

Client Alert

A report
for clients
and friends
of the Firm **May 2008**

OMIG Medicaid Work Plan for SFY 2008-09

On April 18, 2008, James G. Sheehan, the Medicaid Inspector General for the State of New York, issued the first official work plan of the Office of the Medicaid Inspector General (“OMIG”) for the 2008-2009 state fiscal year. Established by statute in November 2006, the OMIG is tasked with coordinating Medicaid fraud, waste and abuse control activities in order to recover state funds improperly claimed by individuals and providers.

The work plan offers an ambitious agenda for the OMIG, including audits on a variety of health care providers, fraud and abuse investigations, and data mining. The recovery of state funds is a particularly important aspect of the work plan because of the agreement entered into between the State of New York and the Center for Medicare and Medicaid Services (“CMS”) in 2006, which required the State to identify fraud and abuse recoveries of \$215 million in federal fiscal year 2008, with mandated recoveries increasing each year until reaching \$644 million in 2011. The penalty for failing to meet those goals is repayment by New York to the federal government of the difference between each year’s goal and the amount actually recovered. Effectively, New York paid \$1.50 for every \$1.00 received (up to mandated amount).

Audits

According to the work plan, the OMIG plans to undertake extensive audits of health care entities to determine compliance with applicable New York regulations. Health care entities subject to review include home health agencies, hospitals, nursing facilities, managed care plans, pharmacies, and durable medical equipment providers.

As part of this auditing process, the OMIG will review Medicaid payments and provider records to ensure documentation of the justification for certain services,

such as the need for ambulatory surgery services and the medical necessity of prescriptions for drugs covered by Medicaid. In addition, the OMIG will focus on improper billing practices, such as upcoding to obtain higher reimbursement, lack of proper authorization for billed services, and duplicate billing for services covered under a facility’s capitated rate. The OMIG also plans to conduct data mining to identify other trends leading to Medicaid overpayment.

According to the work plan, the OMIG will verify that the personnel of certain facilities, such as adult day health care centers and home health agencies, meet the necessary licensure and regulatory requirements.

The OMIG plans to work together with other state agencies, such as the Office of Alcoholism and Substance Abuse Services (“OASAS”) and the Office of Mental Health (“OMH”), to review Medicaid payments for compliance with Medicaid reimbursement regulations.

In addition, the OMIG continues participation in the CMS five-year pilot demonstration project related to home health care services. The purpose of this demonstration project is to determine the Medicare share of the cost of the home health service claims for dual-eligible beneficiaries that were inadvertently submitted to and paid by the Medicaid agencies.

Data Analysis

The OMIG’s Division of Information Technology plans to expand and improve upon its data mining efforts in order to identify targets of improper Medicaid payments. Specifically, the OMIG will focus on the identification of recipient duplicates, matching recipients with vital statistics data, and analyzing the pool of active and sanctioned providers. The OMIG plans to improve the quality and capacity of its data mining efforts in order to identify systemic issues where providers bill claims improperly.

The OMIG is also seeking to expand its Cardswipe and Post & Clear programs, which track the prescription and laboratory orders of certain designated providers. For example, the OMIG plans to add an additional 2,000 providers to the Cardswipe program.

The OMIG will continue its involvement in the CMS-sponsored Medi-Medi Project, which was established to detect and prevent fraud and abuse in the Medicare and Medicaid programs. As part of this project, the New York Medicare Medicaid Data Analysis Center will perform computerized matching and analysis of Medicare and Medicaid data to identify a variety of billing issues.

Investigation & Enforcement

The OMIG's Bureau of Investigations and Enforcement ("BIE") is responsible for overseeing the investigations of fraud and abuse related to the New York State Medicaid program. The OMIG work plan specifically identified several investigative focus areas for the 2008-09 state fiscal year, including the Beneficiary Fraud Unit (which investigates hotline complaints alleging recipient fraud) and a program to exclude providers from participating in Medicaid as a punishment for fraud and abuse.

Importantly, the BIE plans to investigate health care fraud related to Medicaid billings for services not rendered, claims that manipulate payment codes to improperly increase reimbursement, and false claims submitted to obtain Medicaid funds. Other areas of investigative focus include business arrangements allegedly violating the federal Anti-Kickback Law and Stark Law. The BIE will continue to investigate attempts to illegally distribute Medicaid-reimbursable prescription drugs. Furthermore, the BIE will review quality-of-care issues for Medicaid beneficiaries residing in nursing facilities.

Other units of the OMIG will continue to monitor and evaluate the efficiency, effectiveness, and use of Medicaid program services by both Medicaid beneficiaries and providers.

Legislation & Regulation

The Office of Counsel ("OOC") of the OMIG drafts legislation, regulations and compliance guidance. According to the work plan, the OOC plans to issue regulations implementing the Social Services Law §363-d compliance program requirements. The OOC will also issue compliance program guidance specific to certain types of providers.

Conclusion

Based on the ambitious work plan issued by the OMIG, providers and entities participating in the Medicaid program should expect significant enforcement activity by the OMIG in the upcoming years. This is especially true considering the State of New York's looming repayment requirements to the federal government and the OMIG's aggressive enforcement actions to date. We advise Medicaid providers to review their compliance programs and ensure that billing practices conform to the auditing and investigative areas of focus outlined in the OMIG's work plan.

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