

Agency Programs/Activities: Inventory and Key Data
 Office of the Medicaid Inspector General

Relation to Core Mission (H/M/L)	Program/Activity	Spending Category (SO, ATL, CAP)	3/31/09 FTEs (All Funds)	General Fund Disbursements (\$000s)				State Special Revenue Funds Disbursements (\$000s)			
				2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected	2006-07 Actual	2007-08 Actual	2008-09 Plan	2009-10 Projected
H	Audit and Recoveries Activities	SO	370	\$6,338	\$7,916	\$14,824	\$18,105	\$4,186	\$4,315	\$2,847	\$2,520
H	Investigations & Enforcement Activities	SO	116.8	2,523	2,516	4,408	5,739	0	0	581	629
H	Information Technology Services, Fraud Detection and Payment Controls, Revenue Initiatives	SO	99.2	2,166	2,831	4,099	5,064	0	0	540	555
M	Administration Activities and Support	SO	65	582	1,503	2,920	2,701	0	0	385	296
M	Legal Support Services	SO	31	227	512	1,039	1,350	0	0	137	148
L	Litigation Services Provided by the Department of Law	SO	0	550	624	788	800	0	0	0	0
	Totals		682	\$12,386	\$15,902	\$28,078	\$33,759	\$4,186	\$4,315	\$4,490	\$4,148

OFFICE OF THE MEDICAID INSPECTOR GENERAL PROGRAM INFORMATION SHEET

Program: Audit and Recovery Activities

Mandate: State Statute – Chapter 442 of the Laws of 2006, including Public Health Law (Sections 30, 31, 32, 33 and 35) and Social Services Law (Sections 145 and 363). State Regulations – 18 NYCRR §515, §516, §517, §518 and §519.

Mandated Funding Level: None.

Brief Description/History/Background: The Bureau of Medicaid Audit (BMA) conducts audits and reviews of Medicaid providers to ensure compliance with program requirements, including quality of care, and to determine and recover overpayments made. The Bureau's primary responsibility is to ensure that Medicaid expenditures are utilized for their intended purpose and that the services provided to Medicaid clients are meeting program requirements. The Bureau conducts billing audits of Medicaid providers paid on a fee-for-service basis, as well as rate-based facilities providing outpatient services. Additionally, financial audits and desk reviews of cost reports used to set rates for Medicaid providers are conducted. The BMA organizes and coordinates statewide projects to address the broad spectrum of Medicaid-covered services and the various program initiatives of the Department of Health (DOH), Office of Mental Health, Office of Mental Retardation and Developmental Disabilities (OMRDD), and the Office of Alcoholism and Substance Abuse Services.

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

On July 26, 2006, Chapter 442 of the Laws of 2006 was signed, which established the OMIG as a separate, independent entity within the DOH. This legislation amended several existing statutes to accomplish the reform needed to effectively fight fraud, waste and abuse in the Medicaid system (see Mandate Section above). The OMIG, through audit, investigative, fraud detection and enforcement efforts, recovers State funds that have been inappropriately claimed by individuals and providers. To assist achieve its mission, the OMIG is expanding its audit capabilities and conducting and expanding its audits of rate-based providers and other service areas, which have had no or diminished/minimal comprehensive audit activity over the past few years. The OMIG will also be assuming the responsibility for audits of OMRDD programs currently conducted by OMRDD staff.

Issues: The OMIG continues to embark upon an aggressive campaign to recruit, hire and retain qualified audit staff in an effort to reach its currently authorized personnel target of 753 positions. These staff are critical to assisting the OMIG meet its prescribed Federal-State Health Reform Partnership (F-SHRP) milestones and 2008-09 Audit Plan target of \$675 million (State share). The 2006 F-SHRP Agreement between New York and the Federal Centers for Medicare and Medicaid Services (CMS) requires that New York – through September 30, 2011 – identify specific provider recoveries (excluding cost avoidance savings) greater than those realized by any state in the 40 year history of the Medicaid program. The annual identified F-SHRP recovery amount, which New York must achieve by September 30, 2008 is \$215 million. However, the recent CMS announcement that the State cannot count voided claims as part of its F-SHRP recoveries requires the OMIG to achieve additional recoveries in other areas. Accordingly, it is vital that the additional audit staff provided in the 2008-09 Budget be filled as soon as possible.

Population Served: New York State taxpayers, Medicaid recipients and the healthcare provider community.

Performance Measures: Audits Initiated (281), Audits Completed (183) and Recoveries Identified (\$17.8M) -- reflects the period April – June 2008.

OFFICE OF THE MEDICAID INSPECTOR GENERAL PROGRAM INFORMATION SHEET

Program: Investigations & Enforcement Activities

Mandate: State Statute – Chapter 442 of the Laws of 2006, including Public Health Law (Sections 30, 31, 32, 33 and 35), Social Services Law (Sections 145, 363 and 367) and Executive Law (Section 835). State Regulations – 18 NYCRR §515 and §518.

Mandated Funding Level: None.

Brief Description/History/Background: This Bureau of Investigations & Enforcement (BIE) ensures the integrity of the Medicaid Program by conducting investigations into provider and recipient fraud, which may result in administrative actions (e.g., exclusion from participating in the Medicaid Program), recovery of overpayments, the imposition of penalties through civil and administrative proceedings, or referral for criminal prosecution. Suspected provider fraud is generally referred to the New York State Attorney General's Medicaid Fraud Control Unit (MFCU) and suspected client fraud is generally referred to fraud units within local social services districts that interface with the local district attorney. The BIE also identifies recipients who abuse services and where appropriate, restricts recipients to a primary care provider under the Restricted Recipient Program. The Bureau works with local agencies to prosecute recipients who commit such illegal acts as sharing recipients' identification cards or engaging in drug diversion activities.

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Issues: The OMIG continues to embark upon an aggressive campaign to recruit, hire and retain qualified staff in an effort to reach its currently authorized personnel target of 753 positions. This includes over 60 investigations and enforcement positions yet to be filled. These staff are critical to assisting the OMIG meet its prescribed Federal-State Health Reform Partnership (F-SHRP) milestones. The 2006 F-SHRP Agreement between New York and the Federal Centers for Medicare and Medicaid Services (CMS) requires that New York – through September 30, 2011 – identify specific provider recoveries (excluding cost avoidance savings) greater than those realized by any state in the 40 year history of the Medicaid program. The annual identified F-SHRP recovery amount, which New York must achieve by September 30, 2008 is \$215 million. The recent CMS announcement that the State cannot count voided claims as part of its F-SHRP recoveries requires the OMIG to achieve additional recoveries in other areas. Accordingly, it is vital that additional investigations staff provided in the 2008-09 Budget be filled as soon as possible.

BIE staff will work closely in the current year and future years with county local districts of social services to provide training, statewide leadership and expertise relative to the investigation of beneficiaries who defraud the State Medicaid Program.

Population Served: New York State taxpayers, Medicaid recipients and the healthcare provider community.

Performance Measures: Provider and beneficiary investigations opened (729), provider exclusions (159), provider terminations (11), enrollment denials (31), provider referrals to the Attorney General's Medicaid Fraud Control Unit and other agencies (11), beneficiary referrals (94). Reflects the period April 2008 – June 2008.

OFFICE OF THE MEDICAID INSPECTOR GENERAL PROGRAM INFORMATION SHEET

Program: Information Technology Services, Fraud Detection and Payment Controls, Revenue Initiatives

Mandate: State Statute – Chapter 442 of the Laws of 2006, including Public Health Law (Sections 30, 31, 32, 33 and 35) and Social Services Law (Sections 145 and 367).

Mandated Funding Level: None.

Brief Description/History/Background: The Division of Information Technology provides a myriad of information technology and systems support services to the OMIG and its employees, and oversees vital program activities to assist combat Medicaid fraud, waste and abuse. This Division sponsors the procurement and implementation of commercial software products, which enhance the OMIG's ability to conduct sophisticated data mining and data analysis for identification of difficult-to-detect instances of Medicaid fraud and abuse. This Program is also responsible for the oversight of the designation of certain providers to participate in the Cardswipe and/or Post & Clear Programs. The Cardswipe Program was developed to reduce the incidence of recipient card loaning and theft by unauthorized or Medicaid ineligible individuals. The Post & Clear Program reduces the incidence of stolen prescriptions by requiring prescribers to post the prescriptions they write on the eMedNY Medicaid Eligibility Verification System, and requiring pharmacies to clear the prescriptions before they are dispensed. This Division performs vital prepayment review functions (e.g., Edit 1141) and third party recovery activities, which generates significant cash and cost avoidance savings for the State.

On July 26, 2006, Chapter 442 of the Laws of 2006 was signed, which established the Office of the Medicaid Inspector General (OMIG) as a separate, independent entity within the Department of Health (DOH). This legislation amended several existing statutes to accomplish the reform needed to effectively fight fraud, waste and abuse in the Medicaid system (see Mandate Section above). The OMIG, through audit, investigative, fraud detection and enforcement efforts, recovers State funds that have been inappropriately claimed by individuals and providers. The Office is expanding its front end editing and prepayment review functions, as well as the Cardswipe Program and Post & Clear Program. Additionally, the OMIG continues to increase its data mining capabilities, including in the areas of systems analysis and contractor oversight initiatives.

The OMIG is moving forward with the disengagement of the OMIG systems/technology infrastructure from the DOH infrastructure, and will contract for services with the Office for Technology to provide the necessary expertise, management and support required to implement and maintain the OMIG network infrastructure.

Issues: The OMIG continues to embark upon an aggressive campaign to recruit, hire and retain qualified staff in an effort to reach its currently authorized personnel target of 753 positions. This includes critical systems development/analysis and data mining staff. These staff are critical to assisting the OMIG meet its prescribed Federal-State Health Reform Partnership (F-SHRP) milestones. The 2006 F-SHRP Agreement between New York and the Federal Centers for Medicare and Medicaid Services (CMS) requires that New York – through September 30, 2011 – identify specific provider recoveries (excluding cost avoidance savings) greater than those realized by any state in the 40 year history of the Medicaid program. The annual identified F-SHRP recovery amount, which New York must achieve by September 30, 2008, is \$215 million. The recent CMS announcement that the State cannot count voided claims as part of its F-SHRP recoveries requires the OMIG to achieve additional recoveries in other areas. Enhancing the OMIG's systems development and data analysis capabilities and skills is critical to this effort. The OMIG is improving its focus on data mining and is using more sophisticated methods to discover data relationships to assist identify providers who demonstrate aberrant behavior, which demands a closer look through investigation and/or audit.

Population Served: New York State taxpayers, Medicaid recipients and the healthcare provider community.

Performance Measures: Cash and cost avoidance savings achieved through third party recovery activities and various system edits (counted towards OMIG Audit Plan Target) -- \$131.7M (State Share) for the period April 2008 through June 2008.

OFFICE OF THE MEDICAID INSPECTOR GENERAL PROGRAM INFORMATION SHEET

Program: Executive/Administration Activities and Support

Mandate: State Statute – Chapter 442 of the Laws of 2006, including Public Health Law (Sections 30, 31, 32, 33, 34 and 35) and Executive Law (Section 835). State Regulations – 18 NYCRR §518.

Mandated Funding Level: None.

Brief Description/History/Background: The Executive/Administration Activities and Support function provides executive leadership and general administrative and support services to the Office of the Medicaid Inspector General and its employees. The Division of Administration is responsible for the OMIG's budget planning, execution, management and reporting processes; provides information, procedures and guidance on the Office's accounting, payroll, travel, purchasing; contracting and payment activities and processes; oversees and conducts all collections activities resulting from audits and investigations conducted by the Bureau of Medicaid Audit and the Bureau of Investigations & Enforcement; assists in the planning, coordination, development and implementation of all activities related to the human resources areas; provides operational and logistical support relative to OMIG buildings/structures and employees (e.g., processing of mail, provisioning of office supplies, coordination of all aspects of leased and State-owned office space); and conducts required internal controls activities.

On July 26, 2006, Chapter 442 of the Laws of 2006 was signed, which established the Office of the Medicaid Inspector General (OMIG) as a separate, independent entity within the DOH. This legislation amended several existing statutes to accomplish the reform needed to effectively fight fraud, waste and abuse in the Medicaid system (see Mandate Section above). The OMIG, through audit, investigative, fraud detection and enforcement efforts, recovers State funds that have been inappropriately claimed by individuals and providers. Due to the lack of necessary administration staff, however, critical personnel and finance activities were performed ("hosted") by the Division of the Budget (DOB). The 2007-08 and 2008-09 State Budgets have provided additional funding and personnel target authorization to support essential new administration positions. By April 2008, all personnel (excluding employee/labor relations activities) and finance activities previously performed by the DOB were transferred to the OMIG. This has created a significant workload burden on an already burgeoning area of responsibility.

Issues: The OMIG continues to embark upon an aggressive campaign to recruit, hire and retain qualified staff in an effort to reach its currently authorized personnel target of 753 positions. However, as with any newly established State agency, this process is complex and lengthy. The OMIG is working with the Department of Civil Service to increase its candidate pools and improve recruitment efforts through a variety of measures, including an aggressive outreach program targeting colleges and universities across New York State and an expedited hiring process for Auditor Trainees. Through these programs and initiatives, it is anticipated that the OMIG will fill a total of 682 Full Time Equivalent positions by March 31, 2009 and 753 positions by June 2009. The OMIG is also pursuing its own, separate appointing authority from the Department of Health – consistent with existing State statute.

The Centers for Medicare and Medicaid Services (CMS) requires that New York – through September 30, 2011 – identify specific provider recoveries (excluding cost avoidance savings) greater than those realized by any state in the 40 year history of the Medicaid program. The 2006 Federal-State Health Reform Partnership (F-SHRP) recovery target that New York must achieve by September 30, 2008 is \$215 million. However, the recent CMS announcement that the State cannot count voided claims as part of its F-SHRP recoveries requires the OMIG to achieve additional recoveries in other areas. The OMIG Collections Unit is aggressively monitoring all collection activities in an effort to ensure that prescribed FSHRP milestones are met.

Population Served: New York State taxpayers, Medicaid recipients and the healthcare provider community.

Performance Measures: Number of filled positions – 536 as of August 6, 2008.

OFFICE OF THE MEDICAID INSPECTOR GENERAL PROGRAM INFORMATION SHEET

Program: Attorney and Legal Support Services

Mandate: State Statute – Chapter 442 of the Laws of 2006, including Public Health Law (Sections 30, 31, 32, 33, 35 and 36), Social Services Law (Sections 145 and 363). State Regulations – 18 NYCRR §518 and §519.

Mandated Funding Level: None.

Brief Description/History/Background:

The Office of Counsel (OOC) provides day-to-day internal legal advice and representation to the Office of the Medicaid Inspector General (OMIG). The OOC represents the OMIG in administrative litigation, including challenges to OMIG findings of overpayments, sanctions, program exclusions and civil monetary penalties. The OOC also issues appeals decisions of immediate exclusions and works with the Office of the Attorney General to represent the OMIG in litigation pending in court. The OOC is also responsible for drafting legislation and regulations to strengthen the OMIG's mission and efforts, and compliance guidance specific to particular types of providers; providing legal advice and support regarding Freedom of Information requests; assisting all OMIG program areas, including the Bureau of Medicaid Audit and Bureau of Investigations & Enforcement to develop audit and investigations procedures and protocols, provide training to staff regarding legal issues, drafting subpoenas, and addressing legal issues arising in the planning and conducting of audits and investigations; and assisting the Division of Administration with legal issues involving human resources, labor relations, and contract issues.

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Issues:

The OMIG continues to embark upon an aggressive campaign to recruit, hire and retain qualified staff in an effort to reach its currently authorized personnel target of 753 positions. The lack of viable civil service lists and qualified candidates has made it difficult to fill critical attorney and legal support positions. As a result, the OOC remains understaffed, which impedes the OMIG's ability to conduct hearings on a timely basis thereby affecting the Office's ability to finalize overpayment determinations and obtain recoveries; finalize sanctions, recoup penalties and exclude providers from the Medicaid Program; provide needed legal advice to the Bureau of Medicaid Audit, resulting in delays in the issuance of audit findings; meet statutory obligations to issue compliance guidance; and develop regulations to strengthen recoupment efforts.

Population Served: New York State taxpayers, Medicaid recipients and the healthcare provider community.

Performance Measures: Continuous progress on the OMIG's legislative and regulatory agendas -- through June 2008, 2 regulations/statutes were proposed and 2 were enacted. Administrative cases resolved -- in calendar year 2007, approximately 31 administrative cases were resolved by hearing decision or settlement agreement, and approximately 67 appeals decisions rendered. There are approximately 175 cases pending administratively or in court. These types of cases are rising dramatically due to increased enforcement activity by the OMIG. For example, eight of the 41 currently pending court lawsuits were filed within the past month.

**OFFICE OF THE MEDICAID INSPECTOR GENERAL
PROGRAM INFORMATION SHEET**

Program: Litigation Services Provided by the Department of Law (DOL)

Mandate: State Statute – Executive Law (Section 63) states that the Attorney General shall "prosecute and defend all actions and proceedings in which the state is interested, and have charge and control of all the legal business of the departments and bureaus of the state, or of any office thereof which requires the services of attorney or counsel".

Mandated Funding Level: None.

Brief Description/History/Background:

The 2008-09 Office of the Medicaid Inspector General (OMIG) Budget includes a General Fund appropriation of approximately \$1.7 million to support services and expenses incurred by the DOL in litigation representing the OMIG, including services and expenses for outside experts and other expenditures. A Memorandum of Understanding (MOU) between the OMIG and DOL was executed in January 2007 to support the DOL efforts to pursue both affirmative and defensive Medicaid related cases. Pursuant to the MOU, the terms of the agreement shall be automatically renewed for one year terms – consistent with the State Fiscal Year period -- provided that the DOL submit a revised expenditure plan for each year of the MOU.

The DOL representation of State agencies in matters of litigation is a statutory requirement (see Mandate Section above). Actual spending by the DOL in this area over the past few years has been significantly below appropriated amounts. State Fiscal Year 2008-09 spending is also anticipated to result in additional General Fund savings.

Issues:

Since its inception, the OMIG has been working with the DOL to ascertain the actual Medicaid fraud cases litigated and relative outcomes, as well as current litigation efforts being performed by the DOL on behalf of the OMIG. Information provided has been limited. A meeting has been scheduled with the DOL to further discuss this issue as well as projected 2008-09 spending.

Population Served: New York State taxpayers, Medicaid recipients and the healthcare provider community.

Performance Measures:

Medicaid fraud cases litigated on behalf of the OMIG. The level of activity performed by the DOL is currently unclear pending detailed information on the cases litigated on behalf of the OMIG (see "Issues" Section above).