regularly with the MCOs' SIU representative to discuss fraud, waste, and abuse-related referrals and general fraud trends. The liaison process was implemented to improve communications and increase referrals so that appropriate action can be taken to address overall program integrity. OMIG currently conducts operational surveys and onsite reviews of MCOs to determine whether SIUs are adequately performing investigative functions to detect and prevent fraud, waste and abuse.
- **Retroactive Disenrollments:** OMIG will continue to review whether MCOs are returning or voiding monthly capitation payments when consumers are retroactively disenrolled by local departments of social services (LDSSs), the NYSoH, and NYC HRA.

5. Transportation

New Initiatives (none)

Continuing Initiatives

- **Claim Integrity:** OMIG will continue to work with the NYS Department of Motor vehicles, MFCU, DOH, and the NYS Department of Transportation, to review Medicaid ambulette and taxi services claims, with a focus on whether services were properly ordered; paid services were provided; Medicaid claims were accurately submitted to eMedNY; and drivers were qualified to drive the vehicles used to provide the service.

6. Ongoing Program Integrity Activities

The 2018-19 OMIG Work Plan identifies a number of continuing initiatives, including FFS provider audits and program integrity activities that apply to all providers.

FFS Audits

New Initiatives

- **Health Home Audits:** OMIG will conduct FFS audits of Health Homes. No additional information is provided. The timing and designation of the audits as “FFS” is curious as Health Home billing is preparing to move into MCO capitation.
- **OASAS Audits:** OMIG will conduct audits of OASAS Opioid Treatment Programs.

Continuing Initiatives

OMIG will conduct audits of various FFS providers in areas of concern or to meet federal waiver requirements. While the 2018-19 OMIG Work Plan does not identify initiatives for each provider, initiatives described in prior Work Plans (most recently, the 2016-17 Work Plan) are included below for your reference, as we would anticipate OMIG would continue these initiatives as part of its oversight to ensure provider compliance with Medicaid requirements.

- **Diagnostic and Treatment Centers:** In the 2016-17 Work Plan, OMIG indicated it would continue to monitor D&TC payments for periods prior to the full implementation of APGs (i.e. prior to January 1, 2012) to determine whether services were provided, appropriate coding was used, and whether services were medically necessary. OMIG also indicated it would focus these reviews on payments for physical, speech, and occupational therapy services and HIV primary care services.
- **Durable Medical Equipment (DME):** In the 2016-17 Work Plan, OMIG indicated it would determine whether claims submitted by DME providers were submitted in accordance with Medicaid rules and regulations, whether DME equipment and supplies were authorized by a licensed practitioner, whether items were rendered for the dates billed, and that appropriate procedure codes were used in the billing process. OMIG also indicated it would identify duplicate DME dual-eligible claims submitted directly from the provider to Medicaid, and a separate claim crossed over from Medicare to Medicaid.
- **Hospice:** The 2018-19 Work Plan does not include FFS audits of hospice providers. OMIG identifies hospice as an area it hopes to expand oversight of through the Unified Program Integrity Contract (UPIC), discussed in the next section.
- **Office of Alcohol and Substance Abuse Services**
 - Outpatient Services
 - Inpatient Rehabilitation Services
- **Office of Mental Health**
 - Clinic Treatment
 - Continuing Day Treatment
 - Children’s Day Treatment
 - Partial Hospitalization

- Intensive Psychiatric Rehabilitation Program
 - Children with Serious Emotional Disturbances
- Office of Alcohol and Substance Abuse Services
 - Outpatient Services
 - Inpatient Rehabilitation Services
- Office for Persons with Developmental Disabilities (OPWDD): The 2016-17 Work Plan was the first time OMIG indicated it would begin audits of Article 16 OPWDD clinics. These clinics provide an array of clinical and medical services to individuals with developmental disabilities to allow them to remain in residential settings. Services provided include PT, OT, speech, social work, medical/dental services, and health care services such as nursing, dietetics and nutrition, audiology, and podiatry. The 2016-17 Work Plan noted that OMIG began reviewing these facilities to determine whether services are provided in accordance with Medicaid program requirements.

The 2018-19 OMIG Work Plan notes that audits will continue for the following OPWDD service providers:

- Clinical and Medical Services
 - Day and Residential Habilitation
- Pre-School and School Supportive Health Services: OMIG will continue to identify duplicate payments for School Supportive Health Services program services resulting from claims from both school districts and the Office for People with Developmental Disabilities' (OPWDD) intermediate care facilities, and will continue to audit school districts and preschool programs to ensure services provided were in accordance with individualized education plans (IEPs).
- Private Duty Nursing Agencies: The 2018-19 Work Plan indicates OMIG will conduct audits of Private Duty Nursing agencies. No additional information is provided. PDN services are medically necessary, skilled nursing services provided to eligible individuals who reside in their homes. These services are limited to licensed home care service agencies (LHCSA) or private practicing licensed practical nurses (LPN) and registered professional nurses (RN) who are individually enrolled as Medicaid providers. In the 2016-17 Work Plan, OMIG indicated its oversight of PDN services would include reviews of recipients' medical charts to ensure services were rendered for hours billed. **In light of the increased scrutiny on LHCSAs, it is likely this initiative and LHCSA oversight in general may become a key focus of OMIG this fiscal year.**

Ongoing Initiatives that apply to all Business Lines

In addition to the initiatives applicable to OMIG's five priority areas described above, OMIG has identified a number of initiatives in its 2018-19 Work Plan that apply across business lines. Relevant initiatives are summarized below.

- Self-Disclosures: OMIG will continue to encourage the use of its self-disclosure protocol to report and return overpayments.
- EHR Incentives: OMIG will conduct reviews of providers participating in the Medicaid Electronic Health Record (EHR) Incentive Payment program to ensure that participating providers meet eligibility requirements.
- Beneficiary Fraud: OMIG will continue to investigate allegations of fraud conducted by Medicaid beneficiaries, including the misuse of benefit cards, fraudulent enrollment, and drug diversion.

GOAL 3: DEVELOP INNOVATIVE ANALYTIC CAPABILITIES TO DETECT FRAUDULENT OR WASTEFUL ACTIVITIES

New Initiatives

- Improper Payments for Deceased/Incarcerated Enrollees: OMIG and DOH will be partnering with a data analytics firm to recover improper payments made on behalf of incarcerated and/or deceased recipients. Currently, OMIG maintains a database file to monitor retroactive disenrollment of enrollees with data separately provided from multiple sources to determine whether inappropriate payments have been made to an MCO due to an enrollee's death, incarceration, institutionalization, etc. While additional details about this initiative are not provided, this appears to be a new initiative to improve oversight efficiency and recoveries.

Continuing Initiatives

- SGS Contract: OMIG will continue its collaboration with Safeguard Services (SGS) through the Unified Program Integrity Contract (UPIC). The UPIC is a collaborative effort between CMS and the state Medicaid agencies that combines the previous Medi-Medi and Medicaid Integrity Contracts into one contract. Safeguard Services (SGS) has been awarded the contract to work with New York and other states in the Northeast. The 2018-19 Work Plan indicates multiple projects are in process involving data analysis, audits, investigations, and pre-payment reviews covering the following program areas: dental providers; home health; CDPAP; and opioids. Additionally, as noted earlier, OMIG is looking to expand UPIC review areas to hospice and transportation providers.
- Encounter Data Integrity: Continuing the trend of oversight and review of managed care plan reporting, OMIG will continue to perform comparative analytics of MCO encounter data and other plan-submitted data sources to assess the consistency and completeness of encounter data reporting by MCOs. This is somewhat similar to the long-standing DOH initiative that compares encounter data against Medicaid Managed Care Operating Reports (MMCORs). OMIG's Bureau of Business Intelligence (BBI) staff will continue to analyze and evaluate the integrity of encounter data.

- Medicaid Data Warehouse: OMIG analysts will continue to collaborate with DOH to improve data reporting by plans and facilitate data availability in the Medicaid Data Warehouse (MDW).
- Third Party Liability: OMIG will continue to focus on third-party recovery activities through a variety of initiatives, including pre-payment insurance verification, FFS retroactive third-party recovery, managed care third-party retroactive recovery, estate and casualty recoveries, Medicare coordination of benefits, third-party liability and commercial direct billing to ensure retroactive claims processing are performed. These activities will continued to be overseen by the Third-Party Liability (TPL) Unit and performed by OMIG's contractor, Health Management Systems, Inc. (HMS).
- Data Mining: OMIG will continue to use analytical tools and techniques, as well as knowledge of Medicaid program rules, to data mine Medicaid claims and identify improper claim conditions for potential recoveries of inappropriate Medicaid expenditures.
- Home Health and Duals: OMIG will continue to review home health claims for dual eligibles to determine whether Medicaid reimbursed services should have been paid for by Medicare. This Medicare maximization review will be conducted by OMIG in conjunction with its subcontractor, the University of Massachusetts Medical School.
- RAC Collaboration: OMIG will continue to collaborate with the CMS Medicaid Recovery Audit Contractor (RAC), Health Management Services, Inc. (HMS). During the 2018-19 Fiscal Year, HMS will focus reviews on the following:
 - Credit Balance Audit FFS and Encounter
 - Graduated Medical Education and Indirection Medical Education
 - MCO/FFS/Same Plan Overlap
 - Long-Term Care - Bed Hold Days/Net Available Monthly Income/Correct Co-insurance/Coordination of Benefit Errors/Rate Code Errors
 - Duplicate Payment of Professional Services Included in Ambulatory Patient Group Rate Code
 - Alternate Level of Care Days
 - Medicare - Inpatient Part B/Crossover Overpayment/Incorrect Reimbursement for Medicare Part C Claims (NY RAC 033)
 - Medicare Medicaid Duplicate Payment/Crossover Overpayments
 - Medicaid Payment Exceeds Billed Charge
 - Intensity Modulated Radiation Therapy Plan Unbundling
 - Duplicate Comprehensive Psychiatric Emergency Program Case Rates/Inpatient Overlap/Brief vs. Full
 - Intensive Rehab Add On
 - Ordered Ambulatory Services
 - JCode Incorrect Reimbursement
 - Home Health

CONCLUSION

We recommend that Medicaid plans and providers carefully review the 2018-19 OMIG Work Plan, with particular attention to the high-risk areas identified in this memorandum, and any additional high-risk areas that may be added to the Work Plan over the course of the year as this may indicate a new priority target for OMIG. In addition, we recommend plans and providers review and make any necessary changes to their compliance plans and incorporate relevant high-risk areas into their internal audit plans.